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The Concept of Client Orientation in Health Care Organizations: A Conceptual Development and Preliminary Assessment

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The relative neglect of the role of client in the study of organizations coupled with the importance of the client to the existence and survival of most organizations suggests the potential value of such a perspective. Basically, it is our feeling that the manner in which an organization views its clients will be directly related to the manner in which activities are carried out in that organization. This is felt to be especially true for health-care organizations. An awareness of this relationship is reflected in several sources from the literature on organizations. Parsons (1960) points out that hospitals belong to a class of organizations, along with schools and universities, that are required to make the client an operative member of the organization, in order to provide their service. Perrow notes that the primary task of hospitals is "to alter the state of human material" (1965, p. 914, italics in original). Both authors suggest that these characteristics have a tremendous impact on the structure and functioning of the service-producing organization. Blau and Scott (1962) assert that organizations will reflect the characteristics of the public they serve. The organization's client orientation certainly plays a major role in defining which client characteristics are considered relevant, and therefore which will be taken into account in the process of organizing. Etzioni (1964) argues the salience of an organization's definition of the public it serves (client orientation) to the choice of the control mechanisms which it adopts. Further, Lefton and Rosengren (1966) argue the relevance of client orientation in defining the organizational problems of securing client compliance, obtaining staff consensus, and

collaboration with other organizations. Presumably, the organizational solutions to these problems reflect the variance in their definitions.

It is felt that health-care organizations will be differentially aware of and responsive to different portions of the patient's "personal system". The degree to which the health-care organization recognizes that in the person of the patient it has brought within its boundaries a "total" person and the extent to which the organization is responsive to the total person will reflect the client orientation of that health-care organization. Thus, for purposes of this paper we will define client orientation as follows:

Definition: Client Orientation - the extent to which there is an awareness of, a concern for, and responsiveness to the client (patient) as a 'whole' person on the part of the health-care organization.[1]

As was mentioned earlier, our definition of client orientation is based on the conceptual framework developed by Lefton and Rosengren (1966) and later further elaborated by Lefton (1970). Essentially, they offer a perspective for analyzing organizations that aim to take into account the fact that "organizations have contrasting interest in their clients" (1966, p. 805). They argue that an organization's interest in its clients may vary independently along two major dimensions. First, the organization's concern may vary along a time dimension, from very short time periods (as

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[1] In this paper, the terms 'patient' and 'client' will be used interchangeably.

in a hospital emergency room) to a very long span of time (as in a long-term mental institution. Second, the organization's interest may vary along a dimension of "biographical space". That is, organizations may be interested only in a narrow range of client properties (i.e., his illness, as in a psychiatric outpatient clinic). Lefton and Rosengren refer to these dimensions as longitudinal and lateral, respectively.

An understanding of the basic underpinnings and implications of the concept of client orientation can be found by introducing the concept of social role as it related to organization and behavior in organizations. As Katz and Kahn state:

> "The organization neither requires nor wants the whole person...The organizational role stipulates behaviors which imply only a "psychological slice' of this person, yet people are not recruited to organization on this basis; willy-nilly the organization brings within its boundaries the entire person" (1970, p. 50).

As Katz and Kahn point out, when the individual becomes a member of an organizational he brings with him his entire personality and self. This is just as true for the patient entering the hospital as it is to the factory worker punching his time card at the start of his day. As Lefton puts it:

> "(the patient)....brings his 'personal system' a configuration of psychophysical and psychosocial attributes, his ideational system, and his personality. The person in the world of the hospital is a patient. For him there is no prescribed role to assume, but into this he injects his own style, strengths and weaknesses, and his own complicating potential" (1970, p. 22).

The implications of this 'mismatch' of role expections between the organization and the client are rather obvious. As is indicated in the introduction to this paper, it is the apparent failure on the part of health-care organizations to realize that this reactive potential of patients exists which leads to the claims and charges of dehumanizing treatment leveled against the health-care system. Remembering our definition of client orientation as the extent to which there is an awareness of, a concern for, and a responsiveness to the patient as a whole person on the part of the health-care organization, a relevant question becomes how does the health-care organization become aware of the patient's 'total needs'? One rather obvious answer is through interpersonal communication. Through exchange of information the health-care organization and the patient can discover the patient's needs and develop means of dealing with those needs. Unfortunately, the free exchange of information between the patient or client and the health-care organization is not as easy as might be expected. To a large extent the exchange of information between the client and the organization tends to be distinctly specified. Relevant information is generally predetermined by the health-care organization. Lefton cites Pine and Levinson's (1961) description of the medical perspective of the patient"

> "The hospitalized patient has been concieved of as a 'case' of a given type of illness treated by the doctor within a supporting hospital facility. In this conception the crucial features of the patient are his 'signs and symptoms' and their origins in a central pathological process; the crucial feature of his hospital environment is the definitive treatment (shock, drugs, psychotherapy, or the like) it gives the patient; and the crucial features of his response in his clinical course toward (or away from) elimination of pathology" (1970, p. 23, emphasis in original).

Such a view of the patient will lead to identification of and interest in only a small portion of the characteristics of the patient. This is not to argue that concern with disease symptoms is inappropriate. In fact, such a concern should have primary consideration. However, the narrow perspective of the patient is the issue. As Lefton points out "such a conception not only depersonalizes the patient, it also over-simplifies the influence of variables not always relevant to diagnosis and treatment." (1970, p. 23-24). Rather than an exclusive concern for information on the symptom-treatment-response, an additional concern for information on "extra-disease" characteristics would seem appropriate.

Lefton suggests that there are three major classes or types of patient-characteristics which should be of concern to the health-care organization - (1) Qualifying (primary) Characteristics, (2) Related (secondary) Characteristics, and (3) Extraneous or Extra-Disease Characteristics. Of these three types Lefton says:

> "(Primary Characteristics)...are specific patient properties thought to be necessary and sufficient grounds for admission to hospital, i.e., explicit diagnostic and symptomatic categories stemming from defined causal roots.
>
> "(Related Characteristics)...refer to properties of patients which are related to a qualifying category in such a way as to affect the course and outcome of treatment, e.g., age, sex, previous illnesses. These are generally treated on an equal basis with Qualifying factors. Their impact exacerbates the Primary condition or limits treatment options. But they are normally perceived as crucial to primary goal attainment and as such are a source of increased laterality at least on a physiological level.
>
> "(Extra-Disease Characteristics)...affect the capacity

> of the patient to utilize hospital services because of ignorance, cultural traditions, psychological dispositions or other impediments. These may block or delay admission, retard or inhibit cooperation while in hospital, or initiate the benefits of hospitalization later. But while these characteristics may be objectively quite relevant they are often not do treated for various reasons." (1970, p. 24).

The three types of patient characteristics can be viewed as types or categories of potentially relevant information about the client. In reference to organizational client orientation, an awareness by the health-care organization that all three categories of patient characteristics are potentially relevant begins to approach a broad client orientation. Basically, these categories describe the scope of client orientation within the health-care system. That is, the health-care system can have a range of interest in patient characteristics which extends from an interest in only "Qualifying" and a limited set of "Related" factors to an interest in all potentially relevant client-related factors. It is the identification and designation of potentially relevant client or patient characteristics which is the essence of the client orientation concept.

Returning to our earlier discussion of information exchange as an operational definition of client orientation we can argue that the type of information about the client that the organization possesses and utilizes is indicative of its organizational client orientation. The types or categories of information which the organization collects and the extent of knowledge on each category of information are indicative of the emphasis which the organization places on the importance of the various types of information and thus are directly related to client

orientation. Thus, we suggest the following as an operational definition of client orientation:

Operational Definition	Client Orientation: the extent to which the organization possesses information about its client (patient). This includes types of information, relative value of the various types of information as evaluated by the organization, the absolute depth of knowledge in reference to each category, and the extent to which the information is taken into account in "treating" the client (patient).

The intent of this paper is describe and develop the concept of client or patient orientation and to present and discuss a preliminary study undertaken to explore the potential for pursuing this line of inquiry. Specifically, the study was intented to first explore the extent to which individual health workers might be differentiated in terms of informational perspective taken towards patients. Second, if such a differentiation is possible, to attempt to specify the nature and basis such differentials. Finally, a preliminary examination of the relationship between organizational client orientation and patient evaluations of care received will be undertaken.

Concerning this last issue, it was felt that beyond the interesting issue of differentiating health care organizations in terms of client orientation is the practical question of "so what?". What are the implications for a health care organization having a broad versus narrow orientation? In the face of increasing charges and demands for "better" and more "humanizing" delivery systems, one obvious probable implication is that a broader client orientation will result in more positive client

orientation will result in more positive client evaluation of the quality of care received; that is, patient's evaluations of the service received will be positively related to the client orientation of the health care organization.

That the patient may find that an organization which indicates a high concern for him/her as a "total" person results in a higher level of satisfaction by the patient would not be surprising. However, if the patient also perceives that an organization having a broad client orientation is also more effective in terms of successfully treating his"illness", then the concept of client orientation takes on a special importance. To test for relationships between client orientation and patient evaluations, as well as to provide a framework for differentiating and characterizing health care organizations in terms of client orientation, are the objectives of this study.

THE STUDY

The research was carried out in 12 health care organizations located in a large metropolitan area. In all 12 organizations, the concern was with ambulatory medical care systems or subsystems only. Included in the sample were two community health centers, the outpatient clinics of three research/teaching hospitals, a U.S. Public Health Service Hospital's outpatient clinics, a large private community clinic and five military health facilities.

There were two groups of respondents in this research: the staff of the health care organization and recent or current patients. For each health care organization, a stratified sample of the personnel was selected. Respondents were randomly selected from each major occupational specialty that typically had direct contact with patients. As the concern is with health care staff

who interface with patients, custodial, maintenance and many clerical personnel were excluded. The other class of respondents -- patients -- was randomly selected from the total class of recent (within the past six months) or current patients of the health care organization.

The primary means of data collection were self-administered, mail-returned questionnaires. Two different instruments were employed -- one for the health care staff and one for the patients. The questionnaire given the health care staff was concerned with gathering data on several dimensions -- their client orientation, descriptions of the organization's structure, personal data on the respondent, and the respondent's satisfaction with his job. The questionnaire that was administered to the patient sample was somewhat simpler than the staff questionnaire. It was primarily concerned with only two dimensions -- the patient's evaluation of the health care organization and personal data about the patient.

A total of 216 staff, representing 12 organizations, and 509 patients, representing 11 organizations, completed and returned questionnaires. Access to patients of one of the community health organizations was denied. Thus, complete data is available from 11 organizations. The questionnaire return rate was 47% and 52% for staff and patients, respectively.

MEASUREMENT OF VARIABLES

1. Client Orientation

Each health care staff member was presented with a list of 16 categories of information about patients whom the health care staff member might potentially have knowledge about. Respondents were asked to indicate which categories of information about patients they had knowledge of and the extent of that knowledge. The content of the list of categories of patient information

was developed with the assistance of a separate group of health care personnel.[2] It was felt that the resultant list of 16 categories essentially covered the universe of potential information the health care system might have about patients. Table 1 lists the 16 information categories.

Table 1 Placed About Here

Distinctions were maintained between major roles of the health care staff. Specifically, all staff were placed into one of five role class categories: physicians, nurses, other health care professionals, laboratory and radiological technicians, and administrative personnel.

For each of the 16 items, the staff member indicated a response on a seven-point scale anchored at the extremes by "essentially no knowledge" (scored 0) and by "very complete knowledge" (scored 6). For each organization, first a mean was computed for each item for each of the five role classes. Then, for each item a mean of the five role class means was computed. Finally, a grand mean for all 16 items was computed. This score was used as a measure of organizational-patient orientation. Scores were also calculated for physician patient orientation and nonphysician patient orientation.

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[2] A group of 15 physicians, nurses and patient affairs representatives developed a list of over 200 'information bits' a health provider might have about a patient. The list was then sorted into 16 general categories and labels placed on those categories. A technique similar to Bavelas' "Echo" technique or Sherif's "Own Categories" technique was used to identify and categorize the types of information about patients. For a further discussion of this technique, see Bavelas (1942). Sherif and Sherif (1964), and Barthol and Bridge (1968).

Table 1: The 16 Patient Informational Categories

1. Patient's chief complaints --
   (eg., patient's expressed symptoms)

2. History of patient's present illness

3. Patient's personal medical history

4. Patient's family medical history

5. Patient's present overall physical
   condition

6. Patient's present emotional condition

7. Patient's personal and social history
   (eg., age, marital status, family size,
   occupation, education, income, etc.)

8. Emotional impact of the illness on the
   patient

9. Emotional impact of the illness on the
   patient's family

10. Impact of the problem on patient's job
    performance and/or finances

11. Patient's attitudes and biases towards
    the medical system

12. Results of patient's laboratory and
    physical examinations

13. Patient's social and political values

14. Patient's feelings about his/her experi-
    ences with other segments of this medical
    organization

15. Patient's satisfaction/dissatisfaction
    with the manner in which he is being
    treated by this medical system

16. Patient's general day-to-day lifestyle--
    problems he is confronted by, what things
    interest him, what's important to him--

2. Patient Evaluations of Organizations

a. Satisfaction: To measure the patient's satisfaction evaluation of the health care organization, the patient was presented the following paragraph.

> "When one is in need of health care services and goes to a health care organization, there are a number of needs the individual brings with him/her. Various health care organizations and the staff within them are to different degrees responsive to these many needs of the individual patient. Generally it is the health care organization which is the most sensitive and responsive to one's needs which is seen as the most satisfying."

Having been presented with this statement, patients were then asked to indicate to what extent they were satisfied with their specific health care organization on a simple seven point satisfaction-dissatisfaction scale. The scale ranged from "very satisfied" to "very dissatisfied" with a neutral midpoint. Intermediate cues were "moderately" and "slightly". An attempt was made to get patients to anchor the scale at the neutral/indifferent point. To accomplish this, the patient was asked to think of the level of health care services that would make him/her neutral or indifferent on a satisfaction-dissatisfaction dimension. Having anchored the scale, the patient was then asked to indicate his or her satisfaction with the health care organization.

b. Effectiveness: In addition to the measure of patient satisfaction, an evaluation of the health care organization's effectiveness was desired. Patients were first presented with the following statement.

> "Just as health care organizations differ in the degree to which they are responsive to the total needs of the individual patient, they may also vary in the degree to which they accurately diagnose and adequately treat the disease/illness of the patient. That is to say, that different health care organizations may vary in the extent to which they effectively diagnose and treat the patient's disease/illness."

Having been presented with this statement, the patient was asked to indicate the extent to which he or she found the health care organization ineffective on a five-point scale. The scale ranged from "always ineffective" to never ineffective" with the choices being "always," "often," "sometimes," "seldom," and "never." Basing the evaluation on ineffectiveness rather than effectiveness was used to damp any tnedency on the part of patients to positively bias their responses. It was felt that, for the most part, health care organizations are effective in their treatment of diseases and it was felt that there may be a tendency to overestimate organizational effectiveness evaluations. Thus, it was felt that having evaluation based on ineffectiveness would highlight the ineffectiveness dimension and damp the positive response bias of the patient.

For both the satisfaction and effectiveness measures, a numerical score was derived. For the seven-point satisfaction scale, a score of one for responses of "very dissatisfied." Then for each organization an organizational score was calculated by computing the mean of the individual satisfaction scores. In a similar manner, the effectiveness measure was scored as a five for responses of "never ineffective" and on to a score of one for responses of "always ineffective." An organizational score was then calculated by computing the mean of the individual effectiveness scores. Thus a high score on the satisfaction and effectiveness scores was indicative of a high level of client satisfaction and a high evaluation of effectiveness, respectively.

RESULTS

As a means for indicating the extent to which individual health workers might be differentiated in terms of the information they possess concerning their patients, the percentage of respondents indicating either a low level or a high level of information was computed for each of the 16 informational categories.[3] Such an analysis was performed for each of the five major role classes. The results of that analysis for physicians and nurses are presented for illustrative purposes in Table 2A. [4]

Table 2 Placed About Here

As Table 2 shows, physicians in the eleven organizations studied by in large evidenced a higher percentage of their class possessing a "high" level of patient information than did the nurses as a class. The dimensions however, which were exceptions to this phenomena are interesting to note. Nurses were found to have a higher percentage of their class possessing a high level of information on the following informational categories: (1) emotional impact of illness on patient's family, (2) patient's attitudes and biases towards medical system, (3) patient's feelings about experiences With other segments of this medical organization, and

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[3] respondents indicating "essentially no knowledge" or "very limited knowledge" for any information category were coded as "low level of information." Respondents checking boxes 4, 5, or 6 "very complete information" were coded as "high level of information."

[4] Results for the other three role-groups, other health professionals, laboratory and radiological technicians, and administrative personnel are presented in Appendix A.

Table 2. Percentage of Physicians and Nurses Indicating High and Low Information Levels on Each Informational Category

INFORMATION CATEGORY	HEALTH WORKER ROLE: PHYSICIANS-N=94 % Low	PHYSICIANS-N=94 % High	NURSES-N=39 % Low	NURSES-N=39 % High
1. Patient's chief complaints -- (e.g., patient's expressed symptoms)	0	93.6	20.5	69.2
2. History of patient's present illness	0	93.6	25.6	64.1
3. Patient's personal medical history	6.4	64.5	43.6	35.9
4. Patient's family medical history	25.5	40.4	64.1	12.8
5. Patient's present overall physical condition	4.3	78.7	30.8	51.3
6. Patient's present emotional condition	14.9	50.0	35.9	38.5
7. Patient's personal and social history (e.g., age, marital status, family size, occupation, education, income, etc.)	21.3	43.6	48.7	33.3
8. Emotional impact of the illness on the patient	10.9	54.3	38.5	41.0
9. Emotional impact of the illness on the patient's family	30.9	22.3	53.8	28.2
10. Impact of the problem on patient's job performance and/or finances	14.9	51.1	48.7	28.2
11. Patient's attitudes and biases towards the medical system	39.4	22.3	41.0	38.5
12. Results of patient's laboratory and physical examinations	1.1	91.5	17.9	60.2
13. Patient's social and political values	60.6	7.4	71.8	7.7
14. Patient's feelings about his/her experiences with other segments of this medical organization	36.2	14.9	46.2	25.6
15. Patient's satisfaction/dissatisfaction with the manner in which he is being treated by this medical system	22.3	41.5	33.3	48.7
16. Patient's general day-to-day life-style--problems he is confronted by, what things interest him, what's important to him	33.0	22.3	61.5	12.8
Mean Percentage for All 16 Categories	20.1	49.5	42.6	37.8

(4) patient's satisfaction/dissatisfaction with manner he/she is being treated by this medical system. It is interesting to note that all of these dimensions speak to the affective or emotional response of the patient to the medical system experience. At this point attempts to explain this finding will be resisted. Rather the distinction will be noted for now and will be discussed further later.

Another distinction evidenced in Table 2 is the fact that physicians as a class consistently indicate a lower percentage than nurses in terms of possessing little or no information on any given dimension. That is to say that for all 16 informational categories, fewer physicians than nurses indicated relative ignorance concerning information possess about patients.

One final distinction worthy of note is that physicians indicate a substantially higher level of information than nurses on those dimensions directly related to the patient's current illness/injury, e.g. categories 1, 2, 3, 5, 12. Nurses on the other hand, as observed, are higher than physicians on emotional issues, e.g. categories 9, 11, 14, 15.

Concerning distinctions between the physician and nurse group and the other three role classes: other health professionals, technicians, and administrative personnel, a couple of points can be made (See Appendix A). First, the other professionals group which includes social workers and other social service personnel, indicate higher percentages of those personnel possessing "high" levels of patient information on non-physical illness/injury related categories (1, 2, 3, 4, 5, 12) - higher percentages than any of the other four role classes.

Second, for the informational categories concerned with the patient's attitudes toward the health system (item #11) and the patient's satisfaction/

dissatisfaction with the way he/she is treated (item #15), the rank-order of the role classes in terms of descending information is other health professionals (50.0,61.5), nurses (38.5,48.7), administrative personnel (35.9,48.7), physicians (22.3,41.5), and technicians (15.8,36.8). The number in parentheses are the percentage of the role indicating a "high" and "low" level of information for item 11 and item 15, respectively.

The data evidenced in Table 2 and Appendix A indicate several interesting differences between the five role groups concerning the informational perspective taken towards patients. Further, with the exception of the not surprising finding that no physicians indicate ignorance on patient's physical illness/injury related dimensions, there is a substantial degree of variance within role groups on each informational category. These results suggest some support for the notion that individual health workers have differential perspectives or orientations towards patients.

To this point, the analysis has focused on the role of the respondent with no distinction made concerning the organization or the relationship which migh exist between information perspective and patient evaluations of care received. In order to test whether such a relationship might exist, patient evaluations of the quality of care received at each organization were examined.

As will be remembered, patients evaluated each of the eleven organizations in terms of both satisfaction and effectiveness. Not surprisingly, the two evaluation scores were highly intercorrelated ($r_s = .69$, $p < .001$). Further, in examining the evaluation scores there appeared to be three distinction clusters: a low evaluation group of three organizations, a middle group made up of five organizations, and a high evaluation group

with three organizations. Table 3 shows the satisfaction and effectiveness scores for each organization and to which "evaluation" group each falls in. For the extreme satisfaction scores in each cluster a "t-statistic" was computed to determine if the means were different. The t-value for the difference between the low and middle cluster Organization (Low) C and Organization (Middle) D was 2.20, $p<.025$ for one-tailed test. The t-value for the difference between middle and high, Organization (Middle) H and Organization (High) I was 0.975, $0.1 < p < .25$ for one-tailed test.

Table 3 Placed About Here

Utilizing the low-middle-high evaluation scheme, the distribution of responses on the sixteen informational categories were examined and compared. In Table 4 the percentage of respondents expressing either a high level of information or a very low (relative ignorance) level of information are presented for each informational category for each of the three evaluation clusters. As Table 4 shows there is a fairly systematic pattern evidenced in that the high evaluation organizational personnel indicate the highest levels of patient information on 15 of the 16 dimensions, the middle evaluation respondents are in the middle on 13 of 16 and the low group self-reports the lowest informational levels on 12 of 16 items and was "tied" with the middle group on 2 items.

Table 4 Placed About Here

TABLE 3

Organizations Clustered by Evaluation Group

Organization	Satisfaction Score	Effectiveness Score
Low Evaluation Group		
Organization (Low) A	4.500	3.237
Organization (Low) B	4.585	3.268
Organization (Low) C	4.644	3.222
Middle Evaluation Group		
Organization (Middle) D	5.542	3.708
Organization (Middle) E	5.821	3.890
Organization (Middle) F	5.933	3.867
Organization (Middle) G	6.000	3.500
Organization (Middle) H	6.000	3.737
High Evaluation Group		
Organization (High) I	6.450	4.150
Organization (High) J	6.559	4.382
Organization (High) K	6.628	4.349

Table 4. Percentage of Sample for Each Evaluation Cluster Indicating High and Low Information Level on Each Informational Category

INFORMATION CATEGORIES	PATIENT EVALUATION CLUSTER HIGH N=64		MIDDLE N=39		LOW N=49	
	%High	%Low	%High	%Low	%High	%Low
1. Patient's chief complaints--(e.g., patient's expressed symptoms	12.5	78.7	13.1	71.7	29.2	50.0
2. History of patient's present illness	15.6	76.6	16.2	69.7	29.2	58.3
3. Patient's personal medical history	28.1	56.2	22.7	49.5	50.0	27.1
4. Patient's family medical history	45.3	31.1	42.4	23.2	70.8	14.6
5. Patient's present overall physical condition	18.8	65.6	22.2	59.6	39.6	35.4
6. Patient's present emotional condition	20.3	46.9	31.3	36.4	47.9	20.8
7. Patient's personal and social history (e.g., age, marital status, family size, occupation, education, income, etc.)	26.6	48.4	38.4	33.3	47.9	27.1
8. Emotional impact of the illness on the patient	25.4	49.2	29.3	42.4	40.4	27.6
9. Emotional impact of the illness on the patient's family	40.6	31.2	48.5	19.2	60.4	14.6
10. Impact of the problem on patient's job performance and/or finances	30.2	55.6	37.4	30.3	47.9	27.1
11. Patient's attitudes and biases towards the medical system	40.6	32.8	37.4	27.3	41.7	31.2
12. Results of patient's laboratory and physical examinations	12.5	75.0	19.2	70.7	16.7	70.8
13. Patient's social and political values	53.1	6.2	73.5	5.1	83.3	4.2
14. Patient's feelings about his/her experiences with other segments of this medical organization	34.4	18.7	42.9	21.4	45.8	29.2
15. Patient's satisfaction/dissatisfaction with the manner in which he is being treated by this medical system	15.6	50.0	30.3	43.4	29.2	43.7
16. Patient's general day-to-day life-style--problems he is confronted by what things interest him, what's important to him--	37.5	28.1	47.5	17.2	75.0	12.5
Mean Percentage for all 16 Information Categories	28.6	47.0	34.5	38.8	47.2	30.0

The single dimension which totally violates the pattern is item 14, patient's feelings about experiences with other segments of this medical system. For item 14, the low group had the highest percentage of their group possessing a high level of information (29.2%) with the middle evaluation group indicating 21.4% possessing a high level of information on that dimension and finally the high evaluation group indicating that only 18.7% of its members felt that they possessed a high level of information. One explanation for this finding might be that connected with the lower patient evaluations, patients of the low evaluation organizations are expressing their dissatisfaction or satisfaction at a higher rate or if not a higher rate then at least more strongly than patients are expressing their satisfaction or dissatisfaction in the middle and high evaluation organization. Further it is likely that in the low evaluation organizations, patient feedback, especially dissatisfaction, is volunteered by patients and results from frustration and some anger over what is perceived as relatively poor care. Thus, it would be expected that growing out of the "tension" caused by the anger and frustration, patients of a dissatisfying organization would be more likely to inform the staff of their "displeasure" than patients of an organization which is meeting their expectations would be to explicitly state their satisfaction. This interpretation is reinforced when it is noted that on items 11, 14, 15; patients attitudes and biases, patient's feelings about experiences with the rest of organization, and patient's satisfaction/dissatisfaction, respectively, the percentages violate the pattern evidenced on the other less affective dimensions

Examining the percentages of respondents expressing low levels of information, the same relatively systematic pattern holds. The high evaluation group had the lowest percentage of its members indicating possession of little or no information on 13 of the 16 categories. The middle group was in the middle on 11 of 16 and the low evaluation group had the highest percentage in 14 of the 16"low information" categories.

The data presented in Table 4; like those data presented earlier, appear to support the notion that there is a meaningful relationship between the informational perspective health workers take towards patients and the patient's evaluation of care/service received in that organization. The relatively consistent pattern of relative level of information within the three evaluation clusters also suggest a cross-sectional consistency of culture. That is it appears if an organization is evaluated as a "good" health care organization, its staff will be relatively well informed along a wide range of patient informational categories. Likewise the converse appears true. That organizations evaluated low in overall quality of care will be charactertized as being less informed on a wide range of patient information dimensions. The exceptions to this pattern which have been noted concern those dimensions which involve information of an evaluative and affective nature concerning the patient. On those dimensions, such as knowledge of the patient's satisfaction or dissatisfaction with the way he/she is being treated, the distinctions between evaluation groups is blurred. Such a finding is not surprising if one accepts the explanation previously offered for its occurance. Unfortunately, further empirical examination and testing of this interpretation is beyond the scope of this paper and these data. Rather, let's turn attention to a discussion of the implications of these findings for the further development and usefulness of the concept of organizational patient orientation.

Discussion and Implications

As was stated earlier, the study reported here was intended to be preliminary in scope. The objective was to examine the potential validity and usefulness of the notion of characterizing health workers and health care organizations in terms of the informational perspective they take towards their patients or their patient and client orientation. The data presented indicate several supportive conclusions concerning the potential usefulness of the concept of patient orientation.

First, there is evidence that for individual health workers there is a high degree of variability in the self-reported level of information possessed. Within each role group for most informational categories there are individuals who indicate high levels of information and those who report possessing very low levels of patient information. This suggests that there may be value in further research to explore the nature of individual health worker patient orientation characteristics, e.g. patterns of information possessed, individual demographic characteristics, attitudes toward work and the organization, etc.

Second, the data in Table 2 and Appendix A, suggest differences between health worker roles in terms of patient orientation. Further examination of this phenomena might uncover differential consequences for patient orientation growing out of training foci and methodologies and/or organizational role expectancies. For example,concerning training foci effects we might expect physicians to be "socialized" to emphasize and value information about the patient's physical condition to the relative neglect of concern for whether the patient is "happy" or "unhappy" with the way he/she is being treated while in the health facility. On the other hand, the receptionist may be trained to emphasize and be aware of patient comfort and convenience to the

relative neglect of concern for patient physical problems. Future study might more systematically examine the interaction between both training emphasis and organization role assignments and "resultant" patient orientation.

The third issue of importance is the notion of organizational patient orientation. By that is meant the organization-wide mileau in terms of patient orientation which a patient might experience as a result of dealing with the health care organization or a health worker would experience and "live" as a member of that organization. The data presented here lends some support for the cross-sectional consistency notion that a "good" health care organization is high on all patient informational categories and that "poor" organization is relatively low on all informational categories. Such a finding raises questions concerning whether there are certain organizational dynamics which might be "producing" such an outcome. Specifically, the formal organizational structure, the nature of interpersonal relationships, supervisor-subordinate relations, organizational climate, individual satisfaction and commitment, should be examined and related to both patient orientation and patient evaluations or care received.

A final suggestion for a focis of future research on patient orientation in health care organizations is an analysis of the relationship between patient orientation and the level of resources available to the organization.

To argue that the amount of resources available to a health-care organization is related to its patient orientation is simple, direct and straightforward. It is almost certainly a truism to say that organizations must have resources in order to carry out their tasks. In the present context, if medical service organizations are to advance beyond a narrow focus on disease treatment

to a wider concern with the "total patient", they must have the resources available to do so. If psychiatric institutions are to provide treatment rather than custodial service, they will require additional resources. This concern for providing adequate resources is reflected in several recent, thoughtful analyses of the contemporary health-care scene (i.e., Folsom, 1970; Somers, 1971).

In general, it is expected that health-care organizations with a relatively adequate level of resources will be better able to implement a wide-ranging orientation toward its patients than will relatively unfunded organizations. There are a wide variety of types of resources that are important to health-care organizations. Three general areas of resources which are especially relevant to the health-care setting are (1) physical facilities (i.e. space available, number of beds, number of treatment rooms, (2) staff resources (i.e. number of doctors and nurses, availability of paramedical personnel, number of social workers or client service representatives), and (3) financial resources (for capital and operating expenditures).

One issue worth emphasizing is the point that the primary concern is with the level of resources as they related to patient treatment potential. Thus, the level of resources should be concerned with a relative rather than absolute measure of available resources. That is, the measure of available resources should be the ratio of resources to the total number of patients or resources available per patient.

Summary and Concluding Comments

The concept of client orientation or patient orientation in the health care setting has been introduced and developed in this paper. Further the results of a study aimed at exploring the nature and consequences of patient

informational perspectives taken by health workers were presented. The findings offer support for the view that individuals, roles, and organizations can be meaningfully differentiated in terms of patient informational perspective. Support was also found for the notion that organizational patient orientation is positively associated with the patient's evaluations of the health-care organization.

The implications for these findings and the proposed future research have b en alluded to throughout this paper. Few would argue with the observation that the demand for health care services is rising and expectations of patients concerning health care is shifting. As Somers and others point out, there is an increasing demand on the part of patients for the health care system to be more responsive to their needs. By and large, American culture is one that places a great emphasis on individuality and the inalienable rights of individuals. This cultural value system has implications for the way our society views 'appropriate' treatment of the mentally or physically ill. For example, Bockover (1957) dates the concern with humane treatment to the French Revolution, and the concurrent increasing emphasis on individuality throughout Europe in the early nineteenth century. Also Rosen (1963) notes the importance of these same contributing factors to a growing awareness of social factors in physical illness and the practice of "social medicine".

Parsons (1960) observes that organizations are constrained in the activities they may undertake, and are directed toward fulfilling the functions prescribed for them by society. That this relationship is imperfect and that organizations do not play a passive role in this process goes without saying. Still it is felt that organizations, especially health care organizations, are subject to important influence by the prevailing system of cultural values.

Examples of this influence are widespread in the literature of organizations. The often expressed concern with the "qualtiy" of health-care in the popular media indicates that these influences are operative in health care organizations. So too is the evidence that doctors and other health care professionals on a wide scale are re-evaluating and changing their views of the practitioner's role in the delivery of health-care. (Wilson, 1963; Somers, 1971).

The pressures being placed on health care systems are to a large extent outgrowth of the patient's demands that the health care organization be more aware of and responsive to its patient system. In order for a health care organization to effectively meet the patient's demands it is necessary for the organization to effectively monitor its patient system. Further, it is suggested that an organization's effectiveness in monitoring of its patient environment will be expressed in the amount and scope of the information the organization possesses about its patients.

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Appendix A: Percentage of Other Professionals, Technicians, and Administrative Personnel Indicating High and Low Information Level on Each Informational Category

INFORMATION CATEGORY	HEALTH WORKER ROLE: OTHER HEALTH PROFESSIONALS N=26 %Low	%High	TECHNICIANS N=19 %Low	%High	ADMINISTRATIVE N=39 %Low	%High
1. Patient's chief complaints--(e.g., patient's expressed symptoms)	26.9	57.7	47.4	21.1	33.3	38.5
2. History of patient's present illness	23.1	50.0	52.6	36.8	41.0	41.0
3. Patient's personal medical history	26.9	50.0	83.3	11.1	53.8	30.8
4. Patient's family medical history	46.2	19.2	94.7	0	71.8	10.3
5. Patient's present overall physical condition	19.2	57.7	73.7	15.8	51.3	25.6
6. Patient's present emotional condition	19.2	46.2	78.9	0	53.8	15.4
7. Patient's personal and social history (e.g., age, marital status, family size, occupation, education, income, etc.)	15.4	76.9	78.9	0	53.8	20.5
8. Emotional impact of the illness on the patient	11.5	57.7	73.7	5.3	59.0	17.9
9. Emotional impact of the illness on the patient's family	34.6	42.3	94.7	5.3	71.8	12.8
10. Impact of the problem on patient's job performance and/or finances	28.0	64.0	78.9	5.3	64.1	15.4
11. Patient's attitudes and biases towards the medical system	15.4	50.0	57.9	15.8	43.6	34.9
12. Results of patient's laboratory and physical examinations	26.9	57.7	47.4	47.4	33.3	48.7
13. Patient's social and political values	53.8	11.5	10.0	0	82.1	2.6
14. Patient's feelings about his/her experiences with other segments of this medical organization	30.8	42.3	57.9	26.3	47.4	23.7
15. Patient's satisfaction/dissatisfaction with the manner in which he is being treated by this medical system	11.5	61.5	52.6	36.8	23.1	48.7
16. Patient's general day-to-day life-style--problems he is confronted by, what things interest him, what's important to him--	38.5	42.3	89.5	5.3	69.2	17.9
Mean Percentage for All 16 Information	26.7	49.2	72.6	14.5	53.3	25.4

(#946 + 947 not used.)