

Administrative Incongruence and Authority Conflict In Four Abortion Clinics

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WHEN THE REFORM New York abortion law was passed and came into effect in July, 1970, one of the most extraordinary upheavals in medical practice occurred in U.S. history. An operation which had been illegal, stigmatized, and clandestinely performed under the most sordid circumstances suddenly became legal and accessible, at least in New York City. Most traditional medical practitioners and hospitals in the state of New York were unprepared to cope with the enormous demand for services. The New York City Health Department made strenuous efforts to prepare hospitals in that metropolis, but officials had no way of knowing the impact of the new law. Thousands of women streamed into New York City from throughout the United States and Western Hemisphere.

One of the results was the emergency of the free-standing abortion clinic devoted entirely to the performance of this procedure. As laws in Washington, D.C. and California changed, more clinics sprang up in these areas. The 1973 decision of the U.S. Supreme Court resulted in the establishment of clinics in most of the major cities (Hausknecht 1973:985; Burnhill 1975:431).

These clinics caught the attention of the public and medical observers, but they particularly appealed to the patients. They offered a minimum of bureaucratic process and delay, relative privacy since no hospital admission was required, and lower cost. In addition, many individuals saw in the clinics an opportunity for social service and advancement of the "cause." This included physicians, lay counselors, social workers, nurses, ministers, and administrators. Some clinics offered the prospect of high pay, especially for doctors, many of whom felt that the activity endangered their professional status or standing with their colleagues.

The free-standing abortion clinic became a unique health care delivery system in providing a highly specialized service for patients whom some define as entirely healthy and others define as having unusual needs. These needs are perceived as including information, education, birth control assistance, and most importantly, emotional support. Differing views about the medical risks of abortion and the emotional status of the prospective abortion patient resulted in varying styles of operation and organization. A question which constantly arose was that of which pattern would yield the best result for both the patients and the clinic staffs.

The early clinics shared many characteristics. There was intense involvement on the part of the actors. There was confusion, constant crisis, drama, and frequently, administrative chaos. The activities took place in a context of public controversy and private anguish. Abortion clinics tended to attract individuals with high social commitment and medical personnel with both poor and exceptionally high technical abilities.

This ménage was colored by conflicts between the desire to offer services at the lowest possible price, the emotional and financial costs of providing good service on a continuing basis, the willingness of patients to pay large sums for any kind of service, and the intent of some to exploit both the patients and the socially committed in order to obtain large profits.

Many abortion clinics have experienced important changes in structure and operating methods along with almost total staff turnovers. Part of this has been the result of the fact that the emotional intensity characteristic in the early days was difficult to sustain. People felt "burnt out" and had to quit or move on. Another source of uncertainty has been widely fluctuating patient loads resulting from increasing availability of services throughout the nation.

The senior author (WH) became interested in the abortion clinic as a social organization after being asked to perform a management study of a model nonprofit clinic in an Atlantic coast city. In this

clinic (Clinic A), he noted some trends in bureaucratization and authority conflict which appeared to produce discomfort for the staff of the clinic if not compromises in the quality of medical care.

Subsequently, WH was asked to help start a small nonprofit abortion clinic (Clinic B) in a Western college town, which he did, serving as Medical Director and performing almost all the abortions for the first 14 months of the clinic's existence.

At the urging of WH, author AO was engaged as Head Nurse at the founding of Clinic B because of her two years' experience as a staff nurse at a large abortion clinic (Clinic D) in another East coast city. She remained in this capacity as Head Nurse until shortly before WH left Clinic B.

MG was present when Clinic C was opened in a northeast industrial city and was subsequently Head Counselor there for a period of one year.

Organizational Theory

In examining the abortion clinic as a social organization, it is useful to study theories of organizational structure, power relationships, and administrative styles. Some of the most helpful concepts have been developed by Etzioni (1961), by Goldhammer and Shils (1939), and by Price (1968).

Etzioni describes three types of compliance structures: normative, utilitarian, and coercive. An example of a normative structure would be a political or religious organization devoted to a certain ideology or other normative values. A utilitarian structure would be characterized by a business corporation or factory. A prison would be the clearest example of a coercive structure.

Each of these organizations tends to utilize its most appropriate, or congruent source of control over its members: normative values, economic remuneration, or coercion.

One theory expressed by Etzioni is that organizations tend to have a compliance structure which is congruent; i.e. a normative organization tends to utilize normative values or expressive communication, such as indoctrination or approval, for control of its members rather than, for example, coercion or economic rewards. Etzioni holds that organizations which have congruent compliance structures resist change toward incongruent compliance structures, and compliance structures which are incongruent tend to become congruent (1961:14).

Leadership styles may generally be defined as either charismatic or instrumental in all but the coercive structure, with which we are not concerned here. While both styles may be found in both normative and utilitarian organizations, charismatic leadership and decision making tends to be more characteristic of normative organizations, whereas calculative or instrumental decision making is more typical of utilitarian organizations.

One possible source of conflict in abortion clinics becomes apparent immediately upon examining Etzioni's typology: the abortion clinic is, or has been, both a force of social change (normative values) and a provider of certain technical and/or professional services (instrumental action).

Depending on the premises or philosophy of the operators, the abortion clinic is more like a professional organization, which Etzioni characterizes as not a "remunerative industry" but is the least normative of normative organizations. Professional organizations tend not to specialize in the creation or expression of culture, as do most normative organizations, but are concerned with the application of culture. They are defined by their goals, which are professional goals such as teaching, research, and therapy. They are also defined by the rank at which professionals are employed (1961:51).

In the professional organization, the top ranks are primarily formed by lay administrators or nonpracticing professionals whose main concerns are means-decisions and instrumental activities such as maintenance of the physical plant, operating budget, and supplies. Professionals in the middle ranks make decisions about ends and their activities relate directly to the organizational goals of, for example, diagnosis and treatment or research (1961:219).

Charisma, which is a major source of legitimation for an organization or its activities, tends in a professional organization to be concentrated among the professionals themselves. Their two sources of ascribed charisma include their status as accredited professionals and their organizational positions.

Etzioni points out that the development of charismatic leadership in the top administrative positions of a professional organization is dysfunctional because it tends to interfere with professional decisions and professional goal related activities (1961:220).

No organization is a pure stereotype of any of these constructs, but is a composite which may have a dominant characteristic. Furthermore, Etzioni offers the dynamic perspective that “Many organizations are more charismatic in the first period of their existence than at later times” (1961:228).

Case Studies

The following case studies of four abortion clinics illustrate some of the principles of administrative incongruence. In the first three (Clinics A, B, and C), authority conflict was endemic in the organizational structure. By contrast, the fourth clinic (Clinic D) contained no authority conflict and superficially, little administrative incongruence. The information was obtained in all cases through the participant observation technique, although none of the authors participated in the described activities in order to report them later, with the exception of the management study of Clinic A. Even here, publication of any of the observations or conclusions was not anticipated.

CLINIC A. Clinic A was opened in 1971 with the purpose of being a model nonprofit abortion clinic. The clinic’s objectives were not only to provide patient care but to provide an example of how a first rate outpatient abortion facility should operate.

The clinic was set up with a full-time medical director who was a highly qualified and experienced Ob-Gyn specialist. There was an intensive training program for lay abortion counselors conducted by a leading local psychiatrist. The counseling program emphasized one-to-one counseling of patients and group counseling for relatives and friends of relatives.

The entire staff was conscious of the clinic’s role as a leader in providing abortion services and as a model for other clinics. Morale was initially high. The counselors, in particular, were strongly committed to the clinic’s activities. They were young, idealistic, and highly dedicated.

At the time of the management study, Clinic A had been open for 18 months and had provided abortions for some 15,000 patients. Between 50 and 60 abortions were done per day. There was a staff of nearly 100. The study was done over a three-week period and included open ended interviews with 59 staff members ranging from the autoclave technician to the executive director. The author also observed and performed a number of abortions and vasectomies as part of the participant-observer strategy. Many informal conversations and observations took place in the staff lounges over coffee and with doctors in between procedures.

The management study showed widespread severe dissatisfaction among the staff, especially the counselors. The principal complaints centered around the lack of communication within the organization and the autocratic methods of the executive director. The first rank professional supervisors, such as the clinic director, nursing director, and director of counseling, often were not informed, much less consulted, regarding major policy or administrative decisions made by the executive director.

For example, decisions about scheduling, the number of patients to be accepted, and hiring of new personnel were frequently not communicated to the supervisors except by accident after the policy had taken effect. The supervisors then had the responsibility for carrying out the policy without having the opportunity to discuss its impact with the executive director. The result was confusion, tension, delays, overwork, and anxiety. These problems were compounded by fears of retribution by the executive director for criticism of the problems or her methods, or even requests for information. “What’s on my mind just stay on my mind anymore.” “When you leave [the conversation] you feel like you’ve had an experience but there has been no progress.” “Saying anything can be treacherous if the person you’re talking to is [the executive director].”

The executive director herself was widely admired as an intelligent, committed, and talented leader with many positive qualities. She was perceived as a dynamic person who really cared what

happened, but she was also perceived as authoritarian, autocratic, paranoid, vindictive, and unable to tolerate questions or complaints.

The executive director felt under great pressure by the overall director of Clinic A to perform and produce revenues by having as many abortions done in the clinic as possible. The funds were being used to finance similar clinics in other cities and expand Clinic A's program to include sex counseling, vasectomy, and pregnancy testing services.

Many staff members, especially counselors, felt that these stresses and expansions were occurring at the expense of good medical care for the abortion patients. "The machine is turning on the people who created it." "It's the nitty-gritty people who keep the place functioning." "The longer the clinic stays open the worse (sic) the situation gets." "[Clinic A] is on the verge of becoming an abortion mill and slighting the patients – especially if it's going to be bankrolling other operations." "Are we moving toward being an abortion mill and a very inefficiently run abortion mill at that?" "Teaching people how to screw is fine after we get some of these other things taken care of."

The conflict between the professional supervisors and the executive director intensified when the executive director was absent. She gave telephone commands occasionally through her secretary, who essentially was in charge of the clinic. The professionals had no autonomy to make decisions and one was in command in her absence. When she was present, disagreements and conflicts abounded. Two plaintive questions reflected this: "Who do you go to?" "Who can you tell the truth to?"

CLINIC B. Clinic B was formed in mid-1973 in response to efforts by several interested women and two male physicians, neither of whom were gynecologists. A male sociology graduate student who had worked with a local drug abuse program was also involved in some unsuccessful early attempts to persuade local gynecologists to help start such a nonprofit clinic.

Because of previous administrative and clinic experience with abortion, WH was invited to help for the clinic and to be the permanent physician. A program plan was proposed and adopted which made the sociology student the executive director and WH the medical director. A board of directors was formed. A loan was obtained and plans went forward to rent space, lease equipment, hire a nurse, and train counselors. The model for the clinic was Clinic A. A head counselor was hired by one of the original physicians, who was a board member, without the knowledge or consent of either the executive director or medical director. The head counselor had experience as a lay counselor at an abortion clinic in New York City, but no professional qualifications or training.

The clinic was launched in late 1973 amid statewide public controversy about its right to exist. The local Right to Life organization attacked the clinic, asking the city council and health department to close it. An attack within the county medical society was directed toward the clinic and the clinic's medical director. The medical director obtained his local hospital privileges over the strenuous objections of some hospital staff members who opposed abortion or who perceived the possibility of economic loss as the result of a low cost abortion service in the community. The State Board of Health called a hearing to consider licensing abortion clinics as the result of an appeal by a community group opposed to the clinic. The medical director testified at the hearing and the matter was dropped.

The atmosphere at the clinic was one of siege, tension, and exhilaration at the sheer establishment of the clinic. The medical director was seen by some members of the clinic staff as somewhat of a hero, albeit a reluctant one.

From an administrative point of view, most of the policies and actions which the medical director recommended at this time were adopted. The medical director's efforts to create both the substance and appearance of a first class medical program were accepted and were successful. The clinic was visited by a delegation from the county medical society, for example, composed of two gynecologists expressing open hostility to the clinic. One of these had been instrumental in having the clinic's first lease cancelled. Their report to the medical society stated that the clinic's medical standards were "exemplary and commendable...equal to the highest medical standards in the city..."

Within eight months after the clinic opened, however, the medical director and head nurse felt overwhelmed by the work load. This consisted not only of care for 25-30 abortion patients per week plus

all screening and follow-up exams, but many routine chores including cleaning and clerical work. There was a serious shortage of equipment. The executive director protested his innocence of administrative responsibilities, claiming to be a sociologist engaged in writing a book about the clinic. The executive director perceived the medical director's requests for additional equipment as unreasonable and unobtainable because of the lack of money. He claimed that the medical director and head nurse should work on their "relationship" as a way of solving the problems.

One year after the opening of the clinic, the head nurse resigned. She felt that she was constantly caught in the middle between the medical director and the executive director, who continued to view the complaints by the physician and nurse as the result of their alleged interpersonal conflict rather than the result of any substantial need for administrative action. Meanwhile, most of the original board of directors resigned, some citing despair at the poor management of the clinic as their reason.

Fearing charges that he was sexist, the executive director decided to have a female codirector and divide the job with her. One of the counselors was chosen for this position. The efficiency of the decision making process was not enhanced by this step. For example, the medical director requested permanent help to clean and prepare instruments in the operating area, to do routine cleaning, and to stock supplies. After several consultations between codirectors, the reply was that this would not be done because there was no money. It was suggested that raising fees would provide the money. "We voted not to raise fees." The medical director repeated an earlier request for locking steel file cabinets for medical records, but a decision either way was not reached.

The conflict and tension grew to the breaking point after the resignation of AO as head nurse. The medical director requested a meeting alone with the executive director and head counselor to work out differences and to ease tensions. He stressed the need for the highest professional standards of medical care. The executive director replied that he "hated professionalism," and the head counselor concurred. The executive director expressed the view that the main purpose of the clinic was the personal growth and maturity of the women who worked in the clinic, and that the patients were secondary and incidental to this purpose. The medical director said he perceived the goal of the clinic to be the provision of safe abortion services for the patients.

The following day, the executive director violated the confidentiality of a patient's records by discussing a sensitive item with the patient's companion without her consent. Shortly thereafter, the medical director asked the board to request the executive director's resignation.

From that point, board meetings as well as daily clinic activities were occasions for hostile confrontation. The head counselor, a strong individual who viewed the clinic as part of a larger political movement, mustered the loyalty of the new board. The medical director was increasingly isolated in his views. His demands were perceived as irrational and impractical by most of the rest of the staff, particularly the executive director. His recommendation that the clinic have a single director with clear authority and responsibility was rejected on the grounds that it gave one person too much power. This brought about a general perception that there should not be anybody over anybody else and, for one thing, the authority of the doctor or doctors in the clinic must be reduced. The board voted to abolish the position of medical director, offering continued part-time employment to the one whose position they had just abolished. He resigned at that point, citing the need for medical accountability which the position of medical director provided.

CLINIC C. The owners of clinic C were not easily characterized as driven by commitment to social change or social justice. Their business was real estate investment and they saw an opportunity for profit by opening the first abortion clinic in the community. They did realize the necessity and commercial value, however, of excellent facilities and good medical care.

The first administrator of Clinic C was a minister, locally known for his work in abortion counseling and leadership in this area. The administrator was therefore a highly visible and well-known individual with a commitment to social progress as his main concern. He concentrated on establishing a strong counseling program for patients and relatives; also, he provided important community liaison for the clinic because of his previous contacts.

The medical director was chosen by the owners, who lived in another city and rarely visited the clinic. The medical director, also highly regarded by his colleagues in the community, operated with relative autonomy from both the owners and the administrator. The staff physicians appointed by the medical director were highly competent in general, albeit wholly insensitive in some cases to the emotional needs of the patients. They operated more or less autonomously once hired since the medical director seldom appeared and almost never supervised them.

The head nurse was hired by the medical director but from that point on functioned without supervision except to receive occasional large shipments of wholly inappropriate supplies obtained as “bargains” by the absentee owners. A large stockroom was used for storing these useless items. The head nurse actually functioned as the medical director, managing physician’s schedules and arranging for treatment of complications as they arose. She ordered supplies and hired nursing personnel as she saw fit without consultation with the administrator.

The first administrator remained during the first eight months of the clinic’s existence, then left to return to graduate school. After a time, he was replaced by another minister who lived near the owners and commuted sporadically to the clinic. The second administrator had a similar background to the first but in addition, he had also helped the owners start a similar clinic earlier. His tenure was only four months since the commute became difficult.

Some time afterward, a third administrator appeared on the scene, a young man with a degree in public health administration. He was hired as an administrator, he thought, because of his professional qualifications in this field. He actually expected to administer the clinic.

His first task as an administrator, as he saw it, was to obtain information about what was happening. He sought reports and figures from every department, designing flow charts and making projections. The one set of information which he could not obtain, however, was the amount of money coming into and going out of the clinic or how it got divided up in between. The bookkeeper knew, but she wouldn’t tell him. She was under orders, in fact, from the owners not to tell any of the administrators. He was just the first to ask.

Any administrator knows, of course, that in order to make intelligent decisions one has to know how much money there is to do whatever is to be done. Power follows money, and money is the bottom line in a profit making operation. Whoever controls that information controls the organization. The owners controlled, and their proxy was the kindly, elderly bookkeeper who was no genius but had an absolutely firm position because, in the words of one of the owners, “she reminds me of my mother.”

Not only did the administrator find it impossible to obtain the essential information which he required for effective decisions, he constantly received instructions, sometimes through the bookkeeper, about medical, nursing, or administrative policies which he was to carry out. These included hiring certain doctors on no other grounds than that they were friends of friends of someone.

The administrator, a man of independent streak and professional pride, lasted approximately two months in the face of the clinic’s total resistance to being administered by someone whose responsibility was to do just that.

The effect on the staff was demoralizing, in one respect, in that constant confusion prevailed in administrative matters. No one really was in charge overall. Those with any supervisory authority, such as the head nurse, fended for themselves, making up policy as they went along. It was a strategy of divide and conquer since no one had enough information to dominate completely another fiefdom.

In other respects, the professionals, such as the head nurse and head counselor, took pride in their work and found it satisfying. They found it possible to work with relatively little interference, isolating themselves partially from the constant injunctions from the owners that the clinic must make money and from the influence of concern for profits over professional considerations.

CLINIC D. One of the busiest abortion clinics in the Northeast was Clinic D. The clinic’s average volume was about 100 patients per day. It was, and still is, a fairly safe place to get an abortion. It was

not and probably never will be a pleasant place to work; not because of the work itself because of the boss. He is feared.

There is no authority conflict in Clinic D. One person, Dr. Z, owns the clinic and runs it on a day-to-day basis. He is a good abortionist. That fact is recognized by everyone. He is absolutely in charge. That fact is also recognized by everyone.

The administrative policies are clear, and the consequences of violating them are immediate. You get fired. There is no talk of idealism here, of social change or making the patients comfortable. This is a business proposition.

Everyone is on the same footing, from doctors to instrument washers. The nurses punch a time clock. Everyone calls it "the factory." The one thing that unites the staff in a superficial way is fear of the management.

Dr. Z wants information and he gets it from his employees. He calls it "feedback." His employees call it "screw your buddy." There is no job security, there is plenty of anxiety, and there is no loyalty beyond the paycheck. It is a gritty, work-like-hell-and-let's-get-out-of-here atmosphere.

Medically, one thing distinguishes Clinic D from others previously described: the patients are under general anesthesia during the abortion. The patients are group counseled and doctor-patient contact is minimum if not nonexistent. When the patients wake up they are woozy, sick, and rather uncommunicative. Their care during the recovery period is little more than custodial, but it is efficient and competent.

What does Dr. Z want? Money. What must he have in order to get it? Performance. Employees perform with precision exactly within the rules provided or they go elsewhere to work. Sometimes, however, they merely lie about their performance.

The doctor is primarily a technician in Clinic D. The doctor is not expected to relate well to patients, explore their medical histories for diagnostic nuances, or be especially pleasant to anyone. What is expected from the doctor is a technically perfect abortion in each case. Too many complications and you're out.

Some doctors don't think this atmosphere squares with their roles as professionals, as independent decision makers. It doesn't, of course, but if you criticize it or try to enlist others in your view, you will soon find a new atmosphere in which to work. Others may share your attitude but don't expect them to join you. They have their jobs to look after.

Discussion

At the time of its opening, Clinic A demonstrated many normative characteristics owing to the high degree of social commitment and altruism of its founders and staff. This was most evident among the counselors. The clinic's original medical director was highly charismatic, being extremely popular among the staff, and in addition his ascribed charisma resulting from professional expertise helped legitimize the clinic's activities.

In time, the clinic necessarily experienced the bureaucratization and routinization of many professional functions, as evidenced by the development of departments headed respectively by a physician, a nurse, and a social worker. The executive director, however, continued to operate in a charismatic fashion which had been appropriate at the beginning. In order to function, the clinic had developed a rational-legal system of decision making (Price 1968:55) which conflicted with her administrative style. She tried to operate a compliance system incongruent with the structure which emerged out of necessity in providing a complex service.

Clinic A provides a perfect example of Etzioni's theory that the development of charisma in the top administrative positions in a professional organization is dysfunctional. Etzioni notes that this development "...gives the administrator additional power, which may be used to overemphasize values such as economy, efficiency, and instrumental expansion, while direct service of the professional goals of the organization is neglected..." (1961:220).

Clinic B illustrates the same principle. Clinic B's origins were even more charismatic and normative as the consequence of the community atmosphere of hostility and controversy. The medical director was thrust into a highly charismatic position, willy-nilly, in addition to his ascribed charismatic properties as a professional. The charisma of his office and function in the clinic was a powerful source of legitimation for the clinic in numerous ways, and the organizational goals which he perceived were achieved rather quickly at the beginning.

As the controversy subsided, however, the medical director's charisma diminished by comparison with its previously exaggerated level. It also diminished within the organization because, as it turned out, the executive director and head counselor held values which were highly antagonistic to the more general ascribed charisma of professionals and doctors in particular. The executive director found himself in a charismatic power position by virtue of the office he held and default of the original board of directors, and the head counselor developed a charismatic power position by the same means.

Both of these individuals not only deprecated the role of professionals but saw the clinic as serving normative goals primarily rather than professional or instrumental goals. This disagreement within the top organizational structure helped create a serious incongruence in the compliance structure as the professionals, the medical director and head nurse, tried to bring about a rational-legal system consistent with service of the professional goals which they perceived.

Clinic C had a figurehead charismatic leader, the first administrator, who played an important role in legitimizing the clinic in its opening months. He was used by the owners to attain some purely instrumental goals of economic profit and was successful in maintaining his position of charismatic leadership as long as he did not use it to attain any real control over the operation of the clinic. The third administrator, who tried to do this, came to grief.

The third administrator tried to exercise his professional expertise and institute a rational-legal decision making system. However, he found his efforts stymied by the distant, all-powerful lay administrators. Their purely utilitarian values and instrumental method of administration through the bookkeeper created incongruence with the professional goals perceived and pursued by the public health administrator. The weakness of the medical director as a force for professional values lent itself to the assumption of this role by the new administrator, who saw himself as protecting those values and goals.

Clinic D operates almost strictly as a utilitarian organization with economic remuneration as its chief source of control. In that sense, there is not only no authority conflict but no administrative incongruence. If any exists, it is visited upon the doctors, who must put aside their ascribed charisma as expert professionals while working in the clinic. The organization is not serving professional goals in the broadest sense; it is serving instrumental goals. In that, it is highly effective.

The cost, however, of forcing the professionals into a utilitarian structure is personal anxiety, fear, loss of self-esteem, alienation with respect to the management and coworkers, nonexistent loyalty, and instability. The professionals maintain their association with the clinic only by means of elaborate self-denial of its significance for their professional values.

Conclusion

Abortion clinics are unique social organizations due to the controversial and emotional nature of the service they provide. The first three clinics described as case studies illustrate a principle common to them and perhaps to many others. They demonstrate an important evolution in the organizational structure and administrative style from normative and charismatic to professional and rational-legal. Administrative incongruence and authority conflict developed in all three because of dissension about organizational goals and differing rates of administrative change within the organizations.

The consequences for the professional staff and employees for all three included tension, anxiety, and confusion. The quality of medical care may have been adversely affected in the process but evidence for this is lacking.

The situation was not really better in the clinic with no authority conflict or significant administrative incongruence. The technical quality of services provided was high although the degree of

emotional support for the patients was significantly less. Perhaps the only real conclusion to this study is this: the organizational structure may not be as important as the personalities and values of the people who are running it.

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