THE REORGANIZATION OF THE SCHOOL OF ALLIED HEALTH SCIENCES
AT WHITMAN UNIVERSITY: A CASE STUDY

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Dedication

Throughout the course of one’s life certain individuals play key roles in shaping who and what we become. There is one individual whose influence, mentorship and friendship played a major role in preparing me for not only academic life, but life’s challenges as well. It is with the greatest respect and gratitude that I dedicate this work to my high school science teacher, Mrs. Elaine King. She was the one who first introduced me to the scientific method and was the first to spark my interest in pursuing the ideal of becoming someone who could make a difference. She recently passed on to greater things and I am sure she is more alive now than ever.
Acknowledgements

Foremost, I want to express my sincere and greatest appreciation to my committee chairperson, Dr. Nancy Chism. Without her guidance and encouragement this study would not have been possible. She, with word and deed, exemplifies the best practice of a committee chair. From her example, it will be my aspiration to encourage and assist my students in a similar manner. I also want to thank the rest of my committee for their guidance, patience and excellent suggestions throughout the process.

I owe a great debt of gratitude to the faculty, staff and administration of the School of Allied Health Sciences. Their trust in me and the candor they put forth during the course of the interviews was paramount to the execution and completion of this study.

The encouragement, prayer and support given to me by family and friends inspired me to persevere and see this project to completion. I would also like to acknowledge my two daughters Ally and Sarah, who played pivotal roles as encouragers and provided the inspiration for me to finish what I had started. In particular, Sarah’s excellent editorial assistance played a key role in the completion of the manuscript. She reminded me of the value of an English degree and I will not forget it.

Of course, without the instruction and mentorship of past professors and teachers this work would not have been possible. I wish I had space to thank them all. However, it was the words of Dr. Gilbert Brown that I remember best. On one dismal day when I was discouraged with the amount of time it was taking me to get everything done, he reminded me that “the tortoise finished the race too.”
William Nelson Crabtree

THE REORGANIZATION OF THE SCHOOL OF ALLIED HEALTH SCIENCES AT WHITMAN UNIVERSITY: A CASE STUDY

This study employed a case study design to explore the phenomena surrounding the reorganization of a School of Allied Health Sciences (SAHS). Using qualitative research methods, three structural categories of interest—internal forces, external forces, and leadership—were identified to guide the data collection and analysis. The themes within each structural category were then identified and categorized. Data analysis was accomplished via a framework of organizational theories. The significance of this study is found in its applicability to the cases of other schools of allied health sciences, which are experiencing financial and identity challenges nationwide.

The reorganization of the SAHS was a two-year process involving multiple procedural steps with complex manifestations. The leadership of the school was found to be the most dominant structural category characterizing the nature of the school’s reorganization process. Internal and external forces were contributing factors, but were less influential than the role of leadership. Organizational change during the school’s reorganization was influenced greatly by the communication disconnect between the Dean and the faculty, specifically the perception that the Dean’s academic and budgetary plan was not the result of a rational decision making process and lacked validity. The overall organizational problem of the SAHS was found to be an identity problem whereby the SAHS was trying to fulfill its academic mission as part of the medical school and the economic reality of this context.
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Chapter 1: Introduction

The Whitman University School of Allied Health Sciences (SAHS) as part of a large academic health center (AHC) finds itself being forced into reorganization due to dire financial exigencies. The SAHS is composed of traditional academic allied health programs granting Associate, Baccalaureate and graduate degrees. The mandated closure of the SAHS represents the end stage of a decade-long experiment in higher education. The experiment began when the school moved toward an “incubator” school status within its parent school, the School of Medicine, in the early 1990s. This “school within a school” configuration was to allow the SAHS to eventually become a freestanding school, or academic unit. The outcome of this experiment in organizational change represents a common theme now occurring across the country. Schools of allied health are finding it difficult to survive due to internal and external forces within today’s academic health center environment.

Purpose of the Study

The purpose of this dissertation will be to “tell the story” of the reorganization of the SAHS at a large Midwestern academic health center located in Whitman University. The specific focus of this study will be to demonstrate how the reorganization progressed by illuminating the life cycle of this academic hybrid of a “school within a school.”

Significance of the Study

A review of the literature has revealed that there has not previously been a research study similar in scope and methodology related to an allied health school in this context. The significance of this research is that it is an original inquiry into an important

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1 Whitman University is a fictitious name that will be used in place of the name of the actual university studied to help maintain the study participants’ anonymity.
trend in academic medicine. Thus, this research effort offers perspectives on the utility of organizational models in analyzing similar cases. It also provides insights that can help other allied health schools facing similar problems to anticipate what lies ahead so that they can prepare strategies for change.

*Conceptual and Operational Orientation*

An in-depth investigation of the SAHS will serve as the core of inquiry, forming the premises for a case study exploring the phenomena surrounding the reorganization of the school. Three separate structural categories will be used to characterize the forces contributing to the school’s reorganization and to guide the data collection and analysis while keeping the study within feasible limits: internal forces, external forces and leadership.
Chapter 2: Literature Review

Introduction

The SAHS was situated in the rapidly changing environment of a large academic health center (AHC) located in an urban setting. Forces within this environment have played an important developmental role in shaping the personality and organizational characteristics of the school. Moreover, the SAHS has had to struggle with a generic allied health identity problem, which plagues most schools of allied health nationally. Historically, allied health programs have been placed in a myriad of homes including nursing schools, medical schools, schools of agriculture as well as schools of allied health. They consist of multiple units that range from technology associates degrees to the doctorate, and the variety of programs constituting allied health differs from one campus to another. So, it is hard to say that there is any one consistent interpretation of what defines a school of allied health. Therefore, in order to gain an understanding of the factors that led to the school’s reorganization, it is important to appreciate not only the environment in which the school existed but to also have an understanding of the conglomerate of health professions known as allied health along with the unique aspects of allied health education. This chapter will review the literature related to these themes and discuss some of the basic aspects of leadership in an academic health center as a means to develop the background for the case study. Additionally, organizational aspects of colleges and universities relevant to the context of the case study will be reviewed.
Academic Health Centers

Purpose, Mission and Role of Academic Health Centers

The goal of medical education is to prepare health care professionals to meet the challenges of practice by fulfilling their roles as clinicians, educators and resource managers (Gonnella, Callahan, Louis, Hojat, Erdman, 2004). Academic health centers have an important role in providing an infrastructure and expertise for both education and health services research. Today’s academic health center is a complex of institutions that educates health professionals, including a university, a medical school, at least one other health professional school and one or more teaching hospitals (Kimmey, 1994). There are over 121 centers in the United States that meet this definition. AHCs are the principal facilities for health professions education, medical and health services research and complex medical case management. AHCs offer a wide array of programs including both undergraduate and graduate medical education and training for other health professions along with related education and research activities. Moreover, academic health centers have had their mission expanded recently as part of homeland defense and the war on terrorism (Eastwood, 2003). In the event of a national disaster, AHCs will be the first responders for delivering healthcare to the injured. In addition to their academic mission, AHCs provide care for the underserved, specialized treatment and community service (Stevens, Lynm, and Glass, 2004). Unfortunately, this system has gotten into trouble as the economy has weakened and changed. Tuition revenues have failed to provide the resources to cover the costs of medical education including the cost of maintaining large teaching hospitals and research facilities.
What is happening today in AHCs is in many ways a reflection of what is occurring in higher education in general: trying to do more with less. However, there are certain characteristics of AHCs that distinguish them from mainstream higher education. Their social responsibility in terms of their service roles to patients and their communities has a profound effect on the functioning of faculty within that framework.

Organizational influences outside the academy, including the effects of managed care also play a role in distinguishing AHCs from the rest of academe. Nevertheless, AHCs are part of the academy and their citizens are part of the academic ethic described by Shils (1983), whereby “the academic ethic is the sum of these obligations which are involved in the pursuit and transmission of advanced knowledge and in roles and in conduct affected by the real or presumed possession of such knowledge.” A study conducted in the late 1990s by the Association of Academic Health Centers was performed to determine the response of academic health centers to their rapid and dramatic evolution (Osterweis, 1998). The study focused primarily on issues surrounding changes in the overall organization, structure and governance of AHCs. The overwhelming impression from these findings is that many academic health centers are making profound changes in every aspect of their organizations to cope with the new health care environment while remaining academic in mission.

Historical Perspective

John White (1997) views the function of the AHC as vocational education by its very nature and poorly adapted to other ideals. So where does the mission of the academic health center fit in the overall purpose and mission of higher education? Perhaps the research mission of the AHC would fit into this “scheme of things” but isn’t
medical education just another form of vocational education? During the early years of American higher education, medicine was considered one of three professions, the others being divinity and law (Rudolf, 1990). However, one of the characteristics of the university movement, which occurred during the early to mid 1800s, was the blurring of the connotation of profession and that of vocation. Recognition of the need for a more broadly practical education was emerging. It was also during this period that universities assumed the responsibility for providing formal professional education. Vocationalism or career preparation was one way for American higher education to enter into the life of the people due to the expansion of the number of careers that were in demand that required formal study and instruction (Rudolf, 1990). Interestingly, the university movement did not actually intrude upon the spirit of professionalism. The American college was still considered preprofessional. After all, it was in 1765 that the first professorship in medicine appeared at the College of Philadelphia. However, what did happen as a result of the university movement was that many colleges entered into alliances or federations with already existing medical schools, particularly in the cities, resulting in the beginnings of what we consider today to be academic health centers.

When reviewing the historical context of the purpose and mission of American higher education, it appears that then as now, the same issue is before us and that the defining statement for higher education in America is as elusive as ever. Clark Kerr points out that we are a “multiversity” (Lucas, 1996). If academic health centers are included in the overall scope of American higher education as they should be, then multiversity certainly applies.
Current Conditions

Today, AHCs in the United States generally consist of multiple institutions sharing the missions of education, research, and patient care. The relationship between medical schools and their teaching hospitals involves a complex and variable mixture of monopoly and monopsony (market) power (Chervenak and McCullough, 2005). Medical schools rely on teaching hospitals for the placement of their students. Thus, the teaching hospital becomes a powerful force, making negotiations with the medical school more challenging. The organizational structure is generally characterized as “loose” with most departments having considerable autonomy (Norlin and Osborn, 1998). Although there are many differences in their makeup, most centers include: (1) health professional schools, e.g., medicine, nursing, pharmacy, allied health, dentistry, (2) hospitals and clinics, and (3) research facilities. All of these aspects represent part of the center’s entire academic mission. The school’s mission generally centers on education, patient care and research. The faculty are links to all components of the center’s academic mission. The medical schools and their faculty usually represent the home of most of the leaders of the medical center. Strong centralized leadership is not characteristic of most academic medical centers (Norlin and Osborn, 1998). Other components, e.g., private practices, community hospitals, health maintenance organizations and research foundations are included in the missions of education and research. The connection of these entities to the academic side range from tightly coupled to independent.

What Are the Driving Calls for Change and Reform?

Academic health centers have faced well-documented internal and external challenges over the past decade, putting pressure on organizational leaders to develop new strategies to improve performance, educational outcomes and research growth (Kirch, et al., 2005). Financing health professions education is a complex undertaking that involves multiple funding sources. In fact, a recent report indicates that AHCs have
“missed the boat” and have failed to increase their competitiveness and efficiency (Roszak, 2000). Another study examining the competitive market dynamics on AHCs between 1994 and 2000 found that AHCs now have fewer financial resources and that resources have decreased to the point where AHCs may no longer be able to fulfill their social missions (Dodson, Koenig, Sen, Ho, and Giliani, 2002). State funding for AHCs in particular is a concern where 22% of AHCs reported closing or downsizing educational programs (Neff, 2003). Academic health centers and other teaching hospitals have higher patient care costs than nonteaching community hospitals because of their missions of research, education and patient complexity (Koenig, Dobson, Ho, Siegel, Blumenthal, Weissman, 2003). Clearly, the most dominant external driving call for reconsideration of the AHC model is the challenge put upon these centers by managed care. Although the challenges put on the AHCs by managed care encompass all aspects of the center’s mission, the main concerns are the resulting financial constraints. AHCs must now ask themselves the question; “What financial condition must we achieve to allow us to accomplish our mission?” (Zelman, Blazer, Gower, Bumgarner, and Cancilla, 1999).

**Academic Health Centers and Managed Care**

Escalating economic pressures on the clinical enterprise threaten the missions of education and research in many academic health centers (Pellegrini, 2001). Managed care and current governmental policies have had a negative impact, especially on urban academic health center reimbursement (Rodriguez, Peterson, Muehlstedt, Zera, West and Bubrick, 2001). The health care market dynamics that support and direct the growth and development of the AHC have changed dramatically over the past several years (Norlin and Osborn, 1998). Their various missions, including education, research and care for patients, are at risk. The missions of education and service to communities and the underserved have always suffered during the evolution of the AHC; they are even more threatened by the emergence of managed care. Third party payers can often dictate their reimbursement amounts, thus greatly affecting the economics of the AHC.
The “special niche” that AHCs once had as innovative and high-tech institutions has slowly eroded as local hospitals have started offering similar services. Thus, new financial pressures as a result of increasing competition are endangering the “academic mission” of the centers. Ultimately, the teaching and academic mission of the centers will have to be open to examination and questions (Reuter, 1995). Academic institutions are typically resistant to change. Redefining the unique mission and organizational structure are future issues for AHC leaders (Harris, DaRosa, Liu and Hash, 2003).

Academic health centers currently face the greatest challenges since their inception. Managed care, increased competition for research funding and inefficiencies all contribute to their present vulnerability (Wilson, 1996). Additionally, their increased reliance on clinical income to subsidize research jeopardizes the success of their missions (Wilson, 1996). The mission, indeed the very existence of the traditional AHC is under siege according to Weitekamp, Thorndyke and Evarts (1996). They insist that the survival of AHC depends on its ability to change. They call for organizational redesign, creation of strategic partnerships and adopting a cybernetic model of continuous measurement along with improvement and adaptability. Others have also called for a broader health science vision and greater collaboration (Bulger, 1996). Another problem that burdens many AHCs is bureaucratic red tape, which reduces their ability to respond to the demanding health care market. In fact, the Oregon Health Sciences University has chosen to change its structure from being part of the state system of higher education to being an independent public corporation (Alexander, Davis, and Kohler, 1997). As just illustrated, the challenges facing AHCs represent concerns that threaten their very existence. Similarly, faculty at these centers are seeing the challenges to their traditional faculty roles as no less of a threat to the health and viability of the AHC.
The Challenges to Faculty Roles at Academic Health Centers

Although health care education clearly benefits from a rich environment including research and patient care, faculty often find themselves in conflicting roles in the complex mix of activities in the academic health center (Howell and Karimbux, 2004). Partly because of the managed care movement and the overall assessment movement in higher education, AHC faculty are finding themselves under more external scrutiny and under greater demands for accountability. Internally, the most pressing calls for change are centered on faculty issues relating to the erosion of tenure and tenure track positions at AHCs and their replacement with nontenure track clinical ranks. As AHCs and universities face budget shortfalls, administrators are seeking ways to become more flexible and adaptable to changes in the marketplace, according to Dr. Christine M. Licata (Ellis, 1999). However, these types of changes are affecting faculty all across the academy, not just in AHCs. Administrators in all departments are seeking ways to cut costs and have greater flexibility. One of the common threads in this milieu is the attack on tenure and tenure track positions.

Across academia, faculty are finding their more traditional roles coming under attack from many different directions. Many AHC administrators now view traditional faculty roles as arcane and unrealistic in today’s rapidly changing academic environment. The now classic work by Shils (1983) is an exhaustive examination of the academic profession. It has served as a template for what comprises academic work for many institutions since its publication. The author states that the report is intended to contribute to the reanimation of discussion regarding the proper end of academic persons and academic institutions. The primary premise of this work is that the academic ethic is the
“sum of obligations, which are involved in the pursuit and transmission of advanced knowledge.” Today, many AHC deans are in effect dissecting the faculty roles into subspecialties whereby some will be given the opportunity to pursue, acquire, and generate knowledge (in this case the research scientist) and others will have the responsibility for facilitating learning (clinical faculty). Separating these faculty roles in this manner, says Shils, dilutes the effectiveness of the unified approach, which helps to distinguish between truth and falsity. For example, Shils says that critical assessment of the knowledge becomes difficult. The clinically oriented faculty will for the most part be engaging in “vocational” technical education (Shils, 1983, p. 73). He says that these role changes present a dangerous situation for the academy. There is a very real danger that the acquired knowledge if taught without proper assessment, could be found unreliable. The status of the academy could then suffer a fatal blow. Therefore, the very health of the academy is directly related to faculty roles (Shils, 1983, p. 41).

Rosovsky (1990) strongly affirms the importance of tenure and states that, “nothing can diminish the need for academic freedom; its absence has reduced universities to caricatures in many parts of the contemporary world.” He views tenure as the very essence of academic life, allowing for a lifetime of building and renewing intellectual capital. Rosovsky also reminds us that nontenure track faculty generally have similar responsibilities as tenured faculty, only for half the pay, less status, fewer amenities and an uncertain future. At the University of Minnesota, fiscal constraints were mentioned as the primary cause for the university to consider adopting a policy that would allow for laying off tenured professors.
On the other hand, some scholars argue for role differentiation among faculty, pointing out that this is not only the most economically feasible approach, but also makes the most appropriate use of different talents. Wergin (1994), for example, talks about differentiated roles within a department, assigning faculty to teaching, research and service in the overall proportions needed by the department, but achieving this effect by balancing different profiles for different faculty. Bess (2000) argues that even within the teaching role, there are different tasks, some of which are better performed by a given faculty member than another. He concludes that teaching should be regarded as a team effort, where those who are good at design, lecture, discussion, assessment, coaching or any of the specific tasks specialize in that aspect while others contribute the rest.

It is especially important for administrators and faculty at academic health centers where market influences may call for rapid action by faculty to understand options for faculty roles and to make assignments intentionally in ways that will further the mission of the unit as well as be economically feasible. What will be needed in the future is “a new form of faculty management that matches the individual faculty member’s priorities and skills with the health center mission” (Arana and McCurdy, 1995, p. 1073).

Summary

Academic health centers have played an important role in the improvement of health care delivery during the past century. However, the current turbulent climate in AHCs provides an opportunity to rethink the way health care education is delivered. Both the AHC model itself and the role of the faculty are being challenged. The information age has changed every facet of our lives, so the future education of health care professionals may no longer be blood and guts, but bits and bites as simulation, virtual
reality and web based electronic learning make medical education cheaper and safer (Gorman, Meier, Rawn, and Krummel, 2000).

Leadership

Leaders of academic health centers hold positions that by their very nature have a high potential for conflict (Chervenak and McCullough, 2004). Their time and energy is occupied by a set of tasks that oftentimes have a business orientation: enhancing revenue, reducing costs, recruiting and managing a diverse workforce, and dealing with customer satisfaction (Grigsby, Hefner, Souba and Kirch, 2004). One of the aspects of the Association of Academic Health Center’s study concerning the evolving structure, organization and governance of academic health centers (Osterweis, 1998), was to assess institutional leadership. The study found that the heads of academic health centers, regardless of title, have powerful jobs. The data also indicate that there is some evidence that the scope of their authority and responsibility has expanded in recent years. A recent study indicated that most new deans or directors of allied health schools had backgrounds in health professions (Layman, Bamberg and Jones, 2002). Clearly, the development of leaders is going to be critical to the future of AHCs. Some have called for internal leadership training programs at academic health centers to meet this challenge (Morahan, et al., 1998). Others have spent considerable energy defining the characteristics that are needed for a leader of an AHC to possess including: ability to influence behavior, the skills of negotiation, facilitation, conflict management, organizational improvement, political savvy, systems thinking, personal mastery, and others (Klauer, Pozehl, and Mahaffey, 1997).

Given the long lists of characteristics in a dean or director, it appears that it may be more useful to ask what leadership characteristics we do not want the leaders in AHCs to use. A look at leadership from a broader perspective may help.
When considering how academic leadership works, Robert Birnbaum offers important insights into some of the myths associated with academic leadership (Birnbaum, 1992). He begins by reviewing the work of Burns (1978) who has attempted to differentiate between two forms of leadership, transactional and transformational. Transactional leadership depends on the exchange of desired goods between leader and follower. The relationship continues as long as the exchange is considered satisfactory for both. Transformational leadership emphasizes values and goals such as liberty, justice and equality. These ideals motivate followers to support the leader-intended change. Thus, transformational leaders are able to introduce advanced and new cultural forms. Birnbaum (1992) qualifies transformational leadership by stating that it is an anomaly in higher education. When studying college presidents, Birnbaum noted that the good presidents synthesized the two approaches. That is, at times they may emphasize supporting the status quo and at other times they may need to focus on changing the organization. It would appear that this “synergy” of approaches would best serve AHC leaders as well, especially during this time of change. Moreover, the ranges of organizational and leadership approaches should reflect the diversity of academic institutions. Each must assess its strengths, weaknesses and opportunities as well as current and potential threats.

As a practical means of determining the effectiveness of a leader, a leadership analysis could be conducted every three years (Birnbaum, 1992). The analysis would be performed as a case study where a faculty committee would review the actions of the leader over that time period. A diagnostic review of the leaders’ actions, leadership style and the vision and objectives he/ she has articulated would be conducted. Based upon this
information, the committee would then determine if the objectives were met, the vision
fully or partly realized and the leadership style appropriate and effective to meet the
identified objectives and vision. A critical evaluation would then be produced with
recommendations for either continuing on the present course or suggesting modifications
for the future.

However, no matter how well constructed, there is no single acceptable definition
of leadership or measure of effectiveness. In higher education, views of effective
leadership vary according to constituency’s levels of analysis and institutional types
(Bensimon, Neumann and Birbaum, 1989). This premise also applies to AHCs, given the
diversity of institutional types.

**Followership Theories**

A review of followership theories may also be helpful in understanding the
leadership dynamics that occurred at Whitman University. Theories of followership are
based upon the interactions of leaders and those who follow them. Leaders are viewed as
activators; the followers are the ones being activated (Burns, 1978). The nature of the
response of activation can best be understood by understanding the context of the
activation. Situational contexts can influence the interaction between the activator and the
activated, in this case the dean and the faculty. Charismatic leaders have the greatest
influence on their followers, who by sheer will and force motivate their followers’
actions. (Lundin and Lancaster, 1990). Leaders who positively influence the self-concept
of followers are the most effective (Brown and Lord, 1999). Followers tend to follow
charismatic leaders who make the followers feel better about their roles within the
organization (Haslam and Platow, 2001). Followers who value achievement, have a high
need for structure, value internal and external rewards and value security and stability are attracted to task-oriented leaders (Earhart and Klein, 2001). Relationship-oriented leaders attract followers who value interpersonal relationships, security at work and participative decision making (Earhart and Klein, 2001). This type of follower also tends to have low self-esteem. They expect the leader to satisfy their need for encouragement and a great sense of self-worth (Earhart and Klein, 2001).

Summary

The complexities of relationships within academic health centers can be fully appreciated only by those with some understanding of the people involved playing out perhaps academe’s most intriguing drama (Morris, 1981). Currently, those who are responsible for the academic leadership of allied health schools are experiencing difficult times and find themselves functioning in a survival-oriented environment. The review of the literature indicates that they hold powerful jobs but external influences such as managed care and decreasing government funding for the institutions’ academic mission are making their positions more complex. Their jobs have become more synergistic in nature, demanding the management and business skills of a large corporate entity with the professional and academic skills of a scientist and health care provider.
Allied Health

Who and What Are Allied Health Practitioners?

In a report discussing the marketing of allied health practitioners, it was pointed out that the composition of the allied health profession is a complex question requiring more than just a list of professions of what the public would perceive as examples of allied health professions (Green, Little, Watson, Warren, Pappas, 1998). Such a list would most likely include just about any non-physician or non-nurse health-related profession. However, many professions that the public may perceive as allied health professions may in fact not consider themselves as fitting in the allied health model. The Association of Schools of Allied Health Professions (ASAHP) is a not-for-profit organization representing 105 higher education institutions and hundreds of individual members who are primarily deans or other administrators and faculty of allied health units at four-year colleges (Wilson, 2002). The term “Allied Health” according to the ASAHP web site, classifies more than 100 professions providing many services including primary care. The ASAHP web site defines allied health professionals in the following manner: “Allied Health professionals are involved with the delivery of health or related services pertaining to the identification, evaluation and prevention of diseases and disorders; dietary and nutrition services; rehabilitation and health systems management, among others” (ASAHP, 2006). Additionally, ASAHP describes allied health education as being as diverse as the services provided, ranging from hospital-based to university-based educational programs.

Allied health professionals fulfill many non-physician and non-nurse functions in the delivery of health care services. They make up a significant portion of the healthcare
workforce, numbering approximately 2.3 million professionals, about one-third of the 10.5 million health care workers in the United States.

The United States is facing a health care workforce crisis in the near future as there is an ever-increasing number of patients needing care with a decreasing number of qualified allied health professionals to provide that care for them. Recent reports indicate a looming shortage of healthcare workers (Keebe, 2005). A particularly severe shortage of medical laboratory workers is expected (Stombler, 2005). Congress, in an attempt to address the shortage introduced “The Allied Health Professions Reinvestment Act” in 2004 H.R.4016 and S.2491 (Stokes, 2004) and re-introduced it in February of 2005 (Diversity Allied Health Newsletter, 2005).

What Is the Origin of the Allied Health Professions?

Subspecialties of medicine and nursing began to evolve over the past century and a half as medical and scientific knowledge advanced (Green, et al. 1998). These areas were primarily developed as the evolution of medical care began moving toward specialization, creating the need for supportive roles for physicians. Thus, “allied” areas of practice emerged with these new practitioners eventually teaching others their particular medical subspecialties. The term allied health was popularized in 1967 during deliberations that led to the passage of the Allied Health Professions Personnel Training Act, 1967 (ASAHP, 2006). Over time, the allied health professions have developed into a very diverse and complex collection of subspecialties that the lay public does not generally understand or appreciate.

This professional evolution is what is primarily responsible for two weaknesses that are shared by all of the allied health professions: lack of visibility and lack of
collaboration. Additionally, the different levels of responsibility and education of practitioners compound the allied health identity problem (Green, et. al. 1998).

**Allied Health Education**

When confronted with the diversity and complexity of allied health, the Institute of Medicine-National Academy of Sciences (IOM-NAS) Committee to Study the Role of Allied Health Personnel reported that because there is no consensus about which disciplines constitute allied health, it is hard to define allied health education (Pew Health Professions Commission, 1992). Additionally, the Pew report mentions that allied health education occurs at a variety of levels and settings covering a wide scope of certificates and degrees awarded at the associate, baccalaureate, and graduate levels. Baccalaureate education in allied health is especially diverse, encompassing as many degrees as there are professions. Recently, graduate education has evolved to meet the needs of professional responsibilities. Moreover, the report states that graduates of programs in the allied health sciences account for as many as one out of every six graduates from institutions of higher learning listed by the U.S. Department of Education. The Pew Commission report also discussed several trends in higher education that affect measurably on the allied health professions. These include the shortage of allied health faculty. Moreover, the complexity and diversity that is allied health has made it difficult to share a broad understanding of allied health, which exacerbates attempts at any policy response for the nationwide shortage of these key health care workers. In 2003, the Institute of Medicine issued a report that identified the need for a major overhaul in the education of the health professions (“Health Professions Education,” 2003).
A report published in 2000 described how the Texas higher education system gave an extensive look to the future for health professions in Texas. The report was commissioned in an attempt to ascertain how well the Texas higher education system would be able to meet the needs for health care professionals if current trends and patterns continued. Allied health education was specifically studied with some interesting results (Rettig, 2000). As it does in many other states, allied health in Texas faces an identity problem. The report mentions that many individuals who are otherwise familiar with health care remain relatively uninformed about the allied health professions. As a primer for policy makers, Dr. Marilyn Harrington, Dean of the School of Allied Health, University of Texas, San Antonio and a member of the Health Professions Task Force, spoke to the definition of allied health. Interestingly, she characterized allied health professionals as not in medicine, not nursing, but more or less the “rest of the gang in health care.”

The Texas report identified several factors that were seen as drivers of change in allied health. These included managed care, which results in cost containment pressures on employers to hire the lowest paid qualified health professional they can find, and the new information technology, which is altering the ways in which health and medical services are being provided.

Moreover, the Texas report identified several national trends affecting allied health education. Only eight percent of allied health professionals are educated in academic health centers. Of more than 233,000 allied health graduates in the U.S. each year, most are educated in four-year institutions (36 %) and community colleges (31 %). The diversity of allied health education has created a regulatory nightmare for allied
health educators and their parent institutions, including numerous accrediting bodies as well as individual licensing boards. This regulatory nightmare is partly due the lack of coherence that personifies allied health education. The Texas report identifies nine allied health-accrediting bodies, which is very different from nursing or medicine. The most comprehensive of the allied health accrediting bodies is the Commission on Accreditation for Allied Health Education Programs (CAAHEP) that represents 18 different allied health professions and over 2,000 different institutions and programs. CAAHEP was created in response to the American Medical Association’s withdrawal from accrediting allied health programs.

“Degree creep” was identified by the Texas report as a current concern. Some of the allied health professions were seen as steadily raising their degree requirements. Some have gone so far as to require the doctorate for entry level into the profession, influencing the program’s entry level requirements (“The Clinical Doctorate,” 2005). The report mentions that while there may be some rationale for increasing degree requirements due to growing scientific and technological knowledge, most requests for new doctoral programs are not accompanied by a compelling educational or health rationale. Making such abrupt changes in degree requirements dramatically increases the state’s cost per student.

In summary, the report concluded that without a more comprehensive information base, policy makers would be faced with a fragmented, piecemeal and incremental approach to addressing the issues around allied health education. They would also be dealing primarily with very specific and highly localized considerations. A more broad-based approach is simply not possible, which is unfortunate considering that the
importance of allied health professionals to the future of health care will only increase because of the pressures of cost containment on health care in the future.

*Allied Health Education Accreditation*

A recent report affirms accreditation as an effective system for assuring the quality of allied health programs (Baker, Morrone, and Gable, 2004). Others have reported a disassociation between accrediting bodies and those they intend to serve (Koehneke, 2003).

Accreditation cost was one of the issues under discussion at the second annual summer retreat sponsored by the Association of Academic Health Centers (AHC) and the Federation of Associations of Schools of the Health Professions (FASHP) (Cocolas and Rubin, 1991). Accreditation was considered by many to be an educational issue that has the tendency to be the most politicized as many of the health professions continue to expand their scope of practice. The discussions at the retreat identified several concerns shared by allied health educators, including the continued fragmentation and prescriptive nature of the accrediting process, barriers to innovation and experimentation, and the changing role of government in the process. Generally, the accreditation process is a self-regulatory activity created by the academic and professional education communities. Non-governmental associations of institutions, programs and professionals in the particular fields administer accreditation. Regional or institutional accrediting agencies establish the guidelines for institutional accreditation.

At the summer retreat allied health participants expounded on the costs of accreditation and the growing conflict of programmatic versus school accreditation. Moreover, participants even questioned the use of accreditation as a measure of quality of
education. An important dilemma concerning accreditation is the impact of multiple levels of accrediting agencies on the institution, requiring different types and presentations of data. Allied health programs are seriously encumbered by what was described as the costly maze of accreditation requirements put upon the schools by the many associations making up this “conglomerate of health professions.” With biotechnology spawning new careers and professions, Cocalas and Rubin, (1991) predict that in the future the situation will only worsen unless the accreditation process becomes more flexible. In the future, greater collaboration between professional organizations and professional educational institutions will be essential in creating a more cost effective and rational approach to accreditation.

More recently, accreditation was identified to still be of major concern with several issues still problematic including accreditation costs, program structures and a common self study format (“Accreditation Remains a Concern,” 2005). In 1999 the Task Force on Accreditation of Health Professions Education issued a report titled: Strategies for Change and Improvement (Gelman, O’Neil, and Kimmey, 1999). The task force identified four major accreditation issues: the need for a more simplified process, the development of an accreditation process that focuses on improvement, generic benchmarks and closer links with customers and clients.
So What Should a Good School of Allied Health Look Like?

Schools of allied health professions have been described as complex structures composed of multiple professional programs. (Blayney and Rogers, 1980). In terms of cultural diversity, a recent study found that 82% of students are white compared to 97% of the faculty (Velde, Wittman, and Bamberg, 2003). Blayney and Rogers conducted a fascinating study in response to the need for the School Community of Alabama (SCAH) and the University of Alabama in Birmingham (UAB) to develop both their short- and long-term goals toward achieving and maintaining excellence. They assembled a panel of six experts and five deans of schools of allied health professions from the southeastern United States and a representative from the Kellogg foundation. Their primary objective was to identify the characteristics of outstanding schools of allied health and thus assist the SCAH and UAB in developing short- and long-term plans for achieving excellence. A questionnaire was developed consisting of 47 traits that the panel considered characteristic of an outstanding school of allied health. The questionnaire was then mailed to each panel member for completion using a five-point scale. The final analysis of the questionnaire by the expert panel indicated that 43 of the 47 characteristics were good indicators of an outstanding school of allied health. The questionnaire was then used to survey allied health deans who were identified on a list supplied by the National Commission on Allied Health Education. The return rate for the questionnaire was 49.2%. Generally, there seemed to be a tendency for all the respondents to rate all characteristics as high. However, there was a marked tendency for internal concerns to be more important than external concerns such as research and service. Most of the emphasis was on good school leadership and producing quality graduates.
Summary

Allied health educators and professionals are only two of many players in today’s academic health center, which includes physicians, nurses and others, all with fundamental differences in their backgrounds. The evolution of allied health careers into a very diverse and complex collection of sub-specialties has created an identity issue for the professions since the public generally doesn’t understand who or what the allied health professions are. Moreover, the literature also indicates that allied health education is as diverse as the services provided. Educational venues for allied health education range from hospital-based to university-based programs.

To address this identity issue, most academic health centers formed schools or other organizational units to give these groups a common identity and voice. Whitman University was no exception, forming the Division of Allied Health Sciences in the School of Medicine, the forerunner of what was later to be known as the School of Allied Health Sciences.
Organizational Aspects of Colleges and Universities

A review of how colleges and universities are organized and how they operate is fundamental to understanding the complex organizational aspects of the Whitman University SAHS. While sharing some organizational structure common to most colleges and universities such as hierarchical leadership where the dean had the top administrative position, the SAHS was peculiar in some aspects, the notion of the SAHS being a school within the School of Medicine being the most obvious.

“Intelligence Evolves”

When considering the evolution of the university as an organization, the quote above from Morgan (1996) comes to mind. Duryea (2000) describes the evolution of university organization as a “complicated process by which the cultures mingle over a history fraught with traditions and happenstance”. Organizationally, Duryea (2000) indicates that the form and function of the university organization was stabilized by the onset of World War I. The use of the corporate form with lay governing boards goes back into the nineteenth century. Organizational expansion and consolidation mark the twentieth century with its associated evidence of dysfunction. The “multiversity” (Lucas, 1996) stands as the ultimate outcome of the modern day university organization, resulting in what Duryea describes as three pervasive organizational inadequacies. The first is attributed to size and complexity, the second to departmentalization and the third to shifting patterns of institutional governance. By becoming large bureaucracies, colleges and universities have had to create a hierarchy of departments, schools, and councils with numerous associated committees. The different attitudes and values associated with these have driven a psychological wedge between faculty members and administrators. The
department as an organizational unit is the second evidence of dysfunction. Specialization has produced a tendency toward fragmentation in the academy. This commitment towards specialization acts as a centrifugal force pushing faculty loyalties out from the university. This fragmentation contributes to the third problem of the shifting of power in universities, the diffusion of governance. The diffusion of governance to departments, administrative offices and faculty governing boards, along with the intrusion of external forces has generally bypassed presidents and boards. Therefore, Duryea states that colleges and universities are now being governed by “confederations of largely autonomous departments” characterized by Shils (1983) as “the hole in the centre.”

Universities as Organisms

Colleges and universities are complex, open systems hierarchical in structure. For example, the schools that function within the university represent a variety of organizational subsystems that are still integrated within the whole; thus, the variety of subsystems is an example of diversification. Morgan’s (1996) metaphorical representation of organizations as organisms provides an excellent model for understanding the university in a holistic fashion and is particularly relevant to understanding the SAHS. Universities are complex systems comprised of sets of interacting subsystems of many varieties allowing for adaptation. There is mutual dependence and interactiveness between the university and its environment; this is both reactive and proactive. The university has different levels of needs, and in satisfying each level, the university develops itself. Universities work to maintain stability and ensure their survival. They also remain the same but change in terms of form and function in
order to adapt successfully. A university can be thought of as a kaleidoscope of patterns, processes, and systems that allows it to adapt to its changing environment.

Universities as Political and Social Systems

Universities may be viewed as political systems (Morgan, 1996). The political model characterizes universities as organizations comprised of loose networks of people with divergent interests who gather for the sake of expediency. Members of the university community become organizational political actors. They understand the political significance of the patterns of meaning enacted in the university’s culture and subculture. Moreover, the university culture may be the driving organizational influence on some campuses; accordingly, the political players have a shared reality of a common set of norms, values and ideas.

Clark (1985) describes two paradigms in organizational theory and research that have relevance to university organizational models. He reports on Getzel and Guba’s model that describes organizations as social systems. The model proposes a social system that consists of two dimensions: the institution with its roles and role expectations (the organizational dimension) and individuals with their own personalities and needs. The social behavior of the organization derives from the interaction of the two dimensions. The second paradigm is a formal bureaucratic structure with specific offices, job descriptions, and goals. During the 1960s and 1970s this model received widespread attention in educational administration. The bureaucratic paradigm was challenged by contingency theorists such as Lawrence and Lorsch (Scott 1981), who argued that there is no best way to organize and manage. Different strategies and tactics will work depending
on the goals of the university and whether the task is simple or complex. Thus, the structural heterogeneity of the organization affects the process.

Tierney (1991) proposes two interesting questions often asked by even seasoned college and university administrators. Is it mission, values, and bureaucratic procedures or strong personalities that hold this place together? How does this place run and what does it expect from its leaders? Understanding the organizational culture of the institution, in his view, is the most important job of institutional leaders. Cultural influences occur at many levels--departmental, institutional, and state. They can all vary dramatically. Therefore, understanding the organizational culture is critical to minimizing the occurrences and consequences of cultural conflict, thus reducing the potential of adversarial relationships. Culture should play a major role in decision making. Understanding the institutional culture will also help leaders understand why different groups in the university hold varying perceptions when it comes to institutional performance.

Moreover, Tierney (2000) addresses the recent cultural trend of educational institutions being viewed as business organizations, mentioning that they should not be assessed on an analysis of profit margin. He goes on to exclaim that, “we should not lose sight of what education is.” Students are not “markets to be tapped or products to be improved.” (p. 547)

*Organizations as “Loosely Coupled Systems”*

Weick (2000) examines educational organizations as “loosely coupled systems” (p. 36). He uses this image to convey the notion that coupled events are responsive but that each preserves its own identity and physical or logical separateness. He goes on to
say that in terms of organizational structure, loose coupling carries connotations of impermanence, dissolvability and tacitness, which are all properties of what holds an organization together. It also suggests the idea of building blocks that can work together in an organization with little disturbance to each other. However, loose coupling has the potential in educational organizations to accentuate the loose coupling between the intentions and actions of organizational members. As a result, administrators may become baffled and angered when things never seem to happen the way they are supposed to. Weick identifies several strengths and potential functions for the loose coupling organizational model in educational institutions. Loose coupling allows for the organization to be able to respond to each little change in the environment that may occur. It also provides a sensitive sensing mechanism, allowing for the organization to know its environment better than a tightly coupled system. This also allows for localized organizational adaptation. Identity, uniqueness and separation of elements of the organization are preserved. The system can also retain a greater number of mutations and novel solutions than a more tightly coupled system. A breakdown in the system would be confined to a specific part of the system’s not affecting the other portions of the organization. Self-determination of the actors is better accomplished in a loosely coupled system. This aspect is important in colleges and universities where professional autonomy is highly valued. A more loosely coupled system takes less time and money to coordinate. Thus, it would be relatively less expensive than one more tightly coupled.

Professionalism in Academic Organizations

Professionalism is another important characteristic of an academic organization wherein the institution hires professionals who are expertly trained for specific tasks.
However, professionalism can also impede the function of the institution. Professionals demand autonomy in their work and freedom from supervision. They tend to have divided loyalties and there are often strong tensions between professional values and bureaucratic expectations. They also demand peer review of their work. This creates a tendency for academic organizations to have fragmented professional staffs.

Environmental Influences on Organizations

Environmental vulnerability is another characteristic that distinguishes academic organizations from many other complex organizations. On the continuum from being “independent” to “captured” by their environments, colleges and universities are somewhere in the middle. Recently powerful external forces have been applied to academic organizations. This external pressure reduces the autonomy of academic professionals. Colleges and universities are steadily losing ground to external forces. As they become more vulnerable, their governance patterns change significantly. Baldridge (2000) summarizes this discussion by characterizing universities according to the term suggested by Cohen and March (2000) that they are best described as “organized anarchy” that is, a system with little organization or control.

Decision Making

“Rational decision making is generally conceded to be a normative ideal, but not susceptible to practice” (Chaffee, 1991).

Chaffee (1991) describes rational decision making as it applies to university budgeting as being comprised of four criteria: goals, alternatives, consequences, and the selection of those circumstances (choice) whose consequences rank highest among the decision maker’s values. This approach is based upon the fact that each decision has a
rule by which one alternative is chosen rather than another. The principal elements that should enter into the criteria for goals include academic importance, student interest, possibility for excellence and funding potential. The second criterion (alternatives) in the rational process would simultaneously consider a wide array of spending alternatives, the key elements being “simultaneously” and “wide array”. The evidence for simultaneous decisions is unequivocal according to Chaffee, since administrators generally have a wide variety of alternatives available to them. The third criterion (consequences) is related to the quality of information administrators have available in the decision making process. It should be sufficient to allow them to relate their preferences through some understanding of the causes and effects. When well informed of the consequences of their decisions, administrators are in good positions to choose rationally. The final criterion (choice) would follow a reasonable confirmation of the first three criteria, resulting in a regression equation of the following form:

\[
\text{Decision result} = \text{preference (1)} + \text{preference (2)} + \ldots + \text{preference (n)}
\]

The preference list of variables would include and be consistent with the administrators’ goals of academic importance, student interest, possibility for excellence and funding potential. Chaffee (1991) concludes that rational reasons for rejecting a request in this context would be seen by most of the university community as reasonable and fair. However, while a rational process is suitable, it is probably neither normative nor unrealistic in most contexts. It should be part of a multifaceted approach to decision making in most institutions, since the entire budgeting process doesn’t lend itself to a single desired model.
**Client Services**

Decision making in health care organizations is heavily influenced by clients. Client service is another important characteristic of the university. Universities are “people processing” institutions. Clients with specific needs are fed into the institution and returned back to the larger society. Therefore client voices have a significant input and often play a significant role in the decision making process. Additionally, serving clients with disparate, complicated needs is also difficult. Therefore, the technology needed by a client-serving organization is difficult to identify. Manufacturing organizations can develop specific technology for their needs but a client-serving organization oftentimes does not know clearly what it is trying to do or how to get it done.

**Garbage Cans, Pigeonholes and Loosely Coupled Systems**

Cohen and March (2000) utilized a “garbage can” metaphor as a means to understanding the processes within organizations. Problems and solutions are dumped by participants into a single garbage can. The single can represents not only what was deposited into the single can but it also represents what garbage was being produced at the moment and the speed at which the garbage was being collected and removed. Thus, they use the garbage can metaphor to describe a situation where a decision is an outcome of several different streams within an organization. The streams they identify are problems, solutions, participants and choice opportunities. Thus, if one considers universities to be organized anarchies, as described above, the garbage can idea of decision making may become particularly appropriate to decision making in higher education, according to Cohen and March. Colleges and universities are generally
described as operating under the metaphors of a political system or hierarchical bureaucracy. However, the actual operation of the academy is considerably attenuated by an ambiguity of goals, lack of clarity and the transitory character of the participants. The great advantage of recognizing the garbage can process is that decision makers can have some sense of understanding the process along with making some attempt to manage it. Alone, the garbage can process does not do a particularly good job of resolving problems but it does enable some choices to be made and some problems to be solved.

**Professional Bureaucracies**

The professional bureaucracy relies on the standardization of skills, training and indoctrinated specialists and professionals for its decision making core (Mintzberg, 2000). The SAHS at Whitman University organizationally possessed some of the characteristics identified in a professional bureaucracy as described below. Essentially bureaucratic, these organizations are characterized by technostructure designs emphasizing authority of a professional nature or expertise. The set of skills the professionals hold are applied to predetermined situations or contingencies. The professional has two basic tasks: to identify the client’s needs and to execute a predetermined program for each situation. People are characterized and placed into a specific decision making situation based upon their expertise and professional nature. Mintzberg describes this process as “pigeonholing.” This simplifies the decision making process by creating a highly decentralized structure. Categories of problems are addressed by professionals skilled in the arena of the problem. This saves considerable resources. Each decision would be addressed only by those professionals who possess the required expertise. However, this type of organizational structure produces stereotypes
and requires categorization of the problems that require decisions. It also reduces the power of the central administration, which primarily is left to address disturbances in the structure. The difficulty in applying the professional bureaucracy to an academic institution is that while the knowledge base of the institution is sophisticated, the technical system or how the professional expertise would be applied is not. Additionally, the pigeonholing process itself can produce a great deal of conflict as a continual reassessment of contingencies and who has the expertise to address them would be ongoing, resulting in a political quagmire.

“Organizations Are Emotional Arenas”

Fineman (1993), quoted above, emphasizes the fact that what people do with their feelings at work plays a large part in shaping the essence of their organization. Feelings contribute to, and reflect, the structure and culture of organizations (Fineman, 1993). He points out that people have personal needs, goals, skills and preferences that will collide, collaborate, resist and comply in ways that make organizational life messy. The social construction of organizations is intensely subjective and personal. Work organizations are sites where individuals make meaning for themselves. There is nowhere this applies more than in colleges and universities. Fineman identifies several studies where loss of identity and reason for living have resulted when one loses a job unexpectedly. He defines “emotional labor” as a term used to describe the way roles and tasks exert overt and covert control over emotional displays. He goes on to say that it is through recruitment, selection, socialization, and performance evaluations that organizations develop a social reality in which feelings become a commodity for achieving instrumental goals. Emotional labor is experienced most strongly when
employees are asked to express emotions that contradict their inner feelings. Additionally, emotions ignite creativity, spiritual development, and contribute to the development of community. Fineman concludes that emotions play a vital role in organizational life. Organizations should be shaped by emotionally centered creativity and mutual understanding as necessary elements for human growth.

When examining high faculty morale and what exemplary colleges do right, Rice and Austin (1991) found several key characteristics in the ten liberal arts colleges they researched that had high scores in faculty satisfaction and morale. A distinctive organizational culture was present in each of them. Factors making up this distinctive culture included campus rituals, a distinctive architecture, and a focus on students, along with a concept of community. Participatory leadership was prevalent on all of these campuses where the campus leadership was aggressively participatory and faculty felt very much a part of the decision making climate. Interestingly, in this same cohort, strong deans were given credit for holding colleges together in difficult times. Presidents and deans in these colleges know how to empower others. They share authority, and in doing so, enhance the effectiveness of their organizations. Information is shared willingly and a respect for faculty and a sense of trust permeates these institutions. Faculty leadership in these institutions was found to be a “structural phenomenon”. All of these factors contribute to an organizational momentum shared by each of the ten institutions creating a sense of these campuses being “on the move.” Thus, the strong sense of community created an environment that fostered collaboration and focused support, not competition. Rice and Austin conclude by stating that the satisfaction of the faculty is critical to the achievement of educational goals.
**Summary**

In describing characteristics of academic organizations, Baldridge (2000) focuses on five distinguishing features. Universities in general are described as complex organizations similar to other organizations in that they have goals, hierarchical systems, structures and officials who are the decision makers and carry out specific duties. However, they also exhibit critical distinguishing characteristics that set them apart. Universities have goals that are usually vague, and ambiguous. The decision making process is fraught with a high degree of ambiguity, uncertainty and conflict. Therefore, goal ambiguity is one of the chief characteristics of academic organizations.

It is within this ambiguous milieu that the Whitman University SAHS found itself in 1999. This study will utilize the literature discussed in this section as a lens for establishing a mechanism for the analysis of the organizational changes the school experienced during a reorganization process.
Chapter 3: Data Collection and Analysis

An in-depth investigation of the SAHS will serve as the core of inquiry, forming the premises for a case study exploring the phenomena surrounding the reorganization of the school. Three distinct theoretical structural categories will be used to study the reorganization of the school, to guide the data collection and analysis, and to keep the study within feasible limits: internal forces, external forces and leadership.

**Data Collection Strategies**

Three phases of data collection, each relying upon a different source of evidence, occurred in this study utilizing qualitative methods as described by Yin (1994). The rationale for using three sources of evidence is that while the sources are complementary, they can be triangulated, thus enhancing the trustworthiness of the overall results. Additionally, triangulation allows for the potential of creating unique insights into the data unobtainable with either one alone. The data collection was accomplished in three phases. Phases I and II used the qualitative research methods of participant observation and document analysis. Phase I focused on an analysis of all documents considered potentially helpful in identifying the themes or trends throughout the school’s history that contributed to its failure. Phase II was conducted in real time allowing for contextual coverage of the events while allowing for insights into interpersonal behavior and motives (participant observation). Phase III used the results of Phases I and II in the development of open-ended questions for interviews to be conducted with key players identified in Phases I and II of the data collection. The document analysis and participant observation in Phases I and II generated a list of topics about which it would be important to collect additional information from the perspectives of key actors. Initially, a collection
of potential interview questions was drafted that was examined for consistency with the results of Phases I and II data collection. From these, the final interview questions were developed. Phase III served as a means to check the trustworthiness of the themes identified in Phases I and II, and potentially to identify new insights into the data.

Cumulatively, this strategy allowed for the completion of a chain of evidence for each structural category, thus assuring the reliability of the results.

Methods

Document Analysis

For this case study, documents will be used in conjunction with the other sources of data collection, observation and interviews, to produce a consistent picture of the factors leading to the school’s reorganization. Ready access to the documents was obtained by the professional relationship of the researcher to the school and through individuals outside the school with an interest in the research. Documents along with related notes were filed according to the categories below in chronological order. Categorizing the documents in this fashion allows for a reduction of bias in interpreting the data. Understanding that each communication between parties was to achieve another objective or some purpose other than the case study helped prevent being misled by the contents of the documents. Constantly identifying these conditions showed appreciation for their usefulness.

A listing of the documents obtained and their categorization is included as part of the study’s database delineated in Table 1.
Table 1

*Database*  

**Documents**

Letters, Memoranda and Email

1. Communications between faculty and SAHS administration
2. Communications between faculty
3. Faculty Council and University Administration communications with the SAHS

Committee Meeting Minutes, Agendas, Announcements and Reports

1. School Executive Committee
2. School Coordinating Council
3. Hospital Consolidation Committees
4. SAHS faculty meetings
5. University Faculty Council

SAHS Administrative Documents

1. SAHS Strategic Plan
2. School enrollment reports
3. Program annual reports
4. Other internal documents

Formal Studies or Evaluations of the SAHS

1. External Advisory Committee Report
2. SAHS Economic Modeling Report
3. Faculty Council Report
4. Five Year Evaluation of the Dean
Mass Media

1. Newspaper articles
2. Departmental and campus wide newsletters

Archival Records

1. Organizational Charts
2. Budget Records
3. Survey Data

Case Study Notes

1. Results of Interviews
2. Observations
3. Document Analysis

Participant Observation Narrative
Participant Observation Narrative

The researcher as a faculty member in the SAHS assumed a variety of roles within the case study, from passive observer to a participant in the events leading to the school’s reorganization and the leadership analysis that followed. This allowed for the researcher to gain access to events and groups that would be otherwise inaccessible while providing the distinctive insight of being within the case study rather than outside looking in. For this case study, the ability of the investigator to provide an accurate accounting of the events surrounding the case study phenomenon is very important in producing an accurate portrayal of the school’s reorganization.

Data collection from the participant observations was formalized by the researcher in a narrative whereby the researcher composed answers to the open-ended questions used during the interview phase of the data collection. Yin describes this process as an analytical one and an important part of the case study analysis. He describes the format for the answers as analogous to that of a “take home” exam used in graduate degree programs, whereby the investigator is the respondent. Using relevant evidence including documents, observations, archival evidence and interviews, the researcher composed what he felt to be an adequate answer. The main purpose of the answers was to document the connection between the themes identified by participant observation and the other phases of data collection. The set of answers became part of the case study database.
Identified biases.

Inherent in this type of data collection are the preexisting biases that accompany this type of observation. Listed below are three potential biases for this phase of data collection.

1. The researcher has less ability to work as an external observer.
2. The researcher could become a supporter of a group or idea within the case.
3. The participant role may not allow the researcher enough attention to the observer role.

Being aware of and articulating these biases was important in reminding the researcher of the potential dangers relative to this type of research. Moreover, the researcher used reflective notes and outside criticism as important means to ensure good scientific practice.

Interviews

The primary purpose of the interviews was to corroborate the themes identified in the document analysis and the participant observations. Open-ended interviews were conducted with key respondents (Table 2). The open-ended interview allowed for the respondents not only to answer the interviewer’s questions but also to express their opinions about events. Additionally, the respondents’ insights into the events surrounding the school’s reorganization yielded further areas for inquiry. The interview questions were formulated based upon the results of the Phase I and II data analysis and are attached as Appendix A.

The interviewer recorded the responses of the informants during the interview with reflective notes included afterward. Due to the sensitivity of the subject matter and
the importance of the respondents’ feeling free to provide their insights, other methods for recording responses including tape recordings were not used.

*Identified biases.*

Interviews, being verbal reports, are often subject to bias, including poor recall or inaccurate articulation. The corroboration of the interviewee’s responses with other data sources assisted in the elimination of many of these common problems but likely did not eliminate them entirely.
Table 2

*Interview List*

One Faculty Member from Each of the Following SAHS Programs

- Occupational Therapy
- Physical Therapy
- Clinical Laboratory Science
- Radiologic Sciences
- Respiratory Therapy
- Health Sciences Education

SAHS Administration and Staff

- Dean
- Director of Student Affairs

Sources External to the SAHS

- Previous Dean (1991-1995)
- External Advisory Committee Member
- University Campus Administrator
- Economic Modeling Professional

*Note.* The interviewees were selected based upon the following criteria: they should have been faculty members throughout the school’s history and they should reflect the diversity of the school’s programmatic structure. Individuals outside the school familiar with its history were also interviewed.
Data Analysis/Interpretation and Method of Reporting

The case study database consisted of case study notes, documents, tabular materials and the participant observation narrative (Table 1). The themes identified from the three Phases of data collection served as structural categories for the study. As illustrated in Figure 1, the conceptual framework for the data analysis linked these themes to the three structural categories that played a role in the reorganization of the school: internal forces, external forces and leadership. Further themes within each structural category were then identified. The convergence in triangulating fashion of the three phases of data collection established trustworthiness. “Pattern matching” was used to link related pieces of information to the three structural categories. Categorizing the data in this fashion allowed for the creation of a chain of evidence for each structural category with clear cross-referencing to methodological procedures and resulting evidence.

The specific criteria for the interpretation of the results evolved with the emerging research design guided by a theoretical framework of organizational theories. Data collection and analysis are summarized in Figure 1.
Document Analysis

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Structural Categories

- Internal Forces
- External Forces
- Leadership

Thematic Categories

Organizational Theories

Discussion and Summary

Figure 1. Data Collection and Analysis
Mechanisms for Establishing Trustworthiness and Treatment of Ethics

This case study, being a controversial topic, requires that the names of the entire case and its participants be disguised. Moreover, the publication of this case report may affect the later actions of those who were studied. Thus, maintaining anonymity is an important mechanism for ensuring trustworthiness. Additionally, as part of a trustworthiness procedure, drafts of the case study were not only read by peers but also by participants and informants in the case as a means of corroborating the evidence presented in the case. Any disagreement over the facts or evidence was addressed through further dialogue and research. This process, which increased the construct validity of the study, enhanced the accuracy of the report.

The use of rival structural categories also contributed to the trustworthiness of the study by allowing for the consideration of alternative perspectives when doing the data analysis and interpretation. This reduced the potential for biased support of a particular point of view.
Chapter 4: Results

Introduction

The reorganization of the SAHS was a two-year process involving multiple procedural steps with complex manifestations, as outlined in the timeline in Appendix B. Moreover, the SAHS was comprised of a diverse collection of programs as illustrated in the organizational chart in Appendix C. These details will be summarized below. Following this overview, this chapter presents the themes from the data collection, organized by the three major forces at play in this case: internal, external, and leadership.

Brief Historical Overview

The Whitman University School of Allied Health Sciences was a fiscal unit of the Whitman University School of Medicine (SOM) and provided both pre-baccalaureate and post-baccalaureate education. The Bachelor of Science degree was first conferred by the faculty of the School of Medicine in 1960, to be given to those students successfully completing the curriculum in four allied health programs. These programs had been offered long before the establishment of the “Division” of Allied Health Sciences within the School of Medicine in 1959. In 1991 the Division of Allied Health Sciences was given school status by the university but within the SOM.

It was one of the oldest allied health academic units in the country and enjoyed a national reputation for excellence. The SAHS was non-departmental, but rather was comprised of 12 program areas and three administrative support units.

The Dean of the School of Medicine was at the top of the organizational structure for the SAHS and functioned as the administrative head. However, all practical administration of the SAHS was delegated to the Dean of the SAHS. The last SAHS
Dean’s administrative staff was composed of three individuals; the Associate Dean of Student and Academic Affairs, the Associate Dean of Research and Graduate Students, and a business manager. The school’s Executive Committee, composed of the school’s program directors, formed the administrative leadership of the school. The program directors, of each of twelve areas of concentration for the various allied health programs offered by the SAHS served on the Executive Committee.

Prior to the first year of the reorganization process that is the topic of this study, concern and discussion about the school’s financial and academic conditions began. Enrollment shifts, accreditation issues and hospital consolidations that were affecting the school were taking place. To address these changing conditions and others, the Dean met with the faculty and recommended that an Ad Hoc Faculty/Administrative Committee be formed to commence the process of economic modeling and subsequently to make recommendations to the school on how to address these issues. Toward the end stages of this process the Dean (SAHS) submitted a statement of financial difficulty to the Dean of the SOM and to the campus chancellor. Following the submission of the financial difficulty statement, the school requested from central administration a campus reallocation of $500,000 to address the school’s immediate financial problems.

Upon submitting the statement of financial difficulty to the campus, the procedural steps for the campus’s newly approved policy entitled; Whitman University Policy on Transfer, Merger, Reorganization, Reduction and Elimination of Academic Programs (PTMR), set the stage for the next steps. One of the first of these steps was the establishment of an Ad Hoc External Advisory Committee, which would be charged with the task of making recommendations concerning the current resources available to the
school and the school’s ability to support the existing structure. The external advisory committee’s conclusions were similar to those of the SAHS Ad Hoc Economic Modeling Committee in determining that the financial resources available to the school were not adequate to support the existing array of programs. After meeting with the SAHS Executive Committee and completing a widespread information gathering effort, the Dean distributed a draft academic and budgeting plan to the SAHS faculty and the deans of schools of related programs. After allowing for feedback from all communities of interest, the Dean submitted his final proposal to the Dean of the SOM, campus chancellor, SAHS faculty, and to the Executive Committee of the campus’s Faculty Council.

Following the submission of the Dean’s plan, the Faculty Council began its review process, which involved hearings with the SAHS faculty and campus-wide hearings with the SAHS’s communities of interest. After all hearings and information gathering efforts were accomplished, the Faculty Council met to review the Dean’s reorganization proposal. Initially, the Dean’s proposal was rejected by the Faculty Council but after suggested revisions were made, the proposal was submitted to the Chancellor along with Faculty Council’s recommendations and other information for the Chancellor to consider for a final recommendation. The Chancellor’s final determination was to accept the Dean’s proposal. After the Chancellor’s acceptance of the Dean’s proposal, the SAHS was reorganized into the School of Health and Rehabilitation Sciences, where four of the programs remained (Physical Therapy, Occupational Therapy, Health Sciences Education and Nutrition and Dietetics). The other programs were moved to other academic units as illustrated in Appendix D.
The immediate chain of events that is the focus of this study all occurred between 1999 and 2001.

Data Collection and Analysis

As previously discussed, data were derived from three sources: document analysis, interviews, and participant observation. Data analysis was facilitated by the use of Access database software (Microsoft Corporation). The database was comprised of 410 data entries derived from 12 interviews, 18 documents and the participant observation. The data entries were categorized by location, participant type, structural categories, themes and sub themes, along with text segments that were coded according to the data sources and taxonomy table in Appendix D. Due to the sensitive nature of the subject matter, the source of the quotations from the interviewees are presented in generic form, e.g. “faculty quote.” This is necessary to guarantee the anonymity of the source. Additionally, italics and center spacing are sometimes used to add emphasis to the quoted words.

As indicated in the research questions, three major structural categories of interest frame this study: leadership, internal, and external forces. The leadership of the school was found to be the dominant structural category in the school’s reorganization. The other structural categories, internal and external forces, were also contributing factors but were a distant second to leadership’s role. Each of these structural categories will be discussed below, beginning with external forces.
External Forces: “The consolidated hospital ditched our people and didn’t provide the $220K base needed to cover their salaries.”

Economic themes were the overriding topic of the External Forces structural category. Subthemes such as, Responsibility Center Management, the reaction of the SOM, and Physical Therapy (PT) accreditation were also identified. Moreover, early in the reorganization process an External Advisory Committee was formed as an independent body to make recommendations to the SAHS. As indicated by the excerpt below from the SAHS Dean’s reorganization plan, the committee offered important insights into how the process would unfold.

“An External Advisory Committee, formed through collaborative appointments with key segments of the university, studied the school in the spring of 2001 and in a most insightful and futuristic way recommended a set of strategies and principles for academic and budgetary reconciliation.”

The role of the university’s higher administration was also mentioned and centered on its role in advocating and supporting the SAHS dean’s plan.
Responsibility Center Management

Responsibility Center Management (RCM) was mentioned as a subtheme with most of the comments indicating the perception from the faculty that the SAHS was initially underfunded.

“RCM had the school underfunded initially, a problem that goes back to the 70s”

“RCM initially underfunded, no SAHS involvement with RCM funding, out of loop.”

“SAHS is a quasi-responsibility center (RC) within the SOM. The description as a quasi-RC is based on the fact that the SAHS has a separate and distinct budget with state appropriations.”

The Ad Hoc External Advisory Committee report identified the SAHS a “quasi-responsibility center” within the SOM. The descriptive term “quasi” was based upon the fact that the SAHS had a separate and distinct budget within the SOM. Ideally, responsibility centers (RC) are designed to allow for each RC to determine its own economic plan based upon its own academic mission and needs. However, under their existing structure the SAHS faculty never had the opportunity to fully realize the RC ideal. State appropriations were tied to tenure track positions with tuition dollars being the primary source of revenue for the rest of the school’s operation. There was a widespread perception that the school had been significantly underfunded from the beginning. The school’s past dean summarized the RC problem in this way, “RCM was a
complicating factor...we were gaining resources as enrollment went up but we gained expenses... [through such events as the] hospital merger...PT at a nearby sports facility and the badly needed renovation of classroom/lab space in the residence hall.” It was the SOM that determined the beginning funding base for the school, not the campus, as had been the case for the other schools. Therefore, it appears that the “quasi RC” appropriately describes the school’s funding status.

*Hospital Consolidation*

Another economic sub theme that was identified as an external force in the school’s reorganization was the consolidation of three of the academic center’s hospitals prior to the SAHS’s reorganization. The consolidation resulted in the SAHS having to take on the salaries of tenured faculty members that had, up to that point, been covered by the hospitals. The data indicate that the consolidation played a small role, being overshadowed by more significant factors, yet it did contribute to the economic pressures.

When commenting on the role that hospital consolidation played in the reorganization, one faculty member made a comment typical of colleague reactions: “The consolidation process ditched our people and didn’t provide the $220K base needed to cover their salaries.” The Dean’s reorganization plan also noted the challenges placed on the school from the consolidation, “…it soon became clear that the hospital consolidation created a real challenge to going ahead with creating an independent school.” Others indicated that “while the consolidation was a reason for the shortfall...it was a disguise of a real shortfall that existed all along.”
Lack of Administrative Support

The lack of help from the SOM and central administration was seen to have played a minor, although significant, role in the reorganization. Those interviewed for this study expressed concern regarding lack of support for the financial allocations the school had deemed appropriate.

“Campus didn’t help”

“We were viewed as a SOM stepchild and the campus saw us as a SOM problem.”

“Chancellor was convinced that the SOM would bail them out.”

“It is not the role of the SOM to be the savior when others will not accept their legitimate responsibilities.”

The SOM dean was very clear in stating his position that the SAHS was not part of the SOM core mission, nor should the campus expect the SOM to “bail them out.” Interestingly, some of the SAHS faculty and others interviewed for the study did have the perception that the SAHS was a “SOM stepchild” and that the SOM “could have worked out a solution,” as stated by a SAHS faculty member.

With the exception of central administration’s role in helping the physical therapy program, which will be discussed below, the data indicate a very minor role on the part of central administration in the reorganization process. Although a few faculty members felt
that “central administration had led the Dean down the road” and had influenced the plan for the break-up of the school, others felt that central administration “needed a test case for the new campus policy.” The Dean of the Faculties was identified in the data as having helped shape the process by his actions. Study participants said: “He said he would not hear a vote of no confidence…” and “He was more concerned with figuring out a way that no one would lose face.” One central administrator gave the impression that he was discouraging faculty input by stating, “We will expect communication from the faculty to flow through the SAHS Dean and we encourage you to direct your collective responses to the report to us through him.” Other faculty members simply thought that the “campus level was confused.”

The Whitman University Faculty Council was also identified as playing a small role in the school’s reorganization. Some saw it as a pawn of higher administration, such as the study participant who said, “Faculty Council was used when it was convenient for them.”

However, a review of the Faculty Council actions indicates that the Executive Committee did identify problems with the Dean’s original plan, as indicated in this excerpt from the Faculty Council minutes when the Dean’s plan was originally discussed.

“The Executive Committee had some problems with the plan. The fact that funds for tenured faculty members necessarily follow the faculty members does not fit the original spirit and intent of the policy. Meeting the educational needs for health care professionals to service the citizens of the state should be given priority over the need to pay faculty members – otherwise our students get shortchanged. Also, it seems some programs will be discontinued because of the need to recruit doctorally trained faculty members, even though the terminal degree for the discipline is not the doctorate, and that this supposed “need” couldn’t be met led to the closure of the programs – a vicious circle. Also, the assumption that some of the faculty members will be retiring even though retirement is not mandated, was linked to problems with the budgetary figures (although the Dean did address this problem in his written response to the
Executive Committee’s report). Last, there was the general feeling by the members of the Executive Committee that the spirit and intent of the policy was not followed with regard to involving the students and faculty members.”

Moreover, the Faculty Council was thorough and deliberate in keeping the reorganization process on the schedule dictated by applicable campus policies and procedures as identified from this faculty comment, “…the campus policy drove the process.” As delineated in Appendix B, the campus policy (PTMR) provided the framework for the SAHS reorganization process.

*Physical Therapy Program Accreditation*

While the PT accrediting body was a major external force and the probationary accreditation status of the PT program and the post BS mandate did contribute to the overall process, it affected the internal dynamics of the reorganization process more directly, namely the impetus for the loan from central administration to the program, so it will be discussed in the section below on internal forces. Briefly, an accreditation visit found the program unacceptable in certain areas primarily related to classroom and laboratory facilities. Addressing these issues would be at a considerable cost to the school. However, the SAHS had to make the investment if the PT program was to successfully make the transition from the BS program to the Doctorate of Physical Therapy.
Internal Forces: “Inadequate Funding, That’s the Bottom Line.”

Economic themes dominated the Internal Forces structural category. The school’s culture, faculty involvement and the drive for school independence were contributing internal forces to the school’s reorganization, but it was the lack of funding or poor financial planning that produced the most significant theme. Loss of tuition, extramural funding and state dollars were all contributing factors to the school’s economic problems and, to a lesser degree, the hospitals’ consolidation, mentioned earlier.

“Although several things had an adjunct effect, economic factors was the culprit.”

When asked during his five year review how the budget had changed when he took over as dean, the dean replied, “...Three years ago my budget was $4.5 million and it is now $3.9 million, with the same expenses.” Moreover, the Dean stated that, “In the past two years the SAHS has cut nearly $600,000 from its operating budget.” The External Advisory Committee in its report concluded that, “The current financial resources available to the SAHS are not adequate to support the programs. The situation is a result of both historical factors and decisions.” The data indicate that there was a general consensus among the faculty and the administration that the school was not properly funded from the beginning. One faculty member summarized the feelings of most:

“Decreasing enrollments certainly affected tuition revenue but the overall shortfall appeared to me to be too great.”
The advent of school status in 1991 created new fiscal issues. As the SAHS became independent of the SOM, all program budgets including those that had been in SOM departments moved to the SAHS. This meant that the SOM would no longer be buffering enrollment shifts, faculty salaries originally supported by the hospitals, or changes in state appropriations. Initially, tuition dollars were funding the school adequately according to the economic modeling data but with the move to school status, other sources of revenue had to be developed. Shortly thereafter came the hospital merger. The hospitals, as a result of the merger, transitioned from an educational to a business model of operations, resulting in the withdrawal of salary dollars for tenured SAHS faculty that were hospital-based. With rising expenditures, and no new revenue streams, the shortfall began to develop. Commenting on the impact of these factors, faculty members said,

“However, in the space of two years we went from making $17K per year to losing $11K per year.”

“State not supporting at the levels as in the past.”

“Base support not there. Hospital merger killed us.”

Lack of support for tenured faculty members who had been transferred to the SAHS as a result of the hospital merger was one financial stressor. This problem is detailed in this quote from the Dean, “There is $2,246,631 in SAHS tenured faculty cost
with net state appropriations of $2,130,754. As such there are no extra state appropriations remaining to allocate…”

Program expansion also contributed to financial problems. A retrospective faculty comment tells the story, “At the time of the moves people didn’t fully appreciate the potential pitfalls of expanding the number of programs in the school so rapidly.” One of the reasons this may have been allowed to happen was described by a SAHS faculty member, “During the early years of the incubator school, high enrollments were the trend with the PT program going from 35 students to 70, generating enough revenue to cover the programs that couldn’t pay for themselves.” There was a spirit of optimism, “Therefore, in the beginning on paper everything looked okay, tuition dollars were coming in and the previous Dean and a few other faculty members were also bringing in research dollars.” Although not large in terms of dollar amount, these research dollars were needed to keep the SAHS in the black.

When PT enrollments started to fall and the research money left, the school found itself in quite a predicament. The dominant subtheme derived from the data analysis on program expansion was the influence of the Physical Therapy (PT) program. An examination of the various aspects of this subtheme reveals that the economic needs of the PT program were perceived as playing a significant part in the economic crisis that the school was experiencing. Specifically, the PT program went from being in the position of supporting shortfalls in the revenue of other programs to needing subsidy from them.
“During the early years of the incubator school, 1993 high enrollment was the trend with the PT program going from 35 students to 70 generating enough revenue to cover the programs that couldn’t do it on their own.”

“All of this was critical for the school’s survival, if PT died the SAHS budget wouldn’t make it, the school would go under.”

“PT economically was very important to the school.”

“PT’s excess revenue underwrote the other programs, not an adequate state base; rob Peter to pay Paul.”

When asked what role the PT program played in the school’s reorganization a faculty member commented, “An important role. The Dean apparently decided to save the PT program at all costs and used all the cash reserves and took money from other programs to keep them.” Other faculty members agreed, with one stating that, “All of this was critical for the school’s survival; if PT died the SAHS budget would not make it…the school would go under.” Although PT had been relied upon for credit hour generation to support the other units, it now needed funds and thus was a short-term liability. If SAHS wished to continue to rely upon PT revenue, it had to invest in it. And the investment was significant.

Specifically, the renovation of the PT classroom and laboratory space was seen as the most important aspect of the internal economic pressures related to PT. The renovation was needed to address specific problems the program was having with its
accreditation, which had to be rectified before the faculty could continue to accept
students into the existing program and move to the planned Doctor of Physical Therapy
degree, being promoted by its professional association.

“The first priority was to get more space...so we needed $750K of money just to get to
this point.”

“Moving directly to a DPT was the best option.”

“The PT classroom renovation that was required for their reaccredidation used
resources from all of the programs and drained the school’s cash reserves.”

“Rebuilding PT was the catalyst of the reorganization.”

The first priority for keeping the PT program’s accreditation was to address their
dire need for more classroom space. The Dean identified appropriate space with the help
of the SOM but it would need significant renovation. The Dean estimated that it would
take $750K to renovate the space. In order to raise the money the Dean used all of the
school’s reserves and took funds from the other programs. This created very low overall
faculty morale as exemplified in comments by this disgruntled faculty member, “PT got
other program’s dollars…individual programs never got their revenue…therefore there
was no incentive for faculty to generate dollars, it would just be taken away.” The
economic modeling data indicated that after the Dean used the school’s available
resources for PT, a loan of some type would be needed to defer the developing school
deficit. The Dean indicated at that juncture, “…we were losing $300-500K per year in tuition revenue.” as the PT enrollment continued to decrease from a high of approximately 75 students to less than half that by 2001.

It was also decided during this period that moving the program directly to a Doctor of Physical Therapy (DPT) would be the best option for the PT program in view of the current mandate by its accrediting body that faculty move to post baccalaureate education. The rationale was that by offering the DPT program, student interest in the program would increase and more tuition dollars would be generated as mentioned in the report from the External Advisory Committee, “Graduate fees were more promising than undergraduate for revenue generating.” However, going to the DPT would create additional economic problems including the need to hire doctorally prepared faculty. Despite these, SAHS pursued this direction. One faculty member shared that they, “went to DPT…even though the actual dollars were not there!”

When it became clear that a loan for the PT program would be needed and that a transition to the DPT was critical for PT’s success, central administration, at the request of the Dean, entered the picture. One faculty member described the scenario in this fashion, “the dean of the faculties put all his weight behind helping the Dean (SAHS) get what he wanted.” Additionally, the chancellor lent his support as well, as described in a letter from the Chancellor to the SAHS faculty concerning the reorganization process, “We are developing a plan for a loan to the SAHS as the PT program is changed to a graduate level offering.” The following summarizes the overall perception of the faculty concerning PT’s role in the reorganization process, “The Dean (SAHS) convinced central
administration that the DPT was required for the PT program to keep its accreditation and without the PT program the SAHS could not survive.”

The culture of the SAHS at the time of the reorganization process was identified as one of the internal subthemes, along with faculty involvement and the drive for school independence.

Culture and SAHS independence from the SOM are mentioned generally only in passing as part of the reorganization process. Faculty roles changed as the process developed. Faculty developed strong ties to their individual programs and these loyalties sometimes led them to see programs in competition with each other for resources rather than to focus on the common good. The faculty never felt their efforts were being heard and programmatic loyalties began to surface. Eventually, the programs began circling the wagons. The faculty members felt they were “a federation rather that a school entity” and that it was down to “every program for itself.”

The culture of the SAHS was best described by one of the interviewees as “not a school but a collection of programs.” Other faculty, embittered by the process simply stated that the school was a “10-year experiment that failed.”

Involvement

Initially, faculty were shocked with the news of financial crisis and rallied together for support as described in the following quotes.

“We were really surprised to hear the news, especially since he had spent the previous few months touting school independence.”
“Faculty showed a lot of leadership rallying for a solution.

“Faculty did try to pull together and develop their own plan.”

“Did the faculty plan get a fair hearing?”

“The alternative plan never had a chance.”

In the program directors’ response to the dean’s reorganization plan it was mentioned that, “No discussions occurred directly with affected program faculty, students, alumni or leaders of professional organizations before the distribution of the Dean’s proposal.” Their response also states the following, “It is misleading to describe this work as one that allowed for faculty input. The plan was devised by the dean without benefit of the faculty’s collective wisdom.” This theme of faculty involvement is intertwined with the findings detailed below in the third major structural category, leadership.
Leadership: “Not a Good Communicator.”

The quote above from a faculty member was characteristic of the overall themes described in the data analysis related to leadership. Themes related to leadership included several aspects of the Dean’s leadership style. These are central to the findings in this case. While the internal and external forces presented a highly challenging situation for the school, problems related to communication style increased the tension and disturbed the trust level of the faculty, affecting the way in which the SAHS reorganization played out.

“The Dean has poor communication skills…never collaborated”

“Here’s what I think you need to know”… was his most common expression

“Top Down Leadership Style”

The quotes above are consistent with the findings of the Dean’s five-year administrative review conducted immediately following the school’s reorganization. The review committee’s findings identified a significant communication disconnect between the Dean and the faculty as illustrated from the following excerpt from the Dean’s five-year review report.

“The greatest criticism expressed of the Dean regards his communication with the faculty.”
The data indicate that the primary themes and subthemes related to his leadership style were indicative of his communication problems with the faculty as well as their apparent mistrust of the process and his end result of reorganization for the school. Faculty were often quoted as expressing observations such as

“Once he got an idea in his head he went for it.”

“Getting faculty input was an afterthought.”

“He did it on his own but went to great lengths to try and convince everyone it was a collaborative effort with the stakeholders.”

“Some also claimed that he did not follow university policies”

“...It was the dominant role. The Dean’s lack of communication skills created all kinds of problems and made everyone suspicious of the whole process. It created an atmosphere of distrust.”

“However, many felt the books were cooked.”

“His leadership strategy was to be an advocate for his plan and present it as the only option.”

“His attitude was that I have the information and I will give you what you need to know.”

“A man I found hard to trust.”

Another contributing factor to the mistrust of the Dean was an overriding feeling by the faculty that he had his own agenda and was using the financial problems of the school to further his dream of an independent school comprised of programs offering only graduate education.
“Opportunity to do his own thing…Graduate education.”

“The Dean used the school’s predicament to develop a plan that would allow him to realize his dream.”

“The school’s financial issues were not as significant as he made them. If the financial aspects could have been solved he would still have wanted to go for his dream.”

“By the time faculty found out what was happening it really didn’t matter.”

“Faculty weren’t engaged until the end and were pissed!”

Other aspects of the mistrust of the Dean center on the perception that he collaborated in some way with higher administration in developing his plan, as illustrated by these faculty comments.

“The Dean dissolved it 100% with the support of the Chancellor and Dean of the Faculties.”

“The preliminary proposal was distributed to the Chancellor and Dean of Faculties and the SOM Dean before it was shared with the SAHS faculty.

“The Dean kept all of his information close to his chest.”

“They misinformed the entire faculty.”

Moreover, the campus Faculty Council’s Executive Committee echoed the mistrust of dean by the school’s faculty as identified in these excerpts from Faculty Council Meeting minutes.
‘The Executive Committee of the Faculty Council believes the spirit and intent of the
[PTMR] policy was not followed.’

“The Executive Committee questions the budget figures and projections provided in the
SAHS Dean’s plan.”

“The [Whitman] University Faculty Council Executive Committee initially rejected the
Dean’s Academic and Budgetary Plan, then accepted it after revisions and
recommendations were made,”

Positive comments concerning the Dean’s role in the reorganization process were few. However, he was often complimented on his public presentation. One faculty member expressed the following thoughts: “The Dean presents himself well in public. He is prepared and eloquent although vague when he speaks.” He was also complimented on his ability to secure funds for the PT classroom and laboratory renovation and the successful approval and accreditation of the Doctor of Physical Therapy program. One interviewee specifically said that without the Dean’s strong management of the situation, the outcome would have been much worse. He was also characterized by many interviewees during his five year review as being, “a man of integrity and honesty.” A university administrator was quoted as saying,

“In terms of problem solving ability and management of several difficult issues during
his tenure as Dean, I give him high marks.”
Summary

The results of the data analysis clearly articulated the relative significance of each structural category. Leadership was identified as being the most significant structural category contributing to the school’s reorganization. Economic factors from both internal and external forces contributed to the school’s reorganization but were overshadowed by the communication disconnect that permeated the leadership category.
Chapter 5: Discussion and Summary

As recounted in the previous chapter, the reorganization of the SAHS at Whitman University occurred in the context of several forces. Internal and external forces along with leadership played a role in the school’s reorganization. This chapter will highlight for discussion the major aspects of the most significant of these.


Organizational change during the school’s reorganization process can be summarized in two related phenomena, the first being the communication disconnect between the Dean and the faculty and the second, the perception that the Dean’s academic and budgetary plan was not a result of a rational decision making process and lacked validity.

Top Down Management

The Dean’s interactions with the school’s Ad Hoc Economic Modeling Committee were characteristic and predictive of his approach to interacting with other committees and related groups throughout the SAHS reorganization process. The Dean’s interaction with this committee will be used in this discussion as an example of his interactions not only with this committee, but with other decision making bodies as well.

When first becoming aware of the dire financial condition of the SAHS, the Dean initiated deliberations by way of establishing an Ad Hoc Economic Modeling Committee consisting of selected faculty members and chaired by the Associate Dean of the School. This action is customary to most similar types of endeavors in the academy whereby faculty committees are formed by administrators to address issues and are then charged to
hammer out the details and subsequent guidelines of how to deal with the issues and resolve the problem. Once that is accomplished recommendations are then made to the responsible administrator, in this case, the Dean. Unfortunately, faculty confidence in the process and lack of trust in the Dean’s intentions during the economic modeling process largely derailed the process as described in the faculty comments below.

“They developed hundreds of models, none of them correct”

“False scenarios were presented to permit the Dean and Dean of Faculties to do their own thing”

Problems surfaced in faculty perceptions of the Dean’s organizational approach from the start of the SAHS Ad Hoc Economic Modeling Committee. Although he didn’t chair the committee himself, the Dean’s appointment of the Associate Dean was viewed by many as an attempt on his part to influence the committee’s deliberations.

“The Associate Dean was appointed by the Dean to be the Chair of the SAHS economic modeling committee, and at the first meeting, told us that faculty have their own minds but the faculty knew that she would simply report back to the SAHS Dean what we discussed and would be pushing his agenda.” (Quote from a committee member)

As indicated above, the perception among faculty was that the Dean was setting up a hierarchy of functions where there were commanders and commands. The Dean had used a similar approach in the past by inserting administrative liaisons into faculty committees. The Dean’s approach fits very well into Schwartz’s and Ogilvy’s paradigm under the hierarchic to heterarchic construct whereby his inserting the associate dean into the
mix allowed him to interject a net of constraints and influences (Clark, 1985). The strengths of this approach would be to establish a peer committee that would review the data and then come up with recommendations that would appear fair and equitable to the faculty based upon his indirectly applied guiding principles. However, the weaknesses of the Dean’s approach are even more apparent in that he interjected hierarchy through appointing his administrative colleague to chair the committee. Such hierarchical imperatives are ineffective in systems where there are participatory decision making and decentralization, as pointed out by Clark (1985). Although the SAHS is organized in many ways like a bureaucracy, it is far from the classic sense that would be needed for the hierarchical approach to be successful. More consistently, the SAHS organization resembles a professional bureaucracy as described by Mintzberg (2000). In this case it is understood that professionals have considerable control over their work, thus, the professional works independently of his colleagues. Human action, in this case faculty work, cannot be oriented successfully in a hierarchical sense. The faculty committee rejected the Dean’s attempt at this approach of inserting the Associate Dean immediately. During the course of these discussions, Cohen and March’s “garbage can” model of decision making became more and more appealing (Cohen and March, 2000). Eventually, the faculty committee rejected the Dean’s indirect guiding principles and began their own decision making process whereby they used the available data to formulate their own decisions. Unfortunately, the data were made available to them in a piecemeal fashion that were changing as new economic models were being produced.
For each step in the reorganization process the Dean routinely presented choices for addressing the problems and issues facing the various arenas of interest. In some cases he alienated some of the faculty members, as described by one:

"Here’s what I think you need to know… was his most common expression."

The decision makers (committee members), would then discuss alternative approaches to most of the Dean’s suggestions for addressing the school’s problems. The committee clearly did not agree with the mechanical approach of the Dean and gravitated toward a type of interconnectedness described by Clark when commenting on the holographic metaphor where holography is employed as a counter-metaphor to a machine-like approach (Clark, 1985). Morgan’s (1986) description of holographic design had in common many of the characteristics of the committee work during the reorganization process. The committee was very much a “self-organizing, emergent phenomenon” as Morgan describes the holographic style of organization. It seemed that every committee member had strong feelings concerning how the school got into financial difficulty and how they would get out. It was at this juncture that the strengths of the holographic design began to be realized. Although members had their own ideals, the faculty culture made it possible for all members to be willing to listen and learn about the others’ ideas and concerns.

Morgan observes that culture is a major source of power influencing effective management. After much multiple loop (and redundant) discussion it became apparent that the separate parts eventually became integrated into a whole. This permeated the
value system of the individual committee members, thus reproducing itself and essentially changing the tone of the process from one of dictatorial management to an opportunity for the faculty to have a voice. The major weakness of this approach is the danger of self-reference. It is quite likely that in their exercise of “brains looking at brains” they may have overlooked an important source of conflict or information that could have contributed to the final outcome. Another important related consideration is the potential that the committee may have become isolated from the rest of the faculty. Bensimon and Neuman (1993) describe ways in which a team (in this case the committee) may lose touch with the rest of the faculty by “turning in on themselves”.

The evolution of the committee’s organizational considerations resulted in a coupling of classical hierarchical organizational characteristics to a more neo-orthodox holographic approach. Additional organizational considerations center on Clark’s discussion of the importance of negotiating the formal and informal structures of an organization. The committee wrestled with this paradox throughout its deliberations.

Unfortunately, the committee’s endpoint, as a result of this “holographic experience”, was perceived by the faculty as never being fully realized. As described by the outward expressions of the faculty’s dismay presented in the quotes below:

“The Dean wanted faculty engagement but didn’t allow for an open and honest dialogue”

“Biggest problem was the Dean’s belief that the faculty were involved in the process… However, faculty came away thinking “the Dean did this to us” he didn’t listen.”
“No One Would Believe Me!”

The quote above well describes the Dean’s frustration with the overall acceptance of his reorganization plan for the school.

“Bird nest scenario: 14 children but not enough food for all 14 . . . Programs did not come with adequate revenue when jettisoned from other departments to form the SAHS . . . SAHS couldn’t afford them either”

Yet the Dean’s inability to help faculty realize the set of circumstances that faced the school, along with his communication style, led faculty to think that he was not being open or honest, and that in many ways, his plan was not the result of rational thinking, nor was it informed by faculty thinking.

The Dean’s decision making process in addressing the reality described in the university administrator’s quote above is best understood using normative decision theory as described by Chaffee (1991), who describes rational decision making in university budgeting to be a “normative ideal, but not susceptible to practice.” When practiced, rational decision making should consist of four criteria: goals, alternatives, consequences and the selection of those consequences (choice) that rank the highest among the decision maker’s values. The criteria and their associated elements to test the rational model for the Dean’s reorganization plan for the SAHS will be discussed below.
Criterion 1: Goals

The first criterion requires that the Dean have a consistent set of priorities regarding what he was interested in funding for the future. A review of his plan indicates the following principal elements:

1. academic importance
2. potential tuition revenue
3. extramural funding potential
4. preservation of tenured faculty
5. graduate education

The Dean used these as justification for retaining, eliminating or moving academic programs out of the SAHS. The Dean was consistent in his use of the criteria and clearly used these in his decision making process when developing his plan. In the listing of his 11 recommendations for the reorganization of the school, the Dean utilized each of the elements listed above with the end result being a cluster of graduate health science degrees. Thus, it appears the Dean has satisfied the first criterion for the rational model by being consistent in his use of his identified funding priorities. Although the Dean inadvertently articulated these, they were never given to the faculty.

Criterion 2: Alternatives

In a rational process the Dean should have simultaneously considered a wide array of funding alternatives for the SAHS. Several aspects of the Dean’s actions are consistent with this criterion. He utilized economic modeling resources to examine several funding alternatives for the school before deciding on a course of action.
Secondly, he was diligent in following the University’s protocol for financial exigency, which aided him in obtaining numerous pieces of information from, arguably, most communities of interest for the school. Various faculty committees, the Whitman University Faculty Council and an external advisory committee among others, were all instrumental in providing him with a wide array of funding alternatives simultaneously. In communications with the faculty and other stakeholders he stated his intentions and acknowledged the various sources he used in drafting his plan. The chronology of events surrounding the reorganization indicates that the Dean indeed had a wide array of alternatives before him to consider before making his budget decisions. The (PTMR) policy outlined a distinctive working framework and chronology of events guaranteeing him simultaneous information about various funding alternatives. He specifically states in his plan that the basis for the decisions he made incorporated the recommendations of committees formed to study the problem and that he made every effort to be consistent with university personnel and budgetary policies.

Whether or not he thoughtfully considered each alternative is a matter of judgment. However, he certainly had a wide range of alternatives to consider. The evidence for a wide array of simultaneous alternatives is unequivocal and satisfies the second criterion for the rational model.

Criterion 3: Consequences

The third criterion deals with the quality of information available to the Dean. Did the Dean have sufficient information to understand the causes and effects of his decisions? Although many members of the faculty and others felt that the Dean was acting unilaterally, it appears that he did make a conscientious effort to follow the
university’s policies and procedures document and other relevant information, as discussed above. This inherently provided him with numerous scenarios outlining the causes and effects of various objective courses of action. Moreover, early in the scheme of things, the Dean assembled an Ad Hoc Committee to examine the economic models that he was considering and solicited their input into what course of action was needed for the school. However, several of the committee members expressed concerns that he had been meeting with the economic modeling office for sometime prior to the faculty becoming aware of the school’s financial problems and had already developed his plan of action. Whether that was the case or not is just speculation. A systematic review of his plan clearly indicates that the Dean did have sufficient information to be able to understand the causes and effects of his decisions before the release of his plan. Moreover, he solicited numerous pieces of information directly related to causes and effects for each program by asking them to submit reports to him. The report was to describe the academic aspects of their program, but as well to justify their existence. While met with resistance by some program directors, the reports along with other supporting evidence did provide important information to the Dean concerning the causes and effects of eliminating or jettisoning their programs from the school. These reports included information about enrollment trends and specific assessment information, such as the students’ pass rates on their national exams, along with employment and retention data. All of these actions demonstrated a consistent theme of relating causes and effects for each program the Dean was to consider. Although the evidence is not strong that he considered all of the available alternatives, he had many alternatives to choose from when developing his course of action.
Criterion 4: Choice

The rationality of the Dean’s choices can be observed through their links to his previously identified list of funding priorities, which include academic performance, student interest or potential tuition revenue, extramural funding potential, and preservation of tenured faculty and graduate education. Neither academic performance nor funding potential is easily susceptible for measurement. However, if the Dean made his decisions according to any one or more of the five goals, he satisfies the behavioral model of rationality. The Dean was able to measure student interest or potential for tuition revenue by the student’s registration in courses and whether or not the program’s student capacity was filled in recent years. The goal for graduate programs could be easily measured since the program either offered graduate education or it didn’t. The Dean’s priority for excellence can’t be measured as directly, but a reasonable approximation was possible since the Dean had historical information related to student and faculty performance by a number of indicators including students’ performance on their national board exams, enrollment data, faculty publications and service on university committees, to name the major ones. Most of this information was readily accessible to the Dean via the assessment report generated by the school as part of the university’s assessment program. The number of tenured faculty in each program was a critical consideration since the university’s funding for each program was directly related to state appropriations. Thus, the university document on financial exigency basically mandated that the Dean use that element as a major part of his decision making. Therefore, even given that not all of the elements were easily measurable; it does appear
that the Dean should have been able to select his preferences based upon his ability to select the maximizing alternatives.

Summary

The evidence in support of a rational decision process is substantial but not unequivocal. The evidence is strong for a consistent set of goals, for simultaneous selection from a wide array of alternatives, and for at least a satisfying choice among the alternatives. However, the argument for rationality would be more convincing if there were a clearer connection between the data at hand and the ways in which performance information were matched to the decisions, especially in the case of academic performance and extramural funding potential, which were hard to measure.

Although some of the school’s faculty and other observers of the Dean’s decision making process would argue that his decision making process was anything but rational, the process shows substantial signs of procedural and substantive rationality. The Dean’s plan for the school’s reorganization was comprehensive and exhaustive in scope and delineated the accumulated data that he used in his decision making process. In the final analysis however, it is important to take note that whatever the Dean’s decision making model, different treatment of programs by the Dean within the school signaled his organizational priorities and his perception of the program’s worth or power. His failure to articulate the connection between the data he gathered and the resulting decisions led to the perception that his approach was not entirely rational.

In addition to the Dean’s lack of communication, the faculty’s perception of the Dean’s plan was also influenced by their lack of information, denial of their reality and self interests. Moreover, as the reorganization process unfolded, the faculty became less
interested in dialoguing with the Dean, which contributed to the overall breakdown in communication.

“Experiment That Failed”

Morgan’s (1996) discussion of organizations in reference to what he calls “logics of change” applies well to the organizational curiosities associated with the School of Allied Health Sciences (SAHS) and its subsequent failure to survive as characterized by the faculty quote above. Specifically, two of the four processes mentioned by Morgan, autopoiesis and chaos complexity theory are well suited for this purpose.

**Autopoiesis:** The theory of autopoiesis accepts that organizations can be recognized as having environments but insists that the relations with any environment are internally determined (Morgan). For the SAHS there were indeed interactions with many different types of systems within the academy, but oftentimes those relationships were determined by the larger health care environment. For example, the SAHS found itself a school within a school.

**Chaos and Complexity:** When discussing the logic of chaos and complexity theory, Morgan emphasized that chaos theorists paid particular attention to the way system behaviors tend to fall under the influence of different “attractors.” For example, an organization may find itself caught between different “attractors” that go before different situations and the organization finds itself pulled toward one thus diminishing the significance of the other. This concept describes very well the circumstances of the SAHS, where the school found itself being pulled between its academic mission, being part of the medical school and its economic reality.

*Organizational Problem Analysis*

Therefore, the overall organizational problem facing the SAHS can be summarized as an identity problem whereby the SAHS was vacillating between trying to
fulfill its academic mission, being a school within a school, and dwindling economic resources.

Morgan identified this type of organizational problem in his discussion of autopoiesis as an organizational metaphor. He tells us that many of the problems organizations encounter in dealing with their environments are intimately connected with the kind of identity they try to maintain. The SAHS, while expending great resources trying to maintain its academic identity separate from the School of Medicine, found itself self-referenced back to the academic health care environment with the illusion that it had somehow extended its academic identity. The SAHS had some autonomy from the School of Medicine, but not enough to function as a free standing school.

“Change Is Messy”

As described by a faculty member in the quote above, the SAHS was experiencing turmoil in all three of its traditional missions of teaching, research and service. Clashes of values and norms of the cultures within the university and the SAHS hindered effective adaptation to the stresses affecting the SAHS. Administrators, faculty and staff all had strongly conflicting perspectives. In general, the internal organizational structure of the SAHS resembled a professional bureaucracy, as described by Mintzberg (2000) where the professionals have considerable control over their work. This aspect of SAHS governance, along with the observation that most departments within SAHS were part of a “loosely coupled” educational system (Weick, 2000) made any reorganization of any kind difficult for the SAHS.

Schools of allied health sciences have played an important role in the improvement of health care delivery. The schools of allied health sciences that successfully weather the current storm in the health care environment will be stronger institutions. However, in order to do so they must come to terms with their entrenched cultures and create new forms of organization that are more flexible, more adaptive and more agile. They must overcome their current state of schizophrenia and synthesize a
new identity, a “hybrid” of what they are today, part business, and part academic (Vavala, 1996).

The overall lessons to be learned from this case study are threefold. Both faculty and administrators, when faced with a problem of this magnitude, must be willing to face the reality of the situation, be dedicated to the truth and have the discipline to work together. The process of confronting and solving problems is a difficult one. Uncomfortable feelings emerge such as frustration, grief, sadness, anger, fear and anxiety. This phenomenon helps to explain why many of the school’s problems were ignored by both the faculty and the administration until they could be ignored no longer. M. Scott Peck (2003) tells us that “not only individuals but also organizations are notorious for protecting themselves against challenge” (p. 52). He goes on to tell us that in order for organizations to grow in wisdom and be viable and effective they must be willing to accept and welcome challenges.

Recommendations for Future Study

This case study in organizational change identified the inherent necessity of direct and legitimate communication between the SAHS Dean and the faculty. The communication disconnect that was identified as the dominant driving force during the reorganization process directly points to the need for further research into communication techniques and methodologies whereby faculty and administrators can dialogue effectively for their common good. Communication that facilitates a hearty and robust dialogue between the Dean and the faculty was glaringly absent in the SAHS, as pointed out by the case study data, creating a milieu of distrust and anxiety.

Limitations of this study include the single-case design. A multiple case design would strengthen future studies by allowing for the inclusion of multiple institutional characteristics that might broaden the scope of this single case study. Additionally, future case studies would benefit from the larger database that a multiple case design would provide.
References


The clinical doctorate. (2005, July). *Association of Schools of Allied Health Professions Trends, 1.*


education, 22, 7.


Appendix A

*Interview Questions*

*Internal Forces*

- What internal forces contributed to and led to the school’s reorganization?
- What was your perception of the faculty’s reaction, role and response to the school’s predicament?
- In your opinion what led to the economic collapse of the school?
- What if any role did the drive toward school independence play?
- Did the Dean’s desire for graduate education affect the process?
- What role if any did fluctuation in the school’s enrollment play?
- Did the lack or loss of external funding after the previous Dean left play a role?
- What if any role did the economics of the Physical Therapy program play in the schools solvency?
- Was money the major factor? Why or why not?
- Did the faculty’s alternative plan get a fair hearing?
- Was the faculty cohesive or not cohesive during the process? Was it every program for themselves?
- Could a faculty consensus be built?
- Did tenure factor into the mix?
- What role did the previous Dean play in the process?
**External Forces**

- What external forces contributed to and led to the school’s reorganization?
- Was the hospital consolidation a major factor?
- What role did national trends e.g., the Balanced Budget Act play?
- What was your impression of the School of Medicine’s role in the process? e.g., should they have bailed SAHS out?
- Did higher administration play a role and if so, what was it?
- What role did RCM (Responsibility Center Management) play in the school’s reorganization?
- Were university politics a factor?
- Were accreditation issues a factor in the school’s reorganization, e.g., mandated post baccalaureate education for Physical Therapy?
- What role did the Faculty Council play?
- Did the campus policy (PTMR) play a role in the process?
- What is your impression of the role the economic modeling process played?
- What was your impression of the role of the external advisory committee?
Leadership

- What role did leadership play in the reorganization of the school?
- What role did the Dean’s leadership characteristics play in shaping the reorganization process?
- What were your thoughts concerning the development of the Dean’s plan?
- Did the Dean’s leadership team have a role in the process e.g., Associate Dean?
- How would you describe the Dean’s leadership style based upon your personal interactions with him?
- Did the Dean lobby enough for help for the school both within and outside the university?
Appendix B

September 4, 2001

Chronology and Timeline for Consideration of Program Transfer, Merger, Reorganization, Reduction and Elimination in the School of Allied Health Sciences

(Developed by the Deans of the SAHS, SOM, Dean of the Faculties and the Chancellor in consultation with Faculty Council Executive Committee, (8/30/01)

<table>
<thead>
<tr>
<th>1999-2000 (and earlier)</th>
<th>Considerable concern about and discussion of the economic and academic condition of the School due to enrollment shifts, accreditation, hospital consolidation and other complex factors. School of Allied Health Sciences conducts economic modeling of school for 5 year projections.</th>
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<tbody>
<tr>
<td>Summer – Fall, 2000</td>
<td>Ad hoc school faculty/administrative review committee studies economic model and makes recommendations.</td>
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<tr>
<td>December 2000</td>
<td>Dean SAHS submits statement of financial difficulty to Dean SOM and to the Chancellor.</td>
</tr>
<tr>
<td>Spring 2001</td>
<td>School requests campus reallocation of $500,000 to address financial problem as part of established campus budgeting/planning cycle.</td>
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<tr>
<td>Spring 2001</td>
<td>Appointment of ad hoc external review committee and recommendations (committee report provided to Executive Committee).</td>
</tr>
<tr>
<td>June 2001</td>
<td>Dean meets with school executive committee regarding committee reports and next steps.</td>
</tr>
<tr>
<td>*Step 1 June 11, 2001</td>
<td>Dean distributes draft academic and budgeting plan to Allied Health faculty and Deans of schools with related programs (plan provided to</td>
</tr>
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</table>
Executive Committee).

Step 2 June 20, 2001 Faculty meeting with Chancellor, Dean SOM, and Dean of the Faculties to discuss next steps for faculty input prior to Dean’s submission of final set of recommendations and request for formal action (letter to faculty provided to Executive Committee).

Step 3-4 August, 2001 Individual programs in School of Allied Health Sciences complete comments on Dean’s draft proposal (copies of program reports provided to Executive Committee).

*NOTE: Steps refer to those specified to the University’s Policy on Program Transfer, Merger, Reorganization, Reduction and Elimination.

Step 3-4 September 7, 2001 Deadline for faculty commentary to be submitted to Dean SAHS (Note: faculty can continue to provide comments to Dean SAHS and Faculty Council’s Executive Committee until September 24, or Step 8).

Step 5 September 14, 2001 Deadline for Dean SAHS to submit a proposal to Dean SOM (and concurrently forwarded to Allied Health faculty and Faculty Council Executive Committee).

Step 5 September 17, 2001 Deadline for Dean SOM to submit a proposal to Chancellor (and concurrently forwarded to Allied Health faculty and Executive Committee).

Step 6 September 18, 2001 Deadline for Chancellor to refer report to Faculty Council Executive Committee (and concurrently Allied Health faculty).

Step 7 September 20, 2001 Executive Committee meets with Allied Health faculty (Note: Executive committee will assume responsibility for this matter without delegating). Time set for September 20, 1:30-3:30 p.m. in Nursing 103.
Step 8  September 24, 2001  Deadline for written comments to Executive Committee (comments should also address any materials added at Steps 5 and 6). Send comments to University Faculty President.

September 27, 2001  Executive Committee meets to deliberate

Step 9  September 28, 2001  Executive Committee deadline for submitting report to Chancellor, Dean SOM, and Dean SAHS.

Step 10  October 1, 2001  Deadline for Dean SAHS and Dean SOM to submit response to Chancellor and Executive Committee.

  October 2, 2001  Deadline for Executive Committee to submit Dean’s proposal, recommendation of Executive Committee and responses of Dean SAHS and Dean SOM to Faculty Council.

Step 10  October 4, 2001  Meeting of University Faculty Council; one hour discussion of Allied Health scheduled.

Step 11  October 10, 2001  Deadline for Chancellor to declare need for action and to refer proposal—as modified by Deans SAHS and SOM—to Executive Committee with Chancellor’s comments.

Step 12  October 10-19, 2001  Period for Executive Committee to conduct open, campus-wide meeting(s).

  October 11, 2001  An open meeting for all University faculty has been set for 2:00 - 4:00 in Nursing 103 (other meetings may be scheduled).

  October 18, 2001  Executive Committee meets to deliberate.

Step 12  October 24, 2001  Executive Committee distributes Deans’ proposal and Executive Committee response to Faculty Council.

Step 13  November 1, 2001  Meeting of University Faculty Council; a discussion period (minimum of one hour) has been scheduled for the Council to deliberate and
to make recommendations to Chancellor.

<table>
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<th>Date</th>
<th>Description</th>
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<tr>
<td>14</td>
<td>November 30, 2001</td>
<td>Chancellor forwards final determination to Dean SOM and Dean SAHS (with summary to Allied Health faculty, Faculty Council, and academic Deans).</td>
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<tr>
<td></td>
<td>November 2-30, 2001</td>
<td>Chancellor reviews Deans’ proposal, Faculty Council recommendations and other commentary and consults as necessary to make a final determination.</td>
</tr>
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Appendix C

School of Allied Health Sciences Organizational Chart

Dean

Associate Dean
Student and Academic

Director of Student Affairs

Student Affairs Specialist

Assistant to the Dean

Business Manager

Development Director

Programs

Cytotechnology

Health Information Administration

Health Sciences Education

Medical Technology

Nutrition & Dietetics

Histotechnology

Paramedic Science

Occupational Therapy

Radiologic Sciences

Physical Therapy

Radiation Therapy

Respiratory Therapy
Appendix D

School of Allied Health Sciences Post Reorganization Chart

School of Health and Rehabilitation Sciences
  - Health Sciences Education
  - Occupational Therapy
  - Physical Therapy
  - Nutrition & Dietetics

School of Medicine Health Professions programs
  - Cytotechnology
  - Histotechnology
  - Paramedic Science
  - Respiratory Therapy
  - Medical Technology
  - Radiologic Sciences
  - Radiation Therapy

School of Informatics
  - Health Information Administration
## Appendix E

### Data Sources and Taxonomy Table

### Location

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### Participant

**interviewees**

- **Staff**  
  SAHS Staff
- **UA**  
  University Administrator
- **D**  
  Dean
- **HE**  
  Health Sciences Education
- **PD**  
  Previous Dean
- **SFP**  
  SAHS Faculty President, Radiologic Sciences
- **EM**  
  Economic Modeling
- **OT**  
  Occupational Therapy
- **RT**  
  Respiratory Therapy
- **CL**  
  Clinical Laboratory Sciences
- **PT**  
  Physical Therapy
- **EAC**  
  External Advisory Committee Member
documents.

- SR  Dean’s Review committee
- FS  External Advisory Committee Report
- IUE  Whitman U. Faculty Council Executive Committee Report
- RBB  Response of SOM Dean to Chancellor
- SRB  SAHS Dean’s response to SOM Dean to IUE
- FCR  Whitman U. faculty council recommendation for SAHS RP
- PL  Dean of Faculties Letter to the SAHS Faculty
- BMA  Chancellor’s Memo to SAHS Faculty
- CPP  SAHS Program” combined Position Papers
- BAHFM  SOM Dean’s Final Response to the Chancellor
- SFLB  SAHS’s letter of submission to the final reorganization Plan
- ARAP  Administration’s response to the faculties Alternative Plan
- RPES  SAHS Dean’s reorganization Plan-Executive Summary
- FPFCP  SAHS Faculty President’s Presentation to the Univ. Faculty C.
- PD801  Program Directors Planning Meeting 8/01
- PDRRP  Program Director’s Response to the RP
- CLINL  Clinical Lab Programs Response to the Dean taking funds
**Structural Categories**

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**Themes**

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<td>School Independence</td>
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Sub-themes

PT  Physical Therapy Program
OT  Occupational Therapy
FED Federal Legislation
RCM Responsibility Center Management
EXP Experience
PD  Previous Dean
FacA Faculty Anger
CP  Communication Problem with Dean
RP  Reorganization Plan
EM  Economic Modeling
En  Enrollment
HA  Higher administration
UE  University Exigency Policy
XF  Extramural Funding
CL  Merged Hospitals
SA  State Appropriations
SOM  School of Medicine
AP  SAHS Faculty Alternative Plan
CURRICULUM VITAE

Name: Crabtree, William Nelson

Education:

1977 B.S. (Cytotechnology)  
University of Tennessee  
Center for the Health Sciences  
Memphis, Tennessee

1983 M.S., Health Occupations Education  
Indiana University  
Indianapolis, Indiana

2006 Ph.D., Higher Education  
Indiana University School of Education

Academic Appointments:

1982-85 Instructor, Cytotechnology Program  
School of Allied Health Sciences/Department of Pathology  
Indiana University School of Medicine  
Indianapolis, Indiana

1985-91 Assistant Professor of Cytotechnology/School of Allied Health Sciences  
Department of Pathology and Laboratory Medicine  
Indiana University School of Medicine  
Indianapolis, Indiana

1987 - Program Director  
Cytotechnology Program  
Indiana University School of Medicine  
Indianapolis, Indiana

1991- Associate Professor of Pathology and Laboratory Medicine, Department of Pathology and Laboratory Medicine, Indiana University School of Medicine