

A STUDY TO DETERMINE THE ADMINISTRATIVE ORGANIZATIONAL  
APPROV STRUCTURE OF THE CHARLTON-METHODIST HOSPITAL,  
A BRANCH OF METHODIST HOSPITAL  
OF DALLAS, DALLAS, TEXAS

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Requirements for the Degree  
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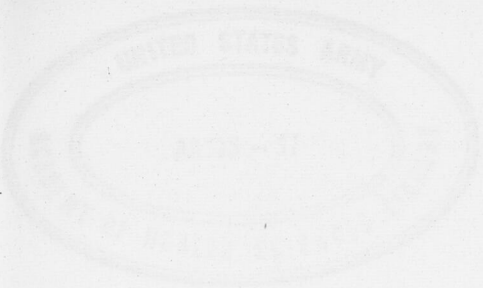
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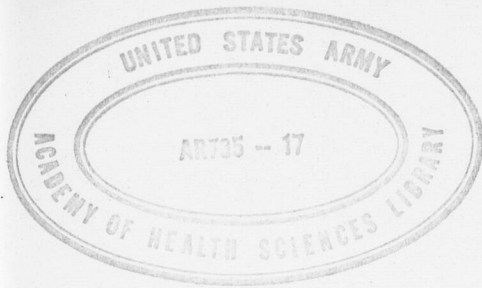


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Because of this demographic development and the myriad of scientific and technological advances, medical facilities have been faced with a challenge to change. The task to be faced is to take advantage of, and employ, the technological advances to deliver care to the expanding and spreading population. This must all be done to better serve the population, and at the same time to meet increasing governmental requirements of quality and financing.

As the inner cities change in character and composition, the hospitals find that their consumers are also

## CHAPTER I

### INTRODUCTION

#### Development of the Problem

##### General information

Throughout the United States there has been a rapid increase of movement of the population to the outer edges of the cities and metropolitan areas. As a result, there is a requirement for more schools, shopping areas, recreational facilities and more readily available health services.

Because of this demographic development and the myriad of scientific and technological advances, medical facilities have been faced with a challenge to change. The task to be faced is to take advantage of, and employ, the technological advances to deliver care to the expanding and spreading population. This must all be done to better serve the population, and at the same time to meet increasing governmental requirements of quality and financing.

As the inner cities change in character and composition, the hospitals find that their consumers are also

changing. The consumers are better informed and want better care. They are more sophisticated in many of their requirements because of legislation and publicity programs surrounding the health care industry. There is an increasing number of these potential consumers that are backed by some type of third-party financing system, whether it be governmental or private insurance. The consumer believes that all facets of life should be improving, and the health industry is required to meet that expectation.

The hospital must provide an equitable distribution of care and service, improve the quality of that care and strengthen the role of the institution in the community. The expansion of the community also expands the problem, because hospitals now located in the heart of metropolitan areas must determine how they can reach that suburban portion of their community. Technology will assist in a portion of the solution--better techniques, new means of emergency and ambulatory transportation--but this is only part of the answer.

Expansion or spreading of the hospital facilities, along with the population shift, is another aspect that is

being implemented or considered by many institutions. Any time a hospital expands its service and physical facilities, it must also adjust its organization to best accomplish its expanded mission. It is the responsibility of the hospital administrator to determine the optimum structure of the organization. It is a prime necessity for proper functioning of the institution; because the organizational structure should complement delineation of authority and responsibility and, to a degree, defines the functions of internal agencies of the hospital.

Conditions which prompted the study

Methodist Hospital of Dallas (MHD) was faced with a need to expand its services and facilities to serve a wider area and extend care to a suburban area through some new delivery system. The decision was made to build a branch facility in the growing suburbs that had no primary care facility. In preparation for the opening of that branch, the administration recognized that the organizational structure of the branch must be carefully planned to optimize achievement of the objectives of the construction.

Methodist Hospital of Dallas is a church-owned, voluntary, general, acute hospital that has been serving the community of Southwest Dallas County since it was originally chartered in January, 1921. Over the past 50 years, it has grown from the initial 100-bed sanitarium to a 520-bed institution that is involved in extensive activities of patient care, education, and research. The current replacement costs of the land, buildings, furnishings, and equipment are estimated to be in excess of \$25 million.<sup>1</sup>

Beginning in 1954, several studies conducted by, or under the sponsorship of, the Health Planning Board of the Dallas County Council of Governments have attempted to conduct some progressive, forward-looking planning to serve the health care needs of the greater Dallas area.<sup>2</sup> Information from these findings and the forecast of population growth in Dallas County indicated that there would be a requirement for additional inpatient beds and services in Southwest Dallas County in the period 1975 to 1995.<sup>3</sup> Studies completed in 1964 recognized the limitation on expansion of existing facilities. While they did recommend expansion in those hospitals where it was deemed both neces-

sary and feasible, it was also recommended that certain existing institutions investigate extension of their coverage by means of branch or satellite facilities. MHD was one of those institutions so designated.<sup>4</sup>

Upon direction of the Board of Trustees, MHD immediately began investigation of the feasibility and possible location of a branch hospital. Although the road was not a smooth and uneventful one, the ultimate decision was made to build Charlton-Methodist Hospital (CMH) on a site approximately eleven road miles southwest of the present main hospital location.

Construction was begun in late 1973 and the new hospital is scheduled to open in the late spring of 1975. It will be an acute-care facility with a 166-bed capacity when fully operational in its initial configuration. It is of semimodular design and may be expanded to over 400 beds by addition of subsequent nursing service towers. Concurrent with the construction of the new hospital, an adjoining professional office building is being built. It will be physically attached to the hospital to facilitate movement of physicians and patients between the offices

and the diagnostic and inpatient facilities of the hospital.<sup>5</sup> Recognizing that there are a number of techniques that can be implemented for the organization and management of the new facility, the administration requested that a study be made to ascertain the organizational structure of the branch hospital.

#### Statement of the problem

The problem is to determine the administrative or-  
ganizational structure of the Charlton-Methodist Hospital,  
a branch of Methodist Hospital of Dallas, Dallas, Texas.

#### Objectives

The objectives of this study are:

1. Review the existing organizational structure of Methodist Hospital of Dallas.
2. Discuss alternative organizational structures for a branch hospital.
3. Analyze and evaluate the advantages and disadvantages of each alternative organizational structure.
4. Provide a written document which contains an organizational structure and delineation of functions, responsibility, and authority.

## Criteria

The criteria are:

1. The organization of the branch hospital will support the concept that the purpose of the branch is to extend health care facilities at a reduced cost by capitalizing on existing expertise and facilities presently available at the parent institution.
2. The organizational structure will provide flexibility so that managers at all levels may attain objectives in the face of a changing environment.
3. There should be a clear line of authority throughout the organizational structure.
4. The organizational structure will identify and delegate those responsibilities necessary to enhance the accomplishment of each agency's mission.
5. The organizational structure should define authority in accordance with responsibility exacted.
6. The organizational structure must provide for economy and efficiency.
7. The structure will attempt to minimize conflict by facilitating internal communications.

### Limitations

The limitations to this study are:

1. There will be no duplication of expensive, sophisticated equipment at the Charlton Branch.
2. The writer and the administrator agreed that this study would not address the actual staffing of the agencies at the Charlton Branch.
3. The structure recommended by this study will be for the fully operational 166-bed facility. It will not address the initial phase between admission of the first patient until it is fully staffed and operational.

### Assumptions

The assumptions are:

1. The population of Dallas County and surrounding area will continue to grow at close to the projected rate of 90 per cent, and thus nearly double in size by 1990.
2. Although a physician may choose to locate patients primarily at either the branch or the central location, membership on the medical staff of the Methodist Hospital of Dallas System will extend privileges for either installation.
3. Methodist Hospital of Dallas, the parent insti-

tution, will continue to operate in its present location throughout the foreseeable future.

### Definitions

Certain commonly used terms are susceptible to various interpretations. For this reason, the following definitions will be used in this study:

Accountability is liability for the proper discharge of duties.<sup>6</sup>

Agency is an organizational element of undefined size and scope. It has some degree of responsibility, authority, and functions but its size is kept intentionally undefined for purposes of this study, as it describes departments, sections, offices, or any combination thereof.

Authority is the legal or rightful power to act.

Branch Hospital is a concept which provides medical care and facilities to patients in the community where they reside. In this study, the term "branch hospital" and "satellite hospital" will be used interchangeably.

Centralized organization is an organization with the tendency to delegate little authority to subordinate managers.<sup>7</sup>

Decentralized organization is an organization with the tendency to delegate authority extensively throughout the various levels of management.<sup>8</sup>

Departmentation divides the work of the organization into semiautonomous units or departments.<sup>9</sup>

Departments and sections. The department is usually larger than a section. It may contain several sections. All departments and some sections report directly to administration. Other sections, depending on their places in the organization, report to department heads. The section is usually concerned with one specialty, whereas a department may have several specialties within it. Some sections operate in connection with, or complement, many departments; therefore, these actions are difficult to isolate under a single department and must be held accountable to Administration.<sup>10</sup>

Organization is the determination and assignment of duties to people, and also the establishment and the maintenance of authority relationships among these grouped activities.<sup>11</sup>

Organizational structure is the framework within

which the various efforts are coordinated and related to each other. It is often furnished by departmentation. It portrays the relationships of departments, sections, and management without regard to staffing or size of each agency.<sup>12</sup>

Responsibility is the obligation of a subordinate to perform the duties specified by his superior.<sup>13</sup>

System is an integrated relationship of components aligned to establish proper functional continuity towards the successful performance of a defined task or tasks.

#### Review of the Literature

The subject of organizational structure in branch or satellite hospitals overlaps two general fields. There has been a considerable amount written on organization and organizational structures in business and industry from the theorist and practitioner's point of view. There is also an increasing amount of offerings on the advantages and general practicability of branch hospitals. There is very little published material which integrates these two subjects. From the viewpoint of organizational theory, there seems to be reluctance or lack of interest in attempt-

ing to apply concepts to an industry as complex and diverse as health care. From the health care view, there appears to be a generally accepted philosophy that each institution is unique, and the organization of each is therefore dependent on the specific situation and personalities present. An examination of both fields, however, does indicate some trends and recommended approaches to the problem.

There is a growing trend toward a flat organization structure. Albers points out that with the increase in communication and information systems there is less attention paid to the span of control that any manager can handle. This lends itself to hospital operations in that there are so many diverse activities involved. He cautions, however, that with more people at any one lateral level, the communications between these individuals becomes more difficult. It thus opens the field to some possibility of new departmental arrangements to assist in the coordination of this effort.<sup>14</sup>

At the same time, the changing role of the hospital in society and the community is being recognized by those in health care management, as well as the consumer. This

emphasizes the need for coordination and professionalism in the hospital to assume its position of community leadership. There is need for consideration of changes in the traditional structure. Brown and Clark are strongly in favor of these changes or at least a willingness to change.<sup>15</sup> With the increased accountability required of health care institutions, there is an increased requirement for expertise and professionalism. This need is being met by a growing reliance on the corporate type of structure. Perrow points out that hospitals lend themselves to multiple leadership because of their multiple objectives and goals; this concept can also be applied to this study.<sup>16</sup> The corporate structure that Clark describes is most applicable as institutions or systems grow in size and complexity, and the multiple leadership from physician and administrative manager is necessary to ensure all elements of the team are pulling together.

Recognition of these trends and guidelines must also be accompanied by the reminder of certain other complexities. Pfiffner and Sherwood emphasize the conflict within any organization.<sup>17</sup> There are the political con-

flicts between the formal and informal organization as well as the personal and professional interest of the various factors. These are not new discoveries but must be considered by the organizational planner. "Thus no one in the organization is without some power and no one has absolute power."<sup>18</sup> It must also be recognized that some functions have inherent power that is only enhanced or diluted by personalities.<sup>19</sup> The organizational planner, then, must be constantly mindful of these complexities. But he cannot give them undue weight as he attempts to lay out the functions and relationships of these functions within the organization for best accomplishment of the mission. Once the organizational structure has been determined, the manager must constantly review the structure and examine the interaction of the structure with the complexities of personalities and possible power shifts with a view toward their effect on organization goals.

As demands increase for quality health care, hospitals are faced with several alternatives if they are to continue to meet this growing requirement. Depending on the specific physical arrangement, they may go through

extensive expansion, renovation, redevelopment, and reorganization in their existing location. If this course of action is not feasible, it may be necessary to relocate entirely to a new site. The third major alternative is to expand by constructing additional facilities at another location. There is a growing employment of this third alternative, as under the proper conditions this seems to be the best way to expand facilities and capabilities, and extend care to greater areas at the lowest relative cost. There is a growing volume of expertise and experience in this field; but, again, the organizational structure employed in each system and within each installation in that system is as variable as the number of institutions and situations surrounding them.<sup>20</sup>

Although A broad interpretation of the ideas expounded in the published literature, as well as a review of unpublished documents from several existing systems, reveals a broad spectrum of types of organization. The range extends from the very centralized, where control is held at one point, to the totally decentralized, where management and control is dispersed throughout the entire system. In

the former type, subordinate agencies and/or branches are totally dependent on central management for policies, direction, and support. In the latter type, each subordinate agency looks to the central agency only for broad policy and goal definition. The subordinate operator or manager is free to make his own decisions and employ his resources, in the manner he sees best, to accomplish his specific mission contributing to the overall goal of the organization. There are an infinite number of variations between the two end points of the spectrum. The primary difference is represented by the relative dependence of the subordinate on central management for policy, direction, guidance, and support. A further examination of several existing institutions with operating branches verifies this premise. Although two systems may be employing the same basic concept and type of organizational structure, the actual arrangement of functions and responsibilities varies with each particular situation.<sup>21</sup>

The management of multiple-unit hospital systems presents a challenge. It is absolutely essential that all of the arrangements and relationships work together to

accomplish the goals of the system. The form of the structure of the individual units must reflect the form and style of the parent or central unit and the entire system. Consequently, the structure for the branch(es) will be a direct reflection of this same system.

The maximally centralized form

The centralized type of organization is concerned with four levels of management: the governing board, the chief executive, the central management and support staff, and the individual(s) who manage the branch institution.

As in a single unit arrangement, overall control and direction is exercised by the board. The administrator or director of the parent institution heads the central management staff determining policies, procedures, controls, and review of operations. The manager of the branch institution reports directly to the central director and staff and is limited to directing the business of the branch in accordance with predetermined policies and patterns of operation.

This system is most advantageous in terms of achieving the goals and objectives of the system. It offers the

maximum in uniformity of policy and decision-making, creates economy and efficiency through closely coordinated control, and minimizes the administrative burden on the branch institution. Under this form of operation, less-qualified managers can operate the satellite unit.

Most of the disadvantages fall to the branch operators. There is very little flexibility for the satellite administrator and his decision-making is almost nil. It also fails to develop managerial ability, as policies and decisions are made by the top level of management at the parent unit. There is relatively little room for the exercise of leadership at the branch hospital.

Following this concept to the interior of the branch hospital reveals multiple ties to comparable agencies in the parent unit. Essentially, this form of structure would reflect nearly the same arrangement as the parent institution. Technical advice, assistance, and supervision emanate from the counterpart department in the main hospital. The manager of the branch finds that he only has "operational control" of most agencies of the branch hospital. Policies, procedures, and guidance are furnished exclus-

ively from the central institution.

The maximally decentralized form

At the opposite end of the spectrum of management and organization are the individual autonomous units that make up a decentralized system. When carried to extremes, this form of structure has separate governing boards for each institution with complete policy-making and decision-making authority residing in each branch. The various elements are held together by name only. The role of the central governing board, in this type of arrangement, is to exercise guidance for the overall system. The executive director of the parent unit formulates long-range plans for achievement of the systems' goals and objectives and deals with external agencies and organizations.

There are more than a few advantages to this type of decentralized organizational structure. It encourages individual initiative and imagination. Consequently, the morale of members of the organization tends to be high. Each individual branch is an autonomous institution, and because authority and initiative are thrust upon those persons most familiar with the actual operations, adaptation

to local conditions can be effectively accomplished. This type of structure is naturally a good training ground for future executives as it stimulates managerial and leadership development. Because top management is relieved of attention to a great amount of detail, it also has a large measure of flexibility.

As the converse of the centralized system, most of the advantages fall to the branch unit and its management, but it is not without disadvantages. Because it creates multiple autonomous units, it may detract from achievement of the overall goals of the system. In that way it may dilute the original intent of the system which was created to have a number of internal units working together for a common goal. It tends to siphon a great deal of authority and control from the executive director of the system. Unity of command and objectives may be nearly lost, and the day-to-day operations are essentially out of his hands. Without extreme care it can also subvert any goals of economy and improved efficiency. If facilities and capabilities are duplicated, if professional jealousies arise-- and they often do as the intersystem competition builds--

many of the basic advantages of the multiple-unit system will not be realized. It poses problems of control and requires better-qualified branch administrators.

As mentioned previously, in the maximally decentralized form of organizational structure, many of the advantages fall to the branch unit. In this situation, the administrator has less of a branch hospital and more of an independent unit. He will still accrue some advantages in terms of central services such as laundry and purchasing, but otherwise he is very much in control of the institution. While this is desirable, particularly from the highly competent and competitive branch administrator's view, it may contribute less to the overall system for those reasons cited above.

#### The moderately decentralized form

The problem for managers, whether it be corporate industry or the health care field, is to find some intermediate point of structural form between the two extremes of the centralization-decentralization continuum. The merger of industrial conglomerates to better utilize the available resources is a time-tested technique. The merger

is made to obtain maximum benefit from capital, equipment, and personnel.

The moderately decentralized form of organizational structure is that compromise. It will vary, where used, with the particular situation involved as the modifier "moderately" encompasses everything between the two extremes of the organizational continuum. Generally, the system will be composed of a single governing board, the chief executive officer is responsible to that board, and the assistant administrators report directly to the chief executive officer. The departments of the parent unit and the branches report to the assistant administrator level. The satellite administrator(s) is responsible for the day-to-day operation of the branch units; but overall policy is determined by the governing board, and the executive director is responsible for long-range planning, relations with external organizations, and establishment of methods and procedures to accomplish overall goals. These methods will provide for review and direction of all activities within the system. Some moderately decentralized systems include a management committee considered necessary for

exchanging information and for reviewing the system's policies and goals. Other systems handle these functions as matters of active management coordination.

While under the moderately decentralized form, policies, programs, and procedures are decided in the top echelon of the parent unit, the application of these plans to specific situations and local conditions of day-to-day operations are delegated to the branch administrator. If this modified form is properly designed, it will achieve the maximum advantages and least number of shortcomings from both ends of the spectrum. It will facilitate achievement of the system's goals and objectives and uniformity of policy nearly as well as the centralized form. This form promotes more freedom in planning and implementation at the branch administrator level; provides for development of executives and achieves flexibility; speeds decision-making at the lower level, since the branch administrator has authority to make decisions adapted to local situations and frees the top administrator from attention to minute detail, and allows him to concentrate on other matters. This model still retains the advantages, however, of eco-

nomy and efficiency through common support of such activities as laundry, purchasing, ADP, food service, and personnel. Again, the variations that can be played on this theme are unlimited and will, and should, vary according to the specific situation of size, complexity, and number and distance between units, of the particular system of interest.

There are still some disadvantages to be reckoned with. They are essentially the same as those enumerated for the two extremes and will vary with the end that the modified form most closely approaches. As long as this is recognized by the planner, the effect on the operations can be at least partially controlled if top management is aware of their presence.

All those writing on this general field point out the advantages of using established resources of personnel and supervision. While the system is small--one branch or several small branches located very close to the main hospital--the support is almost totally from the parent unit. Then as the size, complexity, and responsibility of the system increase, the branch installations tend to become

more independent and autonomous. The central hospital still retains the direction for the system and coordinates the efforts of all elements until such time as the size makes this type of operation infeasible and the corporate structure is adapted. Even at this point, however, there are certain features that remain common. Many of the services furnished may be from a central headquarters. Policies become of increasing importance. The responsibilities must be very clearly outlined and understood at every level. Communications--both physical and attitudinal--must be the optimum available.<sup>22</sup>

In summary, the branch satellite concept is a significant development which appears to offer considerable promise for improved delivery of health care services. It is a major viable alternative for institutions to expand their area of coverage and extend into suburbia at a relatively inexpensive price. How these systems and installations that make up the systems can be best structured organizationally is yet to be determined. Much of the answer to that question relates to the specific situation involved and the relationship of the branch(es) to the parent unit.

Problem-Solving Methodology

The initial approach to this study was to consult with the hospital administrator and the executive administrative group. The primary purposes of these conferences were: (1) to acquire pertinent information about the present policies and their effectiveness, philosophy, goals, and objectives of the parent institution; and (2) to gather background information pertaining to the circumstances and conditions which prompted the construction of the branch hospital.

Next, the current organizational structure of Methodist Hospital of Dallas was considered. Particular attention was directed to existing lines of authority, relationships in the upper levels of management, the groupings of departments, span of control, methods of delegation of authority, and the functions and responsibilities of the administrator, associate administrator, assistant administrators, and key department heads. Also during this time, the writer gathered data to assist in analyzing organizational policies and plans pertaining to the concept of construction and operation of the branch as part of the

hospital system.

David Damberg, a recognized expert from James A. Hamilton Associates of Minneapolis, was consulted to obtain current information relating to the concept of branch hospital organization.<sup>23</sup> Damberg also supplied a listing of hospitals in the United States that are operating branch institutions. Several of these institutions were contacted for current information, based on their experiences. This information served to complement the survey of current literature. The purpose of the survey was to become familiar with current organizational thinking and patterns concerning branch hospitals, their role, and the internal and external relationships between the branch institutions and the parent hospital. Several existing systems were examined to determine the actual working relationships in operating systems.

#### Footnotes

<sup>1</sup>Methodist Hospital at Dallas, The First Golden Years (Dallas: Methodist Hospital, 1972), p. 1.

<sup>2</sup>James A. Hamilton Associates, "A Hospital Plan: The Dallas Area, Texas," a report prepared for the Dallas Citizens Hospital Advisory Council, January, 1964, p. I-2.

- <sup>3</sup> Ibid., p. I-22.
- <sup>4</sup> Ibid., p. III-13.
- <sup>5</sup> Private interview with Glenn Scott, Administrator, Methodist Hospital of Dallas System, Dallas, Texas, March, 1974; Private interview with Dan M. Thompson, Jr., Associate Administrator, Methodist Hospital of Dallas System, Dallas, Texas, March, 1974; Private interview with James M. Luker, Assistant Administrator, Methodist Hospital of Dallas System, Dallas, Texas, March, 1974; Private interview with Stephen D. Trowbridge, Assistant Administrator, Methodist Hospital of Dallas, Dallas, Texas, March, 1974; Private interview with Kevin R. Andrews, Administrative Assistant, Methodist Hospital of Dallas System, Dallas, Texas, March, 1974.
- <sup>6</sup> Ralph C. Davis, The Fundamentals of Top Management (New York: Harper & Row, 1951), p. 20.
- <sup>7</sup> Harold Koontz and Cyril O'Donnell, Principals of Management: An Analysis of Managerial Functions (3d ed.; New York: McGraw-Hill Book Co., Inc., 1964), p. 70.
- <sup>8</sup> Ibid.
- <sup>9</sup> Henry H. Albers, Principles of Organization and Management (2d ed.; New York: John Wiley and Sons, Inc., 1961), p. 96.
- <sup>10</sup> Koontz and O'Donnell, pp. 259-63.
- <sup>11</sup> Theo Haimann, Professional Management Theory and Practice (Boston: Houghton-Mifflin Co., Inc., 1962), p. 136.
- <sup>12</sup> Koontz and O'Donnell, pp. 425-26.
- <sup>13</sup> Haimann, p. 56.
- <sup>14</sup> Albers, pp. 82, 116.

<sup>15</sup> Douglas R. Brown, "A New Administrative Model for Hospitals," Hospital Administration, XII (Fall, 1967), 8, 10, 13; Henry T. Clark, "The Challenge of the Regional Medical Programs' Legislation," Journal of Medical Education, XLI (April, 1966), 348.

<sup>16</sup> Charles Perrow, "Goals and Power Structures: A Historical Case Study," in The Hospital in Modern Society, ed. by Eliot Freidson (London: Free Press of Glencoe, 1963), p. 132.

<sup>17</sup> John M. Pfiffner and Frank P. Sherwood, Administrative Organization (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1960), p. 346.

<sup>18</sup> Ibid., p. 346.

<sup>19</sup> Ibid., p. 348.

<sup>20</sup> Phillip B. Hallen, "Hospitals Branch Out: A Study of Multiple-Unit Operations--Part I," Hospitals, XXXVII (August 1, 1963), 38-45.

<sup>21</sup> This brief description and the discussion that follows is a summary of the options presently in operation. This synthesis was derived from a survey of published literature and unpublished documents of institutions now in operation in health.

<sup>22</sup> Edwin L. Crosby, "Improving the Delivery of Health Care Services," Hospitals, XLI (September 1, 1967), 57; Bruce J. Carter, "Satellite Depends on Base Hospital for All Services," Modern Hospital, CIV (February, 1965), 115-16; Wilson W. Turner, "Satellite Hospitals Bring Health Care to Suburbanites," Modern Hospital, XCIX (November, 1962), 92-93; Robert E. Toomey, "Greenville, S.C.: Hospital System at Work," Modern Hospital, CV (October, 1965), 109; "Satellite Hospitals to Rise Along Houston's Freeways," Hospitals, XXXVII (August 1, 1963), 40; Richard L. Johnson, "Are Satellites Best Answer to Expansion?," Modern Hospital, CV (October, 1965), 104-106; Pfiffner and Sherwood,

p. 460; Charles W. Washington, "A Study to Determine the Optimum Organizational Structure of a Satellite Hospital System for Hillcrest Medical Center, Tulsa, Oklahoma" (unpublished Master's thesis, Baylor University, 1969), pp. 24-28; Greenville General Hospital System, Organization and Function Manual (Greenville, S.C.: Greenville General Hospital System, October, 1965); James A. Hamilton Associates, "Program of Development: Fairview Hospital, Minneapolis, Minnesota," a report prepared April, 1961); Memorial Baptist Hospital System, Organization and Functions Manual (Houston, Tex.: Memorial Baptist Hospital System, October, 1967); Hallen, Part II, August 16, 1963, p. 54; Toomey, p. 107.

<sup>23</sup>Private interview with David J. Damberg, Consultant, James A. Hamilton Associates, Minneapolis, Minnesota, March, 1974.

and the community it serves. Its responsibility is to minister to the needs of those it serves in an efficient and effective manner while maintaining the dignity of the individual. As love and understanding are mandates of the Christian discipline, so shall Methodist Hospital adhere to these same mandates in the actions necessary for delivery of its services.

The services of Methodist Hospital of Dallas shall be available to all persons regardless of their residence, race, religion or ethnic origin. Within its capabilities, the institution shall make health care services available to the general population of the area, considering the southwest section of Dallas County as its primary service area.

Further, the management objective of Methodist Hospital of Dallas to fulfill that purpose is:

To achieve a high degree of organizational effectiveness, Methodist Hospital of Dallas is commit-

## CHAPTER II

### DISCUSSION

Methodist Hospital of Dallas is a modern, progressive institution. The purpose of the organization is as follows:

A voluntary, non-profit health care institution, Methodist Hospital of Dallas is owned and operated by the North Texas Conference of the United Methodist Church. As such, it must always be attuned to the health and welfare needs of the individuals and the community it serves. Its responsibility is to minister to the needs of those it serves in an efficient and effective manner while maintaining the dignity of the individual. As love and understanding are mandates of the Christian discipline, so shall Methodist Hospital adhere to these same mandates in the actions necessary for delivery of its services.

The services of Methodist Hospital of Dallas shall be available to all persons regardless of their residence, race, religion or ethnic origin. Within its capabilities, the institution shall make health care services available to the general population of the area, considering the southwest section of Dallas County as its primary service area.<sup>1</sup>

Further, the management objective of Methodist Hospital of Dallas to fulfill that purpose is:

To achieve a high degree of organizational effectiveness, Methodist Hospital of Dallas is commit-

ted to the use of a results-oriented management approach. In utilizing this method the necessity for all personnel to work and contribute as an integral part of a team becomes an all important component to grow and operate effectively, the hospital must:

Periodically identify departmental goals which support the hospitals objectives and execute plans for their achievement;

Develop and use departmental standards of performance which will foster maximum effectiveness and productivity of personnel;

Create and maintain an atmosphere of productivity which encourages each individual to realize the need to contribute as a member of the health care team;

Develop and maintain usable management information systems;

Establish an effective communication network and constantly endeavor to improve it.<sup>2</sup>

The present organizational structure of the central institution is as shown at Appendix A (Figure 1). In addition to the Board of Trustees, the organizational hierarchy is composed of three management levels: administrator, associate/assistant administrator, and department. Many of the departments are further divided into functional sections. The administrator is the executive director and chief executive officer of the institution. He is not a

trustee but reports directly to the Board of Trustees. He is responsible for accomplishing all activities within the established framework of the policies, purpose, and objectives as directed by the board. At the next level, reporting directly to the administrator are an associate administrator, two assistant administrators, an administrative assistant, and the staff department heads of finance, public relations, development, and volunteer services.

The three associate/assistant administrators and the administrative assistant are responsible for the twenty-five remaining departments. There is a clear line of status in that the associate administrator is senior to the other administrators on this level and serves as the primary manager and director of the day-to-day operation of the main hospital. The grouping of departments under the associate and assistant administrators is not limited by function and, in fact, has very little apparent operational logic. These groupings are the result of a number of years of evolution and adjustment. Departments have been shifted from one assistant administrator to another to increase or decrease the relative responsibility of the administrator

at the time and/or in an attempt to match personalities in working relationships. There is a fairly significant combination of diversification of departments within, and overlap between, each group. There is also some significant fragmentation of functions and responsibilities in various departments. This, again, is the result of long-term relationships of personalities rather than organizational efficiency or effectiveness planning.

For over twenty years, the development and administration of Methodist Hospital was primarily handled by one man. It is only in the relatively recent history that a full-time executive administrative staff has been developed. As a result of this "one-man" operation and his close relationship with both the Board of Trustees and subordinate chiefs, there are some essential management tools lacking. There does not presently exist any formal policy file or organization and functions manual. There is also no formalized nor documented system of long-range planning for the hospital. Present operational procedure entails a great deal of decision or policy making by the administrator and his executive assistants without reduction to for-

malized documents or records. While this may have been functional for many years as the hospital "grew up," it is not considered sound practice for the present system, particularly for its expanded roles and facilities. The continued increase in facilities and staff are beginning to overextend this very personalized system.

#### Organizational Structure Alternatives

Organization of a satellite system involves the process of arranging a whole from separate, but similar and interdependent, parts. The relation of the branch to the parent unit and the structure of the organization at the branch are therefore very closely interwoven. As mentioned earlier, the parent or central installation in any satellite or branch system is normally a larger, general hospital which serves the needs of the area. It benefits by the referrals received from the branch and the consequent extension of its care over a larger area. In return, the parent hospital serves as the coordinating agency for the total

system and performs some degree of functions for the outlying unit(s): The completeness of services and number furnished is usually a function of size and number of branches with emphasis on avoiding duplication of effort in the various units to the maximum degree possible on other than general acute care.<sup>3</sup>

Thus, a discussion of the organizational structure of any one single branch is tied very closely to the relationship of that branch to the parent unit. It must include comments relating to the function, responsibility and authority, and relationships of those individuals who manage the branch, the parent, and the entire system. Even though Charlton-Methodist is the first branch in the Methodist Hospital of Dallas System, there are several alternatives to be examined.

Three alternative methods of organization of a satellite hospital system or of the branch itself have been discussed. The maximally centralized form makes the branch totally dependent upon the parent unit, with minimal authority delegated to it. The maximally decentralized form is the other extreme of the spectrum

and tends to treat the branch as a totally independent unit, with near autonomy of operations. The moderately decentralized form represents some point between the two extremes with relative authority and dependence upon the parent institution variable with the specific situation.

The main advantages and disadvantages are:

1. Maximally centralized structure

a. Advantages: it assists in achieving goals and objectives of the system; it creates economy and efficiency; it achieves uniformity of policy and decision-making; and it decreases the administrative burden on the branch units.

b. Disadvantages: it fails to stimulate managerial development; it lacks flexibility; it slows down the decision-making process; and it lacks the setting for the creation of leadership.

2. Maximally decentralized structure

a. Advantages: it promotes individual initiative and imagination; it stimulates managerial

and leadership development; it speeds decision-making; and it achieves flexibility.

b. Disadvantages: it promotes autonomy; it lacks uniformity of policy-making; it imposes problems of control; it duplicates specialized services; and it lacks unity of command and objective for the system.

3. Moderately decentralized form

a. Advantages: it assists in achieving system goals and objectives; it may speed up decision-making; it may relieve the top executive of the need to turn attention to a great deal of detail; it capitalizes on economy and efficiency through the centralization of services; it provides some degree of executive development; it achieves some flexibility; and it should maintain uniformity of policy.

b. Disadvantages: it may create semi-independent units which may not always react in harmony with the overall goals of the system; it increases problems of control; and it may detract from uniformity

of action and command within the system.

### The Specific Situation

As previously discussed, Methodist Hospital of Dallas is organized in twenty-nine different departments, as shown in Appendix A. The concept for operation of the branch, as expressed by the administrator, is to maximize the utilization of management expertise and facilities now extant at the central unit.<sup>4</sup> In order to gain maximal benefit from economies of scale, Charlton-Methodist Hospital must operate as though it were merely another part of the parent institution. Planning is being done for some modification of procedures at the central unit; but, this fact notwithstanding, there is a requirement for some counterpart agency at the branch that corresponds to twenty-three of the departments or sections now functioning at the main hospital location. Those agencies that will not have full-time personnel located at the branch are: coffee shop, outpatient department, data processing, medical education, development, and public relations. A new section to handle the transportation function for both installations will be

established concurrent with the opening of Charlton-Methodist Hospital.<sup>5</sup>

Emphasizing that the branch hospital is to extend the health care services to a wider community on a more economical basis, several conceptual decisions were made prior to finalizing construction plans. Simply stated, the theme is that maximum support on services will come from the parent unit and that other than "normal, routine" equipment will not be duplicated at the branch location. Patients requiring more sophisticated facilities or treatment than the general acute care available at the branch will be transferred or referred to the central institution. The primary functions associated with laundry, purchasing, and food service preparation will be conducted at the central unit. With the exception of dietary therapists, the function of these three agencies at the branch will be primarily to receive and distribute material from the main hospital and return, as appropriate, reusable items for processing at the parent unit. Other support agencies such as maintenance, medical records, business office, personnel, and housekeeping will have an organization only large enough to handle the day-

to-day requirements of Charlton-Methodist Hospital. Specialized and back-up personnel will function at the parent unit, being available to the branch as required.

When the planner considers these previously mentioned items of management and construction conceptual input, the choices of organizational type are significantly narrowed. With the magnitude of support and dependence on the central installation, the maximally decentralized structure becomes essentially infeasible. If the administrator of Charlton-Methodist Hospital were given free rein to manage the total branch without extensive support and direction from the parent unit, it would require considerable increased resources. Duplication of facilities and/or specialized equipment and personnel seriously conflict with the basic premise of expanded offering of health care at lower relative cost.

Conversely, the maximally centralized structure does not appear to be the most suitable for the system or the branch when the elements are separated by some twelve miles, or twenty to thirty minutes' travel time. Items of routine support can be scheduled on a fairly regularized basis.

Those elements of the branch dealing with and responsible for direct patient care need to be more responsive to specific requirements of the branch hospital. The satellite administrator must have some latitude for decision making to insure his ability to meet day-to-day or moment-to-moment situations and conditions as they arise. The officer operating the branch must be able to respond to, and assist, those services and departments under his operational control. To deny this capability and authority to the administrator of the branch hospital would seriously degrade his responsibility and the timely quality care of patients that is desired.

The third alternative, a moderately decentralized organizational structure, is the best solution for the specific situation being considered. It will most adequately meet the needs of maximum utilization of existing facilities and managerial skill while still providing sufficient latitude for operation of the branch in a manner that is most effective and responsive to the patient at the Charlton location.

Therefore, the basic concept of the organizational

structure at Charlton-Methodist Hospital is an extension and reflection of the structure of the parent unit. The detail of this moderately decentralized structure is at Appendix B. This structure is quite close to the maximally centralized extreme but is considered appropriate to most nearly meet the objectives of opening the branch unit. Because most agencies at the branch still have direct ties to their counterpart agency at the parent unit, it appears that the lines of authority and responsibility are extremely diverse. It also appears that the branch administrator has almost no control over subordinate agencies in the branch. Both of these statements are partially valid. There is, however, a difference between responsibility for a function and the direct supervision of that operation. At this phase of the operation, it is believed that to duplicate supervisory personnel at the satellite would be unsound if it could be avoided without detrimental effect on the patient care provided. Thus, most agencies and the commensurate function at the branch will be the technical responsibility of the department head at the parent unit. The only exceptions to this concept are those agencies/functions that

cannot operate as an extension of a department at the central institution. These agencies are those whose services must be so continuous or responsive that time and distance from the central unit dictate direct responsibility to the branch only. This consists, then, of those agencies dealing with primary patient care: nursing service and administration, emergency room, and patient services, as well as the volunteers and the contiguous professional office building.

Essentially, Charlton-Methodist Hospital is organized to function as though it were another floor(s) on the existing central hospital. It must continue to do so, particularly through this initial phase of 166-bed capacity, until its facilities are expanded and/or its mission changes to meet recognized requirements in the future. To do otherwise is contrary to the principal benefits of its construction.

The primary criterion for the proposed organizational structure is to minimize duplication of equipment, facilities, and key personnel and to maximize the utilization of existing skills and sophisticated items. With this criterion paramount, other criteria become not unimportant, but

decidedly secondary. This fact, notwithstanding, the writer feels that those criteria have been met. The structure provides extensive flexibility as the Charlton branch grows. As missions expand, the agencies at the satellite can also grow and become increasingly independent of their counterparts at the parent unit. It will undoubtedly require some adjustment and education, but the apparent dual responsibility and authority of technical function and operational supervision is sound for the initial size and scope of the branch operation. The most significant learning process will entail learning when to use the respective lines of authority and responsibility. This is greatly simplified if the matter is tested on lines of whether it is primarily technical assistance or operational mission business. This is also somewhat simplified because there is no question as to who an agency reports to or requests assistance from. Finally, this is the most efficient and economical arrangement that can be made. Operations and functions are specifically tailored to meet requirements as they are now known. There is a minimum of "fat" or slack in the structure. It requires very high quality and active management

to make the system function in an optimal fashion. This is again the primary purpose for which Charlton-Methodist Hospital is being constructed.

#### Conclusion

#### Footnotes

<sup>1</sup>Methodist Hospital at Dallas, Purpose and Objectives (Dallas, Tex.: Methodist Hospital, 1972), p. 1.

<sup>2</sup>Ibid., p. 9.

<sup>3</sup>Turner, p. 93; Washington, pp. 20-22; Johnson, pp. 105-106.

<sup>4</sup>Scott interview.

<sup>5</sup>Trowbridge interview.

## CHAPTER III

It is recommended that:

## CONCLUSIONS AND RECOMMENDATIONS

1. The proposed organizational structure for  
Charlton-Methodist Hospital (Appendix B) be approved and

adopted. As a result of this study, the writer has reached  
the following conclusions:

1. An analysis of satellite hospital organizational structures discussed in the literature reveals a trend. This trend reflects that while the system and its satellites are small and relatively simple in concept and service, the structure tends toward centralized control. As the system and the satellites expand and become more complex, the management style, and consequently the organizational structure of both the system and its branch hospitals, move toward the corporate form of decentralization.

2. The mission of Charlton-Methodist Hospital and the Methodist Hospital of Dallas System will best be accomplished by adopting an organizational structure for the branch hospital of the very moderately decentralized form.

of Methodist Hospital of Dallas System. Provisions must

Recommendations

It is recommended that:

1. The proposed organizational structure for Charlton-Methodist Hospital (Appendix B) be approved and adopted.
2. There is potential for a study to be conducted of the present organization, responsibilities, and functions of Methodist Hospital of Dallas. The present grouping and number of departments, the result of years of evolution and numerous minor adjustments, is overly broad and fragmented. It appears to be less than optimally effective in terms of interrelations, communication, and cooperation necessary for optimum mission accomplishment. An objective reorganization of the nonmedical staff personnel, functions, and responsibilities could produce significantly improved economy and effectiveness.
3. There is a need for a published organization and functions manual.
4. There is a need for a comprehensive long-range planning function within the administrative staff of Methodist Hospital of Dallas System. Provisions must

also be made for documentation and recording of planning guidance and decisions--interim, preliminary, and final. The present procedure of personal decisions by the administrative staff relies much too heavily on individual memory and fails to communicate valuable information to all appropriate agencies. In addition to the potential for error in the present system, it retards optimally effective planning and operation.

CURRENT ORGANIZATION STRUCTURE--

METHODIST HOSPITAL OF DALLAS

North Texas Conference  
of  
The United Methodist Church  
Board of Trustees  
Administrator

Finance  
Development  
Public Relations  
Volunteer Services

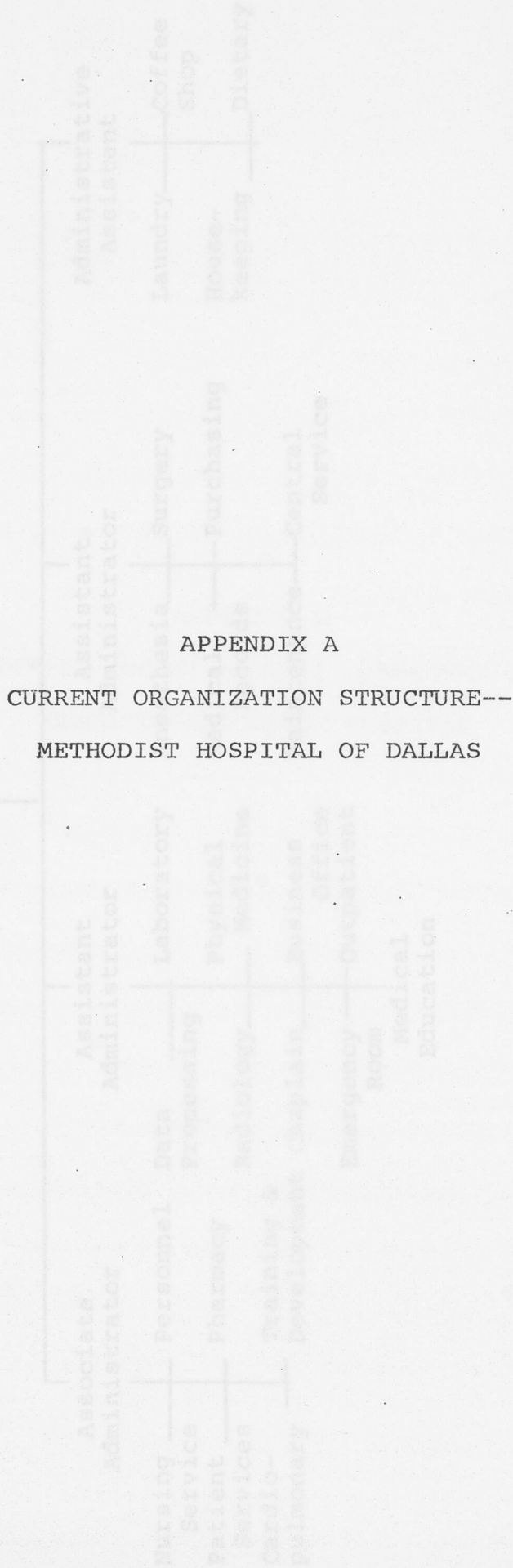


Fig. 1. --Current Organization Structure--Methodist Hospital of Dallas

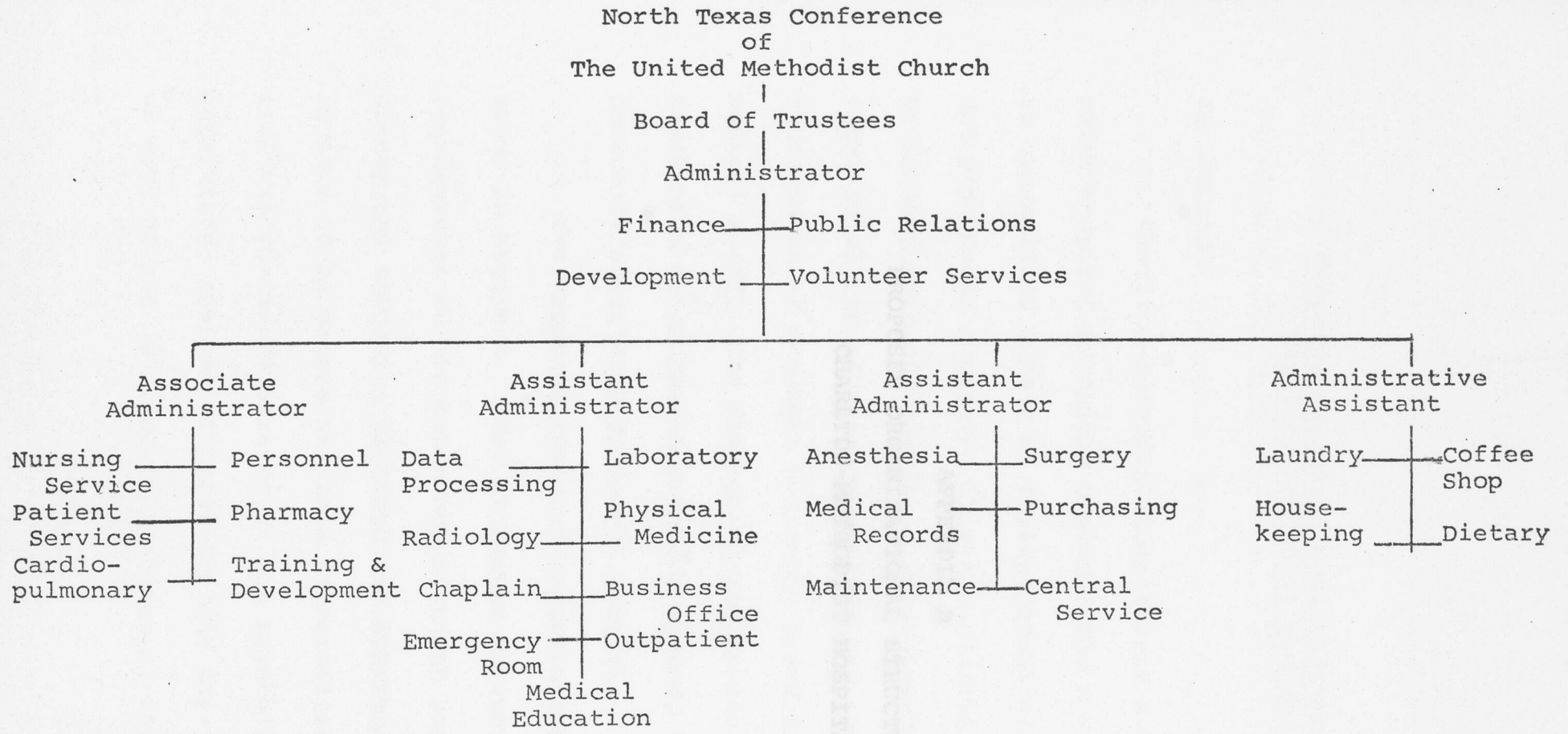


Fig. 1. --Current Organization Structure--Methodist Hospital of Dallas

Proposed Organizational Structure of  
Charlton-Methodist Hospital

I. General

Charlton-Methodist Hospital is a branch of the Methodist Hospital of Dallas System. The system is composed of an unspecified number of smaller hospital facilities which are physically separated from the central unit but operate as if they were a part of the central unit. The Methodist is the first satellite hospital in the system. Both units function under a single governing board and with a single medical staff. The mission is accomplished through the means of a geographically decentralized, but essentially centrally administered, branch unit(s).

APPENDIX B

PROPOSED ORGANIZATIONAL STRUCTURE OF  
CHARLTON-METHODIST HOSPITAL

The proposed skeletal organizational structure is shown in Figure 2. This structure serves to meet the dual requirements of mission accomplishment and maximum efficiency and economy. Although the apparent span of control appears to be excessive, this is permissible in this situation, as the administrator of the branch has only direct supervisory responsibilities for the day-to-day operations of most of the agencies functioning at the branch unit.

54

Proposed Organizational Structure of Services,  
Charlton-Methodist Hospital

I. General

Charlton-Methodist Hospital is a branch of the Methodist Hospital of Dallas System. The system is composed of an unspecified number of smaller hospital facilities which are physically separated from the central unit but operate as if they were one hospital. Charlton-Methodist is the first satellite of this system and, as such, both units function under a single governing board and with a single medical staff. The mission is accomplished through the means of a geographically decentralized, but essentially centrally administered, branch unit(s).

The proposed skeletal organizational structure is shown in Figure 2. This structure serves to meet the dual requirements of mission accomplishment and maximum efficiency and economy. Although the apparent span of control appears to be excessive, this is permissible in this situation, as the administrator of the branch has only direct supervisory responsibilities for the day-to-day operations of most of the agencies functioning at the branch unit.

With the exception of Nursing Service, Patient Services, Volunteers, Emergency Room, and the Professional Office Building, all technical and functional responsibility for the agencies in the branch unit rests with the chief of the appropriate counterpart department at the parent hospital.

It is felt that this concept best achieves the goals and objectives. It provides for economy because it requires the minimum number of additional supervisory personnel and minimizes the duplication of specialized facilities and services already existing at the parent unit. It retains the branch unit as an integral part of the system working as part of a team to accomplish a common mission. The mission and functions of the various agencies at the branch are identical with those of the counterpart department at the parent unit although largely reduced in scope and sophistication. There is a clear line of authority throughout the structure. There is a commonality of purpose, for all agencies at the branch hospital to operate under the same policies, programs, and guidance as those departments at the parent institution. This structure promotes economies of scale as it takes maximum advantage of

existing managerial and technical skills.

II. Responsibilities and Activities to Accomplish Basic Function--Charlton-Methodist Hospital

A. Assistant Administrator--Charlton-Methodist Hospital

1. Plans, organizes, directs, and evaluates patient care activities and day-to-day operations.
2. Develops the budget for Charlton-Methodist Hospital.
3. Assists the Administrator of Methodist Hospital of Dallas in long- and short-range planning.
4. Conducts studies concerning the needs of the branch unit and makes recommendations to the Administrator regarding these needs.
5. Promulgates policies established by the system management and is responsible for assuring implementation.
6. Recommends selection of individuals to fill key positions in the branch hospital.
7. Conduct continuous coordination with other members of the executive administrative staff to assure

maximum efficiency and effectiveness of operation.

B. Administrative Assistant, Charlton-Methodist Hospital

1. Responsible for primary day-to-day management of the Professional Office Building.

2. Supervises day-to-day operations of those agencies under his control.

3. Assists the Assistant Administrator, Charlton-Methodist in conducting studies of branch unit needs.

4. Other duties as directed by the Assistant Administrator, Charlton-Methodist.

C. Chief, Nursing Service Department

1. Plans, organizes, and directs primary patient care at Charlton-Methodist Hospital.

2. Responsible to the Assistant Administrator, Charlton-Methodist for carrying out general policies and practices of the hospital system in the conduct of nursing care.

3. Responsible for developing policies, procedures, and techniques, specifically applicable to nursing service operations at the branch unit.

4. Assists the Assistant Administrator in developing the budget and conducting planning for the branch unit.

5. Organizes and administers the nursing service at the branch unit to assure continuing high-quality care of patients.

6. Maintains continuous coordination with the Director, Nursing Service Department, Methodist Hospital of Dallas, to insure currency of nursing personnel with policies, procedures, and education.

D. Chief, Patient Services Department

1. Provides administrative and environmental management to the inpatient areas and emergency room.

2. Responsible for all nonclinical, clerical, and service functions and all employees who perform them.

3. Maintains control of, and responsibility for, all supplies, equipment, and furniture in inpatient areas and emergency room.

4. Provides administrative assistance to the patient.

5. Conducts continuous monitoring of the physical

environment in areas of responsibility.

6. Conducts continuing coordination with other departments and agencies to identify possible ways of providing better service to the nursing units and the patients.

7. Conducts continuous coordination of policies, procedures, and techniques with the counterpart at Methodist Hospital of Dallas.

8. Assists the Assistant Administrator in planning, and makes recommendations for future operations.

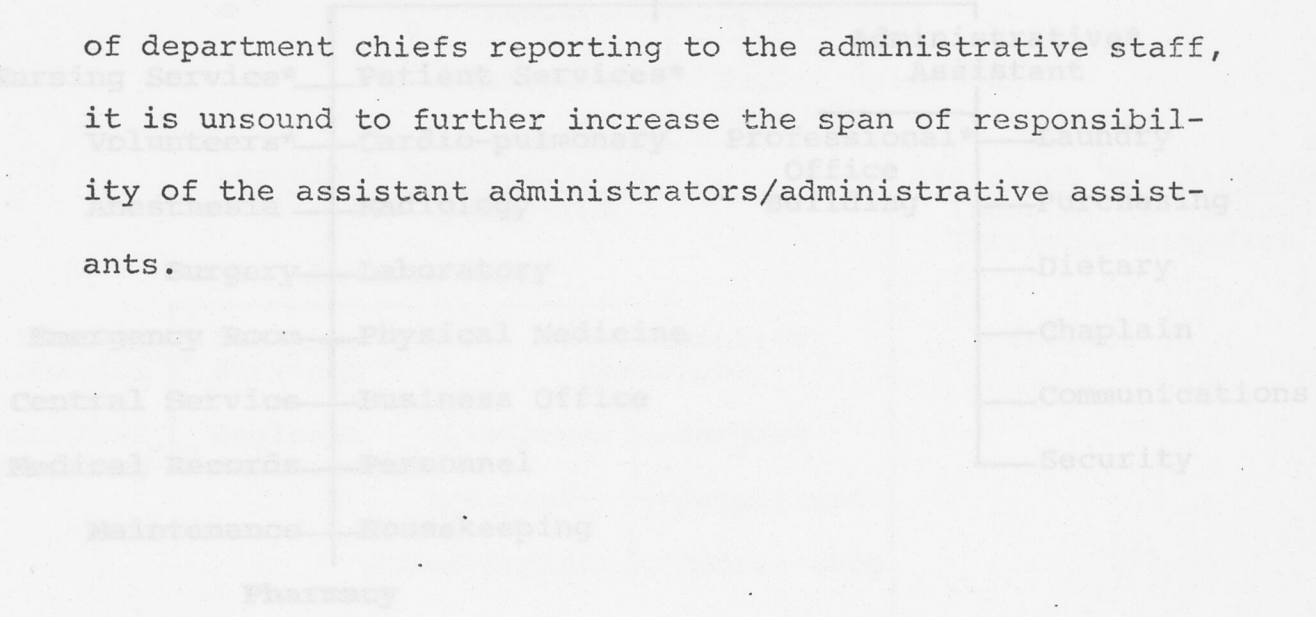
9. Conducts special activities as directed by the Assistant Administrator.

The primary agencies at Charlton-Methodist will be guided by direction of the chief of the respective departments at the central unit. These agencies will be branches of those departments tailored to meet the specific needs of the satellite hospital.

The structural relationship of Charlton-Methodist to Methodist Hospital of Dallas System is shown in Figure 3. The grouping of departments has been rearranged to allow for the inclusion of the branch unit. This rearrangement of departments has also required the addition of one assist-

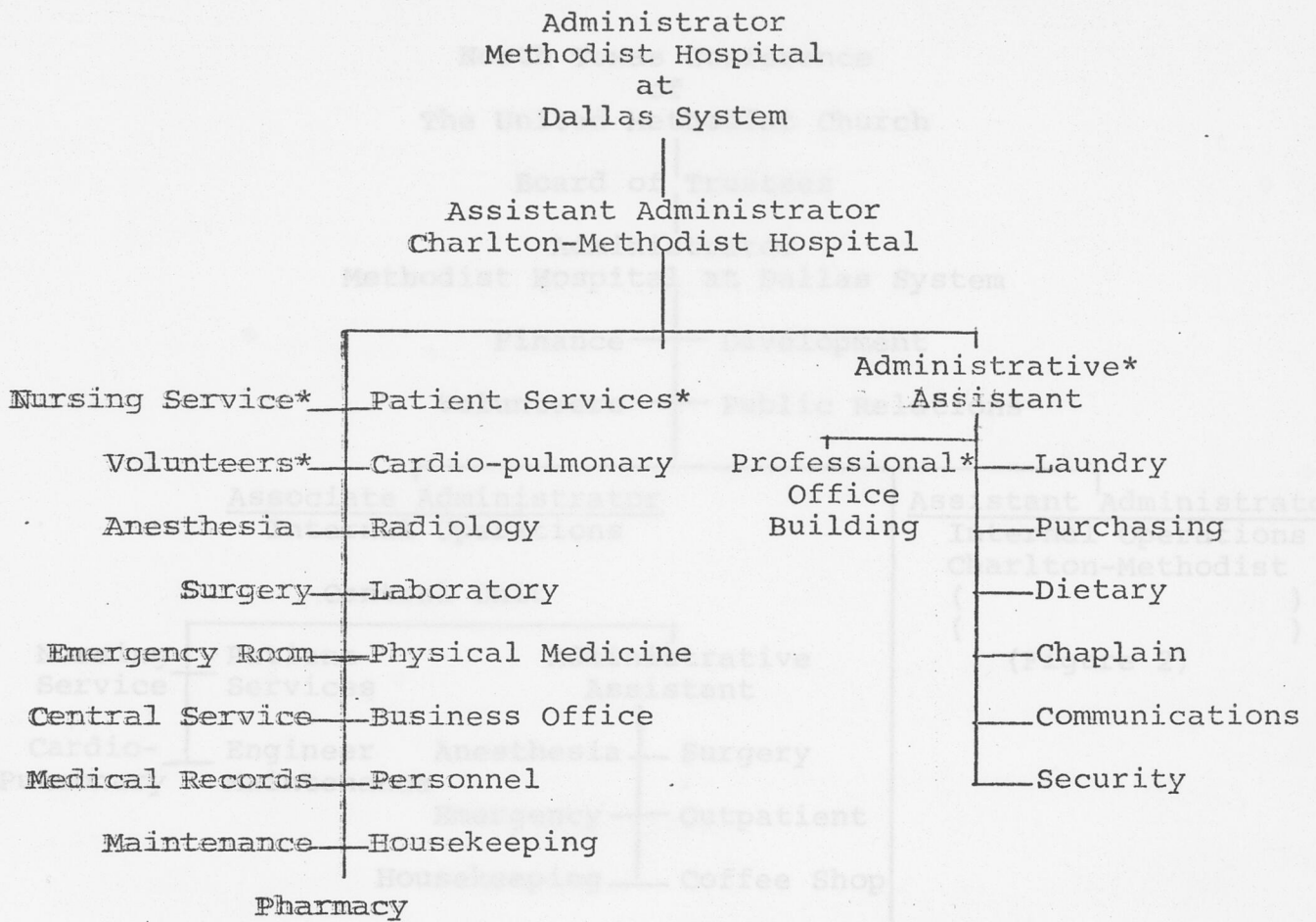
Administrator  
Methodist Hospital  
Dallas System

ant administrator and one administrative assistant to the executive administrative staff. Without an extensive reorganization, consolidation, and reduction of the number of department chiefs reporting to the administrative staff, it is unsound to further increase the span of responsibility of the assistant administrators/administrative assistants.



\*agencies direct responsibility of administration, Charlton-Methodist Hospital. All others are the responsibility of the counterpart department/agency at the parent unit.

Fig. 2. --Proposed Organization Structure of Charlton-Methodist Hospital



\*Agencies direct responsibility of administration, Charlton-Methodist Hospital. All others are the responsibility of the counterpart department/agency at the parent unit.

Fig. 2. --Proposed Organization Structure of Charlton-Methodist Hospital

Fig. 3. --Revised Structure Relationship of Charlton-Methodist Hospital to Methodist Hospital of Dallas System

North Texas Conference  
of  
The United Methodist Church

Board of Trustees

Administrator  
Methodist Hospital at Dallas System

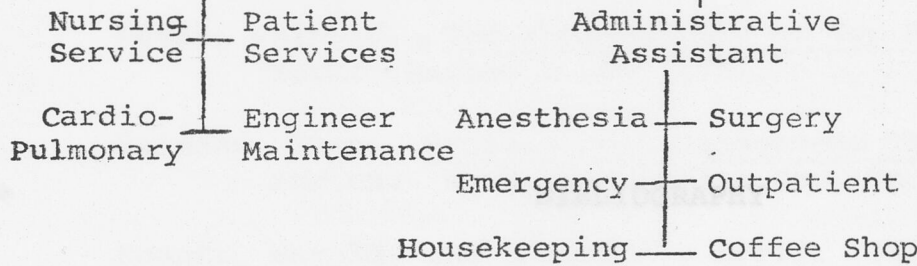
Finance — Development

Volunteers — Public Relations

Associate Administrator  
Internal Operations

Assistant Administrator  
Internal Operations  
Charlton-Methodist

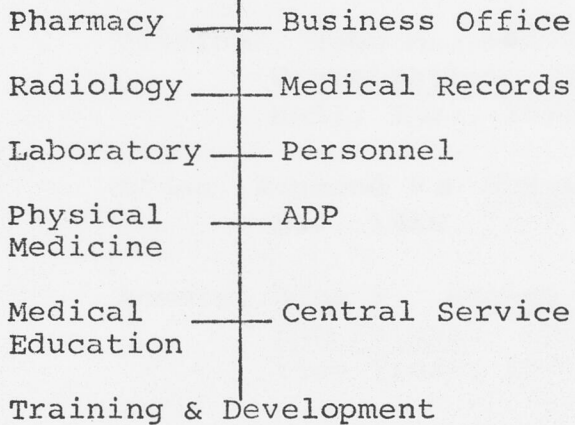
Central Unit



( )  
( )  
( )

(Figure 2)

Assistant Administrator  
Ancillary Services



Assistant Administrator  
Support Services

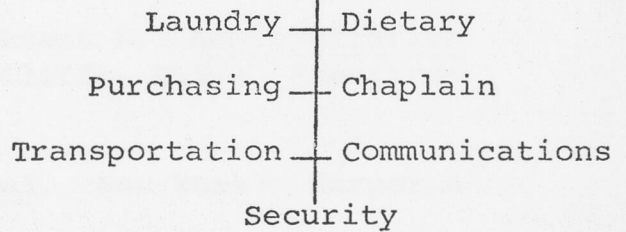


Fig. 3. --Revised Structure Relationship of Charlton-Methodist Hospital to Methodist Hospital of Dallas System

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## ABSTRACT

### A STUDY TO DETERMINE THE ADMINISTRATIVE ORGANIZATIONAL STRUCTURE OF THE CHARLTON- METHODIST HOSPITAL, A BRANCH OF METHODIST HOSPITAL OF DALLAS, DALLAS, TEXAS

A Problem-Solving Thesis Submitted to the Faculty  
of Baylor University in Partial Fulfillment of  
the Requirements for the Degree of  
Master of Hospital Administration

by  
Lieutenant Colonel William R. Crites, MSC

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The problem in this study was to determine the appropriate organizational structure for the administrative staff of Charlton-Methodist Hospital, the first branch of the Methodist Hospital of Dallas System. Data was collected from interviews with the executive administrative staff and department chiefs of the Methodist Hospital of Dallas System, in addition to investigating the files of the hospital to determine the philosophy and concept of operations of the branch unit. Certain trends and models were developed from a review of published literature as well as organizational and development studies done for several hospital systems presently in operation.

It was determined that present systems, and the branches of these systems, cover the entire spectrum from centralized to completely decentralized organizational structures and management styles. The administration of the Methodist Hospital of Dallas System intended to extend service into new areas at maximum economy by capitalizing on existing facilities and expertise of management. This objective would be best accomplished by structuring the Charlton-Methodist Hospital in a moderately decentralized form.