INNOVATIVE DECISION MAKING AND
COOPTATION AS METHODS FOR CHANGE ACCEPTANCE BY
EXTERNAL ENVIRONMENTS

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ABSTRACT

This thesis examines the role of boundary spanners and the importance of innovative decision making and cooptation in prompting external communities to accept changes affected by organizations within their environment. It is the purpose of this paper to demonstrate to organizations the importance of including those they serve in long range decision making processes, particularly when the changes incurred will directly affect an external group.

In addition to already published material, several case studies will be cited. The case studies will show how communication theories applied to internal environments can be taken one step further and used to get the external environment to accept change when involved in the decision making process or through formal or informal cooptation.
Based on the theories discussed in the literature and then applied to the case studies, innovative decision making processes and formal cooptation become very viable methods for an organization to use in an effort to persuade its external environment to accept change.

Service oriented organizations, such as hospitals, are finding it necessary to implement change almost daily in an effort to keep pace with the new competitive health care market. Some of these changes may not be popular with external environments but may be necessary for the survival of the organization. In an effort to persuade and have these environments accept change, organizations should have several communication methods available.
INTRODUCTION

Hospitals have, for years, failed to include their publics in planning for changes in services or construction and rebuilding projects. Some hospitals believed the public was not well versed enough in health care problems or practices; other hospitals believed that since they served the public good, whatever improvements were planned in health care delivery would and should be accepted. The times have, however, changed. Communities surrounding hospitals, both large and small, are now asking, and in some cases demanding, a voice in planning their health care services.

This thesis will examine the role of the community in organizational decision making. It will examine some of the problems hospitals have encountered in long range planning for health care changes without consulting the communities. Three case studies will be cited and compared. In general terms the function of boundary spanners within the organization, and
cooptation as a means of achieving community support of
desired changes will be examined.

By comparing techniques discussed in the
literature I hope to show how an organization can choose
an appropriate method of introducing change into its
environment without disrupting its normal operation and
with minimal opposition.
THE LITERATURE

Boundary Spanners

The literature includes the concepts of boundary spanners and cooptation, which are most helpful in examining how organizational change is managed within the larger community. Boundary spanners play an important role in informing an organization of a community's feelings. Aldrich (1979) notes their importance in linking an organization to specific target groups so they will feel their interests are represented.

Boundary spanners are individuals...

...who are internal communication stars [that is, they are frequently consulted on work related matters] and who have substantial communication with areas outside their unit (Tushman & Scanlan, 1981, p. 84.)

For the purpose of this paper, boundary spanners will be any individuals within the organization,
including members of the board of directors, who have communication with environments outside that organization.

In a study of 57 hospitals in a large midwestern state, Pfeffer (1972) found that the size of boards of directors was related to a hospital's needs for successful linkage with the environment as well as to the functions of the board. He noted the importance of the directors as mechanisms for linking the hospital with its environment, noting the hospital would attract its "resources" according to the composition of its boards. For this reason boards of directors should be composed in such a way so that they represent the social context in which the organization is embedded (Pfeffer, 1972).

However boards of directors have not, until recently, reflected their communities. Along with increased consumer awareness has come more formal pressure for public participation of boards as another means of providing consumer input into health care delivery systems (Freeman, Levine and Reeder, 1979).
Boards are only now beginning to take on a more diversified group of individuals as members. Active solicitation of members of the black community, Hispanics and others is still an innovation. In effect, the directors become boundary spanners for the organizations they represent.

Tushman and Scanlan (1981) also note a perceptable void in the connection of boundary spanners and decision making and call for future research to further investigate the role of boundary spanning individuals in organizational decision making beyond that of simply transferring information (Tushman & Scanlan, 1981, p. 305).

Adams (1976) speaks in terms of boundary roles and notes that within an organization the acquisition and disposal of functions of organizations requires specialized organizational roles (Adams, 1976, p. 1176). She goes on to say that the more hostile the environment an organization operates in, the more important the need for effective organizational boundary functions (Adams, 1976).
Adams (1976) refers to the boundary role person as an "influence agent," one who attempts to influence the behavior of other individuals or organizations whose opinions are typically different from that of his or her own organization.

Ross says that one of the most effective ways an organization can get to know its community and vice versa is for "management people to become really interested in the community..." (p. 170). Community involvement as such would establish management as boundary spanners. Further, Ross (1976) says that thought leaders are not necessarily the economic elite or people with important titles in the usual run of business, civic and political organizations. Ross is saying that thought leaders are found at many levels of society. Thought leaders are those individuals recognized by members of specific communities as wielding influence at any level.

In studying boundary spanning roles in relation to organizational structure, Aldrich and Herker (1977) found that how an organization adapted to changes in its community depended in large part on the expertise of the
boundary spanners in "selecting, transmitting, and interpreting information originating in the environment" (Aldrich & Herker, 1977, p. 219). They specifically noted that one very important role of boards of directors "is to link an organization to its target groups in the environment in a highly visible way" (Aldrich & Herker, 1977, p. 221). This helps make the groups feel their interests are being represented. They also found that if an organization is seeking compromise it will depend in part on the ability of the boundary role incumbent.

An organization's ability to cope with environmental constraints depends in part on the ability of boundary role incumbents to achieve compromise between organizational policy and environmental constraints, to choose strategic moves to overcome constraints, or to create conditions which the organization's autonomy is seldom challenged (Aldrich & Herker, 1977, p. 223).

The organization that recognizes the ongoing need for boundary spanning should also be prepared to use other communication methods with its external environments. However, since each communication method has its own specific requirements, it is important for the organization to recognize each method, its
requirements, and when it should be used.

Cooptation

In addition to using boundary spanners, cooptation is an important and effective method of community involvement and can be used to effectively help bring about desired change.

Formal cooptation

...involves the establishment of openly avowed and formally ordered relationships. Appointments to official posts are made, contracts are signed, new organizations are established—all signifying participation in the process of decision making and administration. What is shared is the responsibility for power rather than power itself (Selznick, 1948, p. 13).

The use of formal cooptation as a means of involving various communities which may disapprove of an organization's plans is an effective method of avoiding long, drawn out struggles between an organization and its external environment.

In informal cooptation, long range plans may have been announced and some dissension among the external environment noted, to which the organization then
responds. Informal cooptation therefore

...is not one of responding to a state of imbalance with respect to the people as a whole but rather one of meeting the pressure of specific individuals or interest groups which are in a position to enforce demands (Selznick, 1948, p. 15).

Integration

Rogers and Shoemaker discuss innovative decision processes, which when applied, are processes that can make formal cooptation work. In Communication of Innovations: A Cross Cultural Approach, Rogers and Shoemaker (1971) looked at decision making processes in various cultural settings, specifically in regard to innovation acceptance. They defined what they called the "innovation decision process." They described this as the steps one goes through after learning about a new program and then coming to a decision to adopt or reject the change and the acknowledgement of the decision.

In collective innovative decision making, an area which, according to Rogers and Shoemaker (1971), is largely neglected, a group involved in the sequential process follows these steps:

1. stimulation interest in a new idea;
2. initiation of the idea in the social system;
3. legitimation of the idea by the power holder;
4. decision to act; and
5. action or execution.

They found that the degree to which an individual was satisfied with, and accepted innovation was directly related to the degree of participation in the decision by the members of the group (Rogers & Shoemaker, 1971). If formal cooptation allows for the establishment of ordered relationships for group participation in decision making, then the steps Rogers and Shoemaker describe as innovative decision processes can be used to help facilitate group participation in the decision making process. Rogers & Shoemaker's understanding of innovation seems to be useful for framing the concepts of cooptation fits into their framework by bringing outside groups into the organizational structure and allowing them to become a part of the decision making process.

In their studies, Rogers & Shoemaker (1971) define a change agent as one who functions as a communication link between two or more social systems.
According to Rogers and Shoemaker, the change agent's success is positively related to:

1. the extent of the change effort;
2. his client's orientation;
3. the degree to which the program is compatible with his client's needs;
4. the change agent's empathy with his client;
5. the change agent's homophily with his client;
6. the extent he works with opinion leaders;
7. the change agent's credibility;
8. the change agent's efforts in increasing his client's ability to evaluate innovations (Rogers & Shoemaker, 1971).

If applied to Aldrich & Herker's (1977) discussion of the boundary spanning role incumbent's job in trying to achieve compromise between organizational policy and environmental constraints, the two are very similar. The change agent and boundary spanner both work with external environments in an effort to learn more about what these environments need, want or require to maintain a working relationship with the organization in question.

It is my argument that the failure of hospitals to recognize the need to involve their communities in
planning processes and decision making roles has caused major problems for many hospitals. Lengthy court cases and struggles within the community have often been the end result. Hospitals that recognize the importance of boundary spanning roles have met with far greater success in bringing desired changes in their services or gaining approval for building proposals. Other hospitals and medical centers are, where necessary, using both formal and informal cooptation to change their communities' minds when opposition arises.

Perhaps the best way to discuss the future successes of such community involvement is to look at some of the problems which have been encountered and apply the findings of the literature. In the following chapters, I shall look at three case studies and subsequently show how the use or non-use of boundary spanners and/or cooptation was or was not successful for the organization.

There are some planning consequences contingent on the use or non-use of boundary spanners and cooptation which will be explored in the case studies. In some instances perhaps boundary spanners could have
been sent into the community. By doing so, an organization might have found opposition to its plan early and then taken steps to compromise and/or change. The organization that formulates change without community involvement and then find the community in opposition can do one of two things. It can prepare for a long struggle, or use the formal or informal cooptation process to expedite the plan even if changes in the plan become necessary for community acceptance.

There are ways to establish mutual support between an organization and its community. It is important that such mutual support be recognized as essential for all to benefit from services offered by the organization. An organization familiar with boundary spanners, cooptation, and innovative decision making processes will find itself in good standing with the community it serves.
CASE STUDY #1

To Build or Not to Build...and Where

The Medical Center of Delaware, Inc., (formerly The Wilmington Medical Center), is a private, not-for-profit hospital that receives no financial support from the City of Wilmington. It receives modest funds from the State of Delaware that in no way begin to cover the cost of health care to the area's medically indigent. In fiscal 1982-83, The Medical Center spent almost $16,000,000 in non-recoverable medical expenses providing health care to the indigent.

The Medical Center is the major source for emergency care, outpatient clinics, and rehabilitation treatment for not only the county, but for the entire state of Delaware. It provides approximately 80.5 percent of the free care in New Castle County and almost
70 percent of the health care to individuals in New Castle County.

In 1974, The Medical Center began to develop a building plan to replace old facilities and enable it to meet the growing health care needs of New Castle County, the state of Delaware and the immediate surrounding areas of Pennsylvania, New Jersey and Maryland, all in The Center's service area.

In 1975, The Center announced plans for the construction of a 780-bed hospital located just southwest of Wilmington at Stanton-Ogletown and New Churchman's Roads, not far from I-95, and for the renovation of the Delaware Division to a 250-bed hospital. A 200-acre site was donated to The Center by the Welfare Foundation. The plan called for the eventual closing of the Memorial and General Divisions and was estimated to cost $76 million. This construction and rebuilding program became known as Plan Omega.

The announcement culminated a long search by The Center's Long Range Planning Committee and the
investigation of a number of different building proposals. The three alternatives studied were:

- Construction of a 240-bed hospital in the southwest part of the county, accompanied by remodeling and renovation of the three existing Medical Center divisions. With the passage of time the unit at I-95 would be enlarged step-wise to 800-beds and obsolete units shut down. This plan offered flexibility and the minimum upset in present care patterns.

- Construct a hospital of from 500 to 570-beds in the southwest, with remodeling of the Delaware Division to some 459-beds. This seemed practical in the spring of 1974, although the cost was worrisome. This plan concerned many medical-dental staff members who felt strongly that they could give the best patient care in a larger hospital where all equipment, facilities and consultation would be readily available, and that two similar-size hospitals would split the physician-dentist population to the detriment of the entire community.

- ...it was asked if there was a way to use roughly the same amount of money to approximate the 'one roof' concept which everyone seemed to accept as most desirable. ...if less was spent on remodeling the Delaware Division reducing its ultimate bed size to 250, and applied that difference to new construction, we could provide an 800-bed hospital at the southwest site at only slightly greater cost than would have been the case with the two hospital plan...(Evening Journal, October 21, 1975).

The public was first made aware of The Center's building decision through articles in the Wilmington
News Journal. The several plans were listed, but the difficulty in making the decision did not seem to come through.

Plans to move any number of hospital beds southwest of Wilmington brought opposition from City officials as well as the urban and suburban populations. Opposition from city leaders was thought to stem from the loss of employee wage taxes if The Medical Center moved most of its patient care—and thus its employees—to the new site. However once the final decision to move had been made, James Panyard, spokesman for then Wilmington Mayor Thomas Maloney, said, "The City of Wilmington has no plans at this time for any campaign against the Omega Plan." (Weekly Post, October 15, 1975) Mayor Maloney's administration was followed by an administration that eventually went to court as friends of the plaintiffs.

The most vocal group opposing The Medical Center's Plan Omega was an inner city coalition of neighborhoods known as Wilmington United Neighborhoods (WUN). WUN opposed the plan at its inception, claiming "...there's more concern for people who drive Cadillacs
than for those who ride buses" (Evening Journal, December 15, 1975). WUN's concern was whether or not the plan would preserve adequate health care for Wilmington residents who had easy access to city hospitals but who would need public transportation to reach the southwest site.

WUN went to court citing the Civil Rights Act, charging that Plan Omega would, in effect, create separate but equal facilities for residents of New Castle County. Following a court ordered investigation of the plan by the Department of Health, Education and Welfare (HEW), now the Department of Health and Human Services (HSS), and following modifications to the plan in some areas, The Medical Center entered into a contractual agreement to avoid any possibility of establishing racially identifiable hospitals. HEW's Office for Civil Rights approved Plan Omega in a letter of findings dated July 5, 1977.

The Medical Center was hopeful this would end community opposition. It did not and litigation proceeded until 1981, at which time the U.S. Third Circuit Court in Philadelphia ruled in The Medical
Center's favor. Ground was broken a few months later. By this time, estimated cost of construction, including the rebuilding of the Delaware Division, was $172 million.
CASE STUDY #2

They Paved Paradise and Put Up a Parking Lot

The Medical Center Hospital of Vermont, located in Burlington, is a 517-bed hospital that serves as a regional referral hospital for much of the state. It is a teaching hospital, affiliated with the University of Vermont College of Medicine. The Medical Center is located in downtown Burlington. Although Burlington is a mid-sized town, it is plagued with many of the problems urban centers face; in this case, lack of adequate parking surrounding the Medical Center.

In January 1977, the Medical Center Hospital entered into an agreement with the Diocese of Burlington to purchase the Bishop's Residence, adjacent to the DeGoesbriand Unit of the Medical Center Hospital. The Medical Center also entered into an agreement at this time, with the University of Vermont College of Medicine to sell the DeGoesbriand Unit to the medical college for
use as a teaching facility for the college.

The proposal called for the university's medical faculty to occupy 60,000 square feet of the DeGoesbriand Unit and for the university to rent the remaining 100,000 square feet back to the hospital for outpatient services. The Bishop's Residence was to be razed in order to gain additional parking for students and others who would now be visiting the DeGoesbriand Unit regularly.

Purchased by the Diocese in 1918 as a residence for the Bishop, the building was, at the time of the sale, about 100 years old. It had been used as the Bishop's Residence since its original purchase.

The public did not object to the sale of the DeGoesbriand Unit or the Bishop's Residence. The problem arose when the public realized that the Bishop's residence was to be torn down to make way for a parking lot. First objections to this proposal were vocalized at the same Burlington Planning Board Meeting which eventually approved the hospital's plan for demolition.
Demolition was approved by a vote of 3-2 (Burlington Free Press, January 28, 1977).

As word of the proposed building demolition spread, opposition grew. Burlington area legislators and the town's mayor became opponents of the demolition project and alternative parking plans were proposed.

The legislators and mayor believed that the Bishop's Residence could be saved if the university and the Medical Center could find a comprehensive parking plan that would alleviate the parking and traffic problems near the campus and the hospital (Burlington Free Press, April 1, 1977).

Mayor Paquette suggested the use of Centennial Field and Gunnerson Field House parking lots connected via a shuttle bus system. Located not far from the campus, opponents to the demolition project believed this to be a fair compromise.

In July 1977 a joint committee of University of Vermont and Medical Center Hospital of Vermont trustees promised to consider alternatives to razing the Bishop's Residence. By the end of the month the special
three man committee unanimously recommended the demolition of the Bishop's Residence.

They believed construction of a new parking lot on this site was the most economical way of solving the parking problem. Prior to reaching their final decision the committee considered building a deck structure over the existing parking lot, allowing the structure to remain. This was seen as economically unfeasible (Burlington Free Press, July 29, 1977).

Around this time, the Medical Center Hospital of Vermont and Burlington Visiting Nurses Association began discussions about the possible purchase of the Bishop's Residence by the association. Any arrangement for such a sale was to include an alternate parking plan for the hospital (Burlington Free Press, September 23, 1977). This deal fell through. While the major problem blocking the sale was one of financing, it was also believed an alternate parking plan could not be found.

The October 5, 1977 issue of the Burlington Free Press reported that the State Health Planning and Development Agency had determined the sale of the
DeGoesbriand Unit to the University of Vermont was unacceptable on two counts:

1) The Medical Center proposal did not meet the criterion of need because the hospital would retain more space than it could use; and

2) It --the sale-- did not meet cost containment standards. Specifically cited were plans for the hospital to pay a $108,000 yearly management fee to the university.

The report did acknowledge however that "Patients should not be expected to support the cost of historical site preservation in payments for health care services." (Burlington Free Press, October 5, 1977)

Following a compromise on the amount of space to be retained by DeGoesbriand and the payment of the yearly management fee, the Vermont Health Department approved the sale. Plans were again begun for razing the Bishop's Residence once settlement of the sale had been completed.

In late October, a public group succeeded in getting the Vermont Environmental Board to rule that the
Medical Center Hospital must obtain a land use permit before proceeding with demolition plans. Medical Center Hospital had intended to file application for the land permit in November. At the last minute plans were changed, and Medical Center Hospital decided against it and went to court to challenge the need for a land use permit. When the lower court upheld the need for application, the Medical Center Hospital appealed to the Vermont State Supreme Court (Burlington Free Press, October 26, 1977).

Finally, in spring 1978, the State Supreme Court issued its ruling. Its decision sent both parties back to "square one". The high court overruled the injunction against the demolition and vacated the Environmental Board's decision that a permit was necessary because the Board did not notify all interested parties in writing that such a ruling was being discussed (Burlington Free Press, June 7, 1978).

Both sides then went back to the lower court and the legal see-saw continued for another year. Again, the lower court decision was against the Medical Center Hospital and again their ruling was appealed. In April
1979, the Vermont Supreme Court dissolved the final demolition injunction and gave its approval for the Bishop's Residence to be razed. The two year struggle increased the cost of the project by nearly $100,000 (Burlington Free Press, April 4, 1979).

On Monday, April 24, 1979, The Committee to Save the Bishop's Residence withdrew their opposition saying they had done all they possibly could to save the structure.

An antiques dealer was hired by the Medical Hospital of Vermont to salvage the antique interior woodwork and on Saturday, June 7, 1978, after two years of litigation, the Bishop's Residence fell to a wrecker's ball.
CASE STUDY #3

This Planning Process Worked

In 1983 The Santa Monica Hospital Medical Center planned to build a 170,000 square foot replacement building. Early in the planning stages administrators realized there would be opposition to the plan. Residents recently had negative experiences relating to the city's overly intensive development efforts and it was believed that these feelings would spill over to the Medical Center.

The purpose of the project was to replace a 50-year old facility. The Hospital Medical Center decided to bring the project to the public's attention in its early stages in the form of a design workshop.
According to hospital President/Executive Director Leonard LaBella,

It was important to indicate hospital concern for neighborhood impact of this project and receive input. A different forum for communication was utilized than normally pursued by hospital planners (Bobrow & Morris, 1983, p. 119).

Over 500 invitations to a broad range of neighborhood citizens' groups, health planning groups, civic leaders, and public officials were mailed. The design workshop would be held on hospital grounds during which time questions could be asked, worries voiced and problems addressed without the formality of city council or planning commission meetings.

The hospital's strategy was threefold:

1. It would start a development process by gaining public support and information.

2. The hospital would receive input on such issues as parking structure, location, traffic, facility height and bulk, and materials, and

3. The hospital would get feedback on its proposed project and be able to anticipate public opinion in subsequent health planning meetings.
The pros and cons of such a workshop were debated by hospital officials.

There was concern that problems would be brought up in the meeting which would adversely affect the city's project approval. There also was concern that few would attend. Deciding to use a workshop was based on the fact that, if the hospital initiated a public outreach it would be perceived as exhibiting concern for Santa Monica's fate (Bobrow & Morrish, 1983, p. 120).

An open forum was set for the workshop structure. Participants were invited to three workshops where issues would be discussed. The hospital's architects recorded comments and concerns on large sheets of paper hanging in the auditorium. The intent was to use these concerns for the project's design criteria. The workshops proceeded from general concerns of the hospital and community to more specific and complicated design issues such as organizational structure and image. Resource manuals were given out during the meetings.

The first workshop attracted only 30 people from the 500 invitations sent out. But the group had many questions and participated actively in discussions. The second workshop was held on a weekday in an effort to
draw more people. The resource manual was mailed to two hundred city officials and neighborhood civic groups as an invitation to the workshop. Sixty people came and again, support for the project was expressed.

The Santa Monica Hospital Medical Center took advantage of boundary spanning, participative decision making and cooptation. Its outreach to its community gained them exactly what it was seeking--community approval for their rebuilding program. Along with the community approval came approval from the local planning commission.
DISCUSSION

The failures of The Medical Center of Delaware and Medical Center Hospital of Vermont are indicative of a failure to carefully assess their communities. The Medical Center of Delaware saw its long range plans improving the quality and expanding the availability of health care. While it is true the public would benefit from the proposed changes, the Wilmington community did not see the plan in the same way.

Shortly after the building plan was announced and public sentiment became clear, The Medical Center held public meetings with various community leaders in an effort to fully explain the plan and assure them The Medical Center was committed to continuing to provide health care in the city. The individuals invited to these meetings were recognized by The Medical Center as
influence agents, defined by Adams (1976) as ones who attempt to influence other individuals whose opinions are typically different from that of his or her own. The Center also used already existing publications to inform employees, trustees, and board members as to the details of the plan. It was recognized that these individuals would go into the community and discuss The Center's position. All of these individuals acted as boundary spanners, or those who have communication with areas outside their organization. (Tushman & Scanlan, 1981).

The ten-point agreement signed by The Center and HEW was a perfect example of informal cooptation: the long range building plans had been announced, external dissension became clear, and The Medical Center responded by meeting the pressure of a specific interest group (in this case WUN) that was in a position to enforce its demands.

Yet something went awry and the contract did not satisfy opponents of the plan. Informal cooptation in this case did not work, possibly due to these key problems:
1. The Medical Center tried to maintain a relatively low profile during this time. According to Nager and Allen (1984) when publics with access to the media perceive that a low media psychology, rather than the issues in questions, dominate an organization's policy, the incident may be blown out of proportion.

When the negative news coverage is high, the more focus becomes not so much the incident, but the client's policies and actions.

2. Repeated charges may lend themselves to perceptions of disregard for public interest. And,

3. Even organizations with a strong tradition of excellent customer and positive media relations may be taken to task--or court--when it is perceived an organization is just protecting its image (Nager & Allen, 1984).

4. The ten point agreement signed by The Medical Center was a commitment to HEW to provide for the inner city. Perhaps a specific agreement between Medical Center officials and WUN would have allowed the informal cooptation process to work.
According to Selznick, formal cooptation works and is a proved method in bringing about desired change when groups are brought together and participate in the process of decision making. WUN was not brought in as a participant to decision making, although issues addressed by HEW and The Medical Center were raised by them. So a crucial part of cooptation -- participation -- was not met.

The University of Vermont Medical Center Hospital did not attempt cooptation, either formal or informal, or use boundary spanners. While hospital officials listened to community complaints regarding the proposed parking facility, no real attempts at participative decision making took place.

Although a number of organizations tried to purchase the Bishop's House, funding was not available and the hospital proceeded with their plans. The only individuals appointed to a committee seeking alternative parking recommendations were all hospital board members. The community remained divided about the entire issue down to the day the Bishop's House was finally razed.
The Success of Santa Monica

Santa Monica Hospital Medical Center realized early in their planning process that any proposals for building within their community could come under fire due to the many construction projects already underway. Taking careful note, they began a formal cooptation process, not only bringing the community into the planning stages, but giving it joint decision making capabilities.

Over 500 members of the community were invited to various planning meetings, yet in most cases fewer than 60 persons actually attended. These people were however, made a part of the decision making process, giving their recommendations as to what they perceived was needed and how different plans should be implemented. These people shared in the responsibility for power, the power of decision making. This, according to Selznick, is important and effective in the formal cooptation process.
THE ISSUES

There are many questions which can be raised by these two community vs. hospital struggles. The main issues seem to be the following:

1. If The Medical Center of Delaware, Inc., or Medical Center Hospital of Vermont had involved various members of the community in the decision making process or in meetings which would have explained the plans prior to being announced, would there have been community opposition to the proposed plans?

2. If either hospital had had strong boundary spanners within their organizations, could they have foreseen the problems which arose after the plans were formulated and announced, and could some of these problems have been avoided?
It is impossible to say whether or not activities by boards, boundary spanners or formal or informal cooptation would have been sufficient to have the plans of The Medical Center of Delaware or Medical Center Hospital of Vermont accepted by their respective communities. In The Medical Center of Delaware's case, an effort at cooptation failed. However, this may have been due to the fact that, as mentioned previously, the contractural agreement reached was between HEW and The Medical Center. WUN was not an actual participant. WUN's participation, according to Selznick's (1948) findings with other groups, was a necessary prime ingredient for the cooptation process to work. Although failure to uphold the statutes of the contract would have been detrimental for The Medical Center, a contract with WUN might have helped the cooptation process.

Lawler and Hackman (1969), in studying employee participation in pay incentive programs, found employees who were involved in the development of such programs were more likely to understand the programs and more likely to be committed to the success of the program. These studies also showed that those who actually
participated in the planning process seemed to become more trusting of organizational intentions (Lawler & Hackman, 1969).

Studies conducted by Rensis Likert (1969) found that those in decision making positions had to be clearly identified with the organization and its objectives and motivated to find answers to the problems which best helped the organization reach its objective. Likert's findings also noted that the response of workers who participated in the decision making process was influenced by whether or not the worker felt the participation was legitimate.

Extending the findings of Lawler and Hackman and Likert's findings, and extending them to a community group, one can argue that community participation in the developmental phases of change probably would have led to acceptance of the change as well as increased trust in the organization. The failures of The Medical Center of Delaware and Medical Center Hospital of Vermont are indicative of a failure to carefully assess their communities.
The Medical Center did learn from past mistakes. Upon the opening of its new Christiana Hospital, The Medical Center's plan called for the closing of both the General and Memorial Divisions and their eventual sale. The neighborhoods surrounding these facilities were very concerned about the buildings' dispositions. With this in mind, both properties were sold to developers on the condition the developers meet with area civic groups, discuss their proposals for the sites, and together, come to some kind of agreement that would be of mutual benefit to the neighborhoods and the developers. There was little problem with proposed condominium towers planned for the Memorial Division site.

The General Division property, however, became a controversial issue. It was only after heated debate that the developer and the local civic associations came to a formal agreement. The developer modified his proposal to meet some of the demands of the neighborhood groups. His compromise allowed The Medical Center to conclude the sale without any further problems.
The Medical Center Hospital of Vermont appears to have made what could be called an honest mistake. Today, many buildings 100 or more years old, are routinely torn without local communities voicing any interest. In this case however, once local opposition did become apparent, there were a number of steps The Medical Center Hospital could have taken to involve the community. They could have, for example, put interested community members on the newly formed alternative parking committee. Instead, they chose to keep this committee closed. Committee members were trustees from either the Medical Center or the University of Vermont Medical College, a lack of using the board as a boundary spanning unit.

They could have looked into the feasibility of moving the structure to another site. This was, as far as my research can tell, not considered as an option and could possibly have been an affordable project for the Save the Bishop's Residence Committee.
CONCLUSIONS

This thesis compares techniques used by various organizations to implement change that directly affect their outside environments and examines the decision making process as it involves their external communities. Such an examination makes it possible to see where problems arose. By applying concepts regarding boundary spanners and formal and informal cooptation cited in the literature it is possible to show how the use of these methods might have helped organizations avoid the conflicts which occurred.

Organizations want to avoid open hostility and conflict. It is imperative for their survival. To do this, an organization must know its external environments and should have methods available to implement change.

Boundary spanners, as members of boards of directors or as in liaison positions within the organization, are important for providing an
organization with information about their external environments and vice versa. It has been said that the size of a hospital's board is directly related to its success in communicating with its environment (Pfeffer, 1972). He noted that a board should be representative of all social strata of a given community. A hospital's board should not only represent the physicians who comprise its staff and the businessmen of the community, but should include a cross section of those people served. Blacks, Hispanics, and other community leaders should be represented. These are the people who will be listened to should doubts or questions arise regarding future planning.

Aldrich and Herker (1977), in their studies, specifically cited the importance of board members as boundary spanners, noting that they link an organization to target groups within its community. By using board members, an organization has the opportunity to remain in touch with its external environment. Feedback from board members and boundary spanners helps to identify supporters and non-supporters. Using them to take the organization's message to the community facilitates
organizational disclosure and lets the community know the what and why of the organization's plans.

As Adams (1976) noted, boundary roles should be clearly defined so hostile environments can be identified. The more hostile the environment, the more important the need for effective organizational boundary spanning.

Neither The Medical Center of Delaware nor the University of Vermont Medical Center was prepared for opposition to their long range plans. Despite the fact that both boards went through lengthy decision making processes and examined other plans, community opposition became clear early on.

Obviously, both the Wilmington and Burlington communities felt left out of the decision making processes. The boards failed in their role as boundary spanners in two areas: 1) The boards did not recognize potential non-supporters and 2) hostile environments were not clearly defined prior to the announcement of the proposed changes. The failure to assess the communities
left both The Medical Center of Delaware and the Medical Center Hospital of Vermont vulnerable to the community conflicts which arose.

The urban population of Wilmington felt they had no input into The Medical Center of Delaware's long range planning and did not understand the complex decision making process detailed in media reports. When, after reviewing several different plans, The Medical Center finally decided to move a major portion of its beds outside of Wilmington, the inner city felt it was being abandoned. The decision to move into the southwest suburbs followed a growth pattern clearly established by studies conducted by the University of Delaware's Department of Urban Affairs.

Selznick (1948) said informal cooptation occurred when an organization recognized and dealt with pressure exerted by individuals or interest groups. In an attempt at informal cooptation, The Medical Center signed a contractual agreement with the Department of Health, Education and Welfare (HEW). That agreement guaranteed an upgrading of the in-city facility, a free transportation system between the new hospital and the
in-city facility, also previously planned; and steps that would insure neither the new hospital nor the Delaware Division, would become racially identifiable facilities. Despite the signing of that contract, litigation continued for almost eight years, delaying The Center's plans and driving up construction costs.

Efforts by board members to go into the community to carefully explain the plan and efforts of a Black community liaison did not persuade WUN opponents to drop their litigation. In 1981, the Third Circuit Court in Philadelphia gave The Medical Center the final go ahead, and ground was broken soon thereafter. In January 1985, The Medical Center of Delaware, formerly The Wilmington Medical Center, opened its Christiana Hospital.

This failure of informal cooptation can be attributed to one simple fact: The Medical Center signed the contract with HEW, not with the community actually involved in the lawsuit. It would have been to The Center's advantage to sign the agreement with HEW and then to sign an additional agreement or pact, this one with representatives of WUN, as a good faith
The University of Vermont Medical Center made no public announcement about the purchase of the Bishop's residence. The first formal announcement regarding the purchase came at the town council meeting which was to vote on issuing the university permits for the demolition project. A public meeting or announcement explaining the project prior to this would probably have made a difference in acceptance of the plan. Even if opposition would have come to light at this time, communication lines would have been available to work out an alternative parking solution and at very least would have resulted in more rational ways to save the building.

The University of Vermont Medical Center was in a perfect position to formally coopt its community. A carefully chosen group of citizens to assist the university in planning a parking proposal would have been an enormous public relations boost for the medical center hospital.

Studies conducted by Rogers and Shoemaker (1971)
examined innovation acceptance by employees within an organization. Their studies took two groups of employees and actively involved one group in decision making processes that changed production methods. The other group was told the change was necessary to increase production output. While both groups eventually met the new production quota, the employees involved in the decision making process actually surpassed the new production quota. This study found that employees were more likely to accept new decisions and adapt to changes when they were involved in helping to make the decisions which affected them.

Santa Monica Hospital Medical Center was keenly aware of the problems it faced in convincing the external community of its need to build newer facilities. Newspaper accounts of community opposition to continued expansion and building programs of other companies detailed an unhappy community: unhappy at other organizations' disregard for community opinion and a haphazard, unplanned city building program with no look toward the future. Recognizing the potential to further alienate the community and risking the
possibility of having city council reject any building requests, the medical center decided to take the community into its planning process, giving it a part in the actual planning of the new building and site development.

Despite meetings where the number of attendees was small as compared to the number actually invited, the medical center continued to invite opinion leaders to planning sessions. These meetings involved architects, site designers, health planners and hospital administrators. Suggestions were noted and considered. Those rejected were done so carefully, with reasons for rejection noted and recorded. Careful explanations as to the why and wherefores of final decisions were made.

When Santa Monical City Council was presented the final building plan, no community opposition was voiced and the council voted its approval without hesitation. Santa Monica Hospital Medical Center successfully communicated its needs with its community. Innovative decision making processes were successfully utilized. Boundary spanners helped identify key members of the community to be involved in the planning
meetings. Once identified, these individuals were coopted by the medical center in that they were brought directly into the planning process.

With this in mind, and based on the experiences of The Medical Center of Delaware, Santa Monica Hospital Medical Center, and the Medical Center Hospital of Vermont, the logical conclusion would take innovation acceptance one more step: A community will be more likely to accept innovations and adapt to changes when it is involved in helping to make decisions which affect it.

Many organizations have, in the past, failed to adequately communicate with their environments. The strength of the consumer movement and special interest groups has made it difficult for organizations to ignore those they serve. Viable communication links to external environments are essential. The consequences of a failure to involve members of the external environment in long range planning may lead to years of litigation, loss of confidence in the institution, and eventual failure of the organization's plan.
The use of boundary spanners, innovative decision making processes and formal and informal cooptation are significant techniques that can be used to win community approval when organizational changes will directly affect these environments.
REFERENCE LIST


