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Health Services Management

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Fourth Edition

Edited by
Anthony R. Kovner and
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Preface to the Fourth Edition

This book was developed as a complementary text to our book, *Health Services Management: Readings and Commentary*, first published in 1978, fifth edition in 1994. We are delighted, in response to user demand and a need to keep more of the cases current, to prepare this fourth edition of our casebook.

We use the same organizing framework as in the book of readings: the health manager, control, organization design, professional integration, adaptation, and accountability. The casebook can stand on its own, however, in teaching students and managers through the case method approach.

There are 15 cases in the fourth edition, five of which are new or updated and 10 of which have been retained as is from the third edition. Several of the cases can be used to illustrate more than one aspect of our organizing framework.

All of these cases have been tested in the classroom. They have been selected because they take place in a variety of settings from the perspective of managers who must define and respond to particular complex situations.

Anthony R. Kovner
Duncan Neuhauser
1994

Learning through the Case Method

Anthony R. Kovner

A challenge for many graduate programs in health services management is bridging the gap between theory and skills and their application by students to health services organizations. Part of the problem lies in the difficulty of attracting and retaining skilled teachers who can integrate perspectives and apply concepts across disciplines in responding to managerial problems and opportunities.

A second challenge is to prepare graduates to communicate effectively, in writing and orally, and to assist them in working effectively in groups. This includes helping students to assess the effects of their personalities or behavioral styles on others. Is the student perceived as abrasive, wishy-washy, manipulative? Is the student aware of how others interpret not only words but tone and body language?

Students in graduate programs of health services management need to understand their own values and those of others who differ in educational background, political and religious orientation, clinical experience, or because of the careers and orientations of their parents and siblings.

A "case" is a description of a situation or problem that is actually faced by a manager and that requires analysis, decision, and planning of a course of action. A decision may be to delay a decision, and a planned course of action may be to take no action. A case takes place in time. A case must have an issue. As McNair says: "There must be a question of what should somebody do, what should somebody have done, who is to blame for the situation, what is the best decision to be made under the circumstances."[1] A case represents selection from a situation; it represents selection by the casewriter.

Case method involves class discussion, guided by a teacher so that students can: diagnose and define important problems in a situation; acquire competence in developing useful alternatives to respond to such problems; and improve judgment in selecting action alternatives. Students learn to diagnose constraints and opportunities faced by the manager in implementation and how to overcome constraints, given limited time and dollars.

Teachers can transmit great quantities of data to students more effectively and certainly more efficiently by lecture. The teacher is assumed to be correct in presentation of facts, and the student transcribes key points of the lecture and transmits them back to the teacher at examination time.

In a case course, the teacher's job is to engage the students in a management simulation so that they think independently, communicate effectively, and can defend their opinions logically with reference to underlying assumptions and values. Often there are no right answers to a case because, in dealing with issues, there are at least two sides to a question.

It is often difficult for students to adjust to a classroom in which there is no authority figure, no lecture from which to take notes; and when the teacher withholds information, at least until the class discussion has ended. Some students find it irritating to have to listen to their peers when they are paying to learn what the teacher has to say.

In a case course, students learn how to use information at the point of decision. Many students dislike "putting themselves on the line" when they are "only" students saying what they think. If there are no "right" answers, students quickly learn in a case course that there are many "wrong" answers in terms of faulty logic or assumptions challenged or contradicted by their peers. Students fear looking foolish and being downgraded accordingly by the teacher. And they must pass the course.[2] Students should consider such exposure to be at low cost in relation to the benefit of appearing mature and skillful after graduation and in the professional environment. Hopefully, they will have gained judgment and learned how to behave and communicate their opinions to others.

As Cantor[3] says, "You don't learn from anybody else's experience or from your own experience unless you go through the experience to learn." This is what the case method has to offer the student—an experience in learning which involves testing opinions and conclusions against the reality of the case and the judgment of peers and teacher.

How do cases bridge the gap between theory and skills and their application by managers? Problems faced by health services managers do not come neatly packaged as separate questions of statistics, economics, organizational theory, or policy analysis. Rather they are organizational, multidisciplinary problems, sometimes difficult to define as well as to resolve.

Problems may include negotiation of a new contract with the chief of radiology, appropriate response to patient complaints, or responsibility for quality improvement in relation to a surgeon's poor performance.

Student performance in a case course is typically assessed on participation in class and on written analysis of case materials. Teachers may not spend sufficient time in analysis of student evaluation, which may be partially corrected by allowing peer evaluation as well. Often teachers ask students to collaborate on complex cases or to evaluate each other's performance. A student should be told if his style or mannerisms interfere with his presentation or its perception by others.

In a case course, students are often asked to adopt the perspectives of certain characters in the case, to play certain roles. To deny someone of something or to persuade someone to do something requires understanding of that person, her needs, and her perceptions of the decision maker. Roleplaying can promote a better understanding of viewpoints which may otherwise seem irrational, given a student's prior understanding of what should be done in a particular situation. Students can better understand their own values and underlying assumptions when their opinions are challenged by peers and teachers.

To conclude, it is important to understand what a case is not and what case method cannot teach. Cases are not real life—they present only part of a situation. Writing or communicating a case may be as difficult or more difficult than evaluating someone else's written case. Like many a consultant, students can never see the results of what would have happened if the case participants had followed their advice.

There are some aspects of management which can only be learned by managing. How else to understand when someone says one thing but means another. How else to judge when, if ever, to confront or oppose a member of the ruling coalition when that member's behavior appears to threaten the long-range interests of the organization. Students and managers have to form and adopt their own value systems and make their own decisions. A case course can give the student a better understanding of the nature of the role he will be playing as a manager—an understanding that can help him to manage better, if not well.

Notes

1. Andrew R. Towl, *To Study Administration by Cases* (Boston: Graduate School of Business Administration, Harvard University, 1969), p. 67.
2. Ibid., p. 68.
3. Ibid., p. 155

A Short History of the Case Method of Teaching

Karen Schachter Weingrod
and Duncan Neuhauser

No doubt teaching by example is as old as the first parent and child. In medicine it surely started with a healer, the first apprentice, and a patient. The ancient Greeks codified medical principles, rules, and laws. University education in medicine started about 800 years ago, focused on abstract principles and scholastic reasoning, and was removed from practicality. By 1750 in England, the professions aspired to gentlemen status.[1] The goldheaded cane of the English physician was the clear symbol that his hands were not expected to touch patients, unlike apothecaries and barber surgeons. Later, the American sociologist Thorstein Veblen, in *The Theory of the Leisure Class,* used the example of the cane as symbolic that a gentleman need not work with his hands.[2] In the late 1700s in France, medical education moved into hospitals or "the clinic" where patients in large numbers could be observed, autopsies performed, and the physiological state linked back to the patients' signs and symptoms.[3] This was one step in the departure from abstract medical theorizing in universities (often about the four humors), which may have had no bearing on actual disease processes.

Education in law also became increasingly abstract, conveyed through the erudite lecture. It built theoretical constructs and was logically well-reasoned. The professor spoke and the student memorized and recited without much opportunity for practical experience or discussion. This had become the standard by the late 1850s.

It is only by comparison with what went before in universities that the case method of teaching was such a striking change. The historical

development of the case method can be traced to Harvard University. Perhaps it is not surprising that this change occurred in the United States rather than in Europe, with the American inclinations toward democratic equality, practicality, and positivism, and the lack of interest in abstract scholastic theorizing.

The change started in 1870 when the president of Harvard University, Charles William Eliot, appointed the obscure lawyer Christopher Columbus Langdell dean of the Harvard Law School.

Langdell believed law to be a science. In his own words: "Law considered as a science, consists of certain principles or doctrines. To have such a mastery of these as to be able to apply them with constant faculty and certainty to the ever-tangled skein of human affairs, is what constitutes a good lawyer; and hence to acquire that mastery should be the business of every earnest student of the law."[4]

The specimens needed for the study of Langdell's science of law were judicial opinions as recorded in books and stored in libraries. He accepted the science of law, but he turned the learning process back to front. Instead of giving a lecture that would define a principle of law and give supporting examples of judicial opinions, he gave the students the judicial opinions without the principle and by use of a Socratic dialogue extracted from the students in the classroom the principles that would make sense out of the cases. The student role was now active rather than passive. Students were subjected to rigorous questioning of the case material. They were asked to defend their judgments and to confess to error when their judgments were illogical. Although this dialectic was carried on by the professor and one or two students at a time, all the students learned and were on the edge of their seats, fearing or hoping to be called on next. The law school style that evolved puts the student under public pressure to reason quickly, clearly, and coherently in a way that is valuable in the courtroom or during negotiation. After a discouraging start, Langdell attracted such able instructors as Oliver Wendell Holmes, Jr. They carried the day, and now the case method of teaching is nearly universal in American law schools.

The introduction of the case method of teaching to medicine is also known. A Harvard medical student of the class of 1901, Walter B. Cannon shared a room with Harry Bigelow, a third-year law student. The excitement with which Bigelow and his classmates debated the issues within the cases they were reading for class contrasted sharply with the passivity of medical school lectures.

In 1900, discussing the value of the case method in medicine, Harvard President Charles Eliot described the earlier medical education as follows:

> I think it was thirty-five years ago that I was a lecturer at the Harvard Medical School for one winter; at that time lectures began in the school at eight o'clock in the morning and went on steadily till two o'clock—six mortal hours, one after the other of lectures, without a question from the professor, without the possibility of an observation by the student, none whatever, just the lecture to be listened to, and possibly taken notes of. Some of the students could hardly write.[5]

In December 1899, Cannon persuaded one of his instructors, G.L. Walton, to present one of the cases in written form from his private practice as an experiment. Walton printed a sheet with the patient's history and allowed the students a week to study it. The lively discussion that ensued in class made Walton an immediate convert.[6] Other faculty soon followed, including Richard C. Cabot.

Through the case method, medical students would learn to judge and interpret clinical data, to estimate the value of evidence, and to recognize the gaps in their knowledge—something that straight lecturing could never reveal. The case method of teaching allowed students to throw off passivity in the lecture hall and integrate their knowledge of anatomy, physiology, pathology, and therapeutics into a unified mode of thought.

As a student, Cannon wrote two articles about the case method in 1900 for the *Boston Medical and Surgical Journal* (later to become *The New England Journal of Medicine*).[7] He sent a copy of one of these papers to the famous clinician professor, Dr. William Osler of Johns Hopkins. Osler replied, "I have long held that the only possible way of teaching students the subject of medicine is by personal daily contact with cases, which they study not only once or twice, but follow systematically."[8] If a written medical case was interesting, a real live patient in the classroom could be memorable. Osler regularly introduced patients to his class, asked students to interview and examine the patients, and discussed the medical problems involved. He would regularly send students to the library and laboratory to seek answers and report back to the rest of the class.[9] This method of teaching is ideal, and his students worshipped Osler. But with today's division of labor in medicine between basic science and clinical medicine, such a synthesis is close to impossible.

The May 24, 1900 issue of the *Boston Medical and Surgical Journal* was devoted to articles and comments about the case method of teaching by Eliot, Cannon, Cabot, and others. In some ways it remains the best general discussion of the case method. This approach was adopted rapidly at other medical schools and books of written cases quickly followed in neurology (1902), surgery (1904), and orthopedic surgery (1905).[10]

Walter Cannon went on to a distinguished career in medical research. Richard C. Cabot joined the medical staff of the Massachusetts General Hospital, and in 1906 published his first book of cases. (He also introduced the first social worker into a hospital.)[11] He was concerned with the undesirable separation of clinical physicians and pathologists. Too many diagnoses were turning out to be false at autopsy. To remedy this, Cabot began to hold his case exercises with students, house officers, and visitors.

In 1906, Cabot described the advantages of the case method for both students and teachers, in the introduction of his 1908 casebook.[12] Cases are presented as met with in practice where important facts are "deceptively entangled with what is irrelevant and misleading." "Then we help the students to disentangle the essentials." "We can test the pupils' ability to gather up and use the knowledge he has acquired from various sources. A single teacher can keep a large class of students actively busy. They are not merely listening or watching, they are doing the work of construction themselves."

According to Cabot, the teacher first reads the case aloud. His cases were half-a-page long and the students followed in their workbook. The teacher calls on a student to summarize the case. "Students must always be called by name, else the exercise will be a failure." The students, after five or ten minutes of thinking over the case, write down a tentative diagnosis and one or two alternatives, signs his name and turns it in. "Each man is thus forced to commit himself before he hears the case discussed." "By looking over these slips rapidly, the teacher can get a good idea of where the class is. . . ." Discussion follows. The teacher lists proposed diagnoses on the black board beginning with the least plausible ones after discarding the wild guesses. The proposing student is asked to explain his reasoning. Unsupported diagnoses are erased. If doubt remains, a vote can be taken, thus publicly committing each student. Then the teacher announces the actual diagnosis as proved by operation or autopsy. If the teacher does not know the answer to a student's question he should say so and say how the answer might be found in the library.

Cabot's clinical/pathological conferences took on a stereotyped style and eventually were adopted in teaching hospitals throughout the world. First, the patient's history, symptoms, and test results would be described. Then an invited specialist would discuss the case, suggest an explanation, and give a diagnosis. Finally, the pathologist would present the autopsy or pathological diagnosis, and questions would follow to elaborate points.

In 1915, Cabot sent written copies of his cases to interested physicians as "at home case method exercises." These became so popular that in 1923 the *Boston Medical and Surgical Journal* began to publish one per issue.[13]

This journal has since changed its name to *The New England Journal of Medicine,* but the "Cabot Case Records" still appear with each issue.

A look at a current *New England Journal of Medicine* case will show how much the case method has changed since Christopher Columbus Langdell's original concept. The student or house officer is no longer asked to discuss the case; rather, it is the expert who puts her reputation on the line. She has the opportunity to demonstrate wisdom, but can also be refuted in front of a large audience. Although every physician in the audience probably makes mental diagnoses, the case presentation has become a passive affair, like a lecture.

Richard Cabot left the Massachusetts General Hospital to head the social relations (sociology, psychology, cultural anthropology) department at Harvard. He brought the case method with him, but it disappeared from use there by the time of his death in 1939.[14] The social science disciplines were concerned with theory building, hypothesis testing, and research methodology, and to such unapplied pure scientists perhaps the case method was considered primitive. Further, the use of the case method also diminished in the first two preclinical years of medical school as clinical scientists came more and more to the fore with their laboratory work and research on physiology, pharmacology, biochemistry, and molecular biology. Currently a return to a problem-solving focus in medical school is being advocated by a task force of the American Association of Medical Colleges.

In 1908, the Harvard Business School was created as a department of the Graduate School of Arts and Sciences. It was initially criticized as merely a school for "successful money-making." Early on there was an effort to teach through the use of written problems involving situations faced by actual business executives, presented in sufficient factual detail to enable students to develop their own decisions. The school's first book of cases, on marketing, was published in 1922 by Melvin T. Copeland.[15]

Today, nearly every class in the Harvard Business School is taught by the case method. In 1957, the Intercollegiate Case Clearing House was founded. Physically located on campus, it housed approximately 40,000 cases and added 1,000 to 1,200 new cases each year. Cases were made available to other universities. Recently the clearing house was renamed HBS Case Services and now limits itself to cases produced at the Harvard Business School.

Unlike the law school where cases come directly from judicial decisions, sometimes abbreviated by the instructor, and the medical school where the patient is the basis for the case, the business faculty and their aides must enter organizations to collect and compile their material. In doing so there

is substantial editorial latitude. Here more than elsewhere the case writer's vision, or lack of it, defines the content of the case.

Unlike a pathologist's autopsy diagnosis, a business case is not designed to have a right answer. In fact, one usually never knows whether the business in question lives or dies. Rather, the cases are written in such a way as to split a large class (up to 80 students) into factions. The best cases are those that create divergent opinions. The professor becomes more of an orchestra leader than a source of truth. The professor's opinion or answer may never be made explicit. Following a discussion, a student's question as to what really happened or what should have been done may be answered "I don't know" or "I think the key issues were picked up in the case discussion." Such hesitancy on the part of the instructor is often desirable. To praise or condemn a particular faction in the classroom can discourage future discussions.

The class atmosphere in a business school is likely to be less pressured than in a law school. Like a good surgeon, a good lawyer must often think very quickly, but unlike the surgeon a lawyer's thinking is demonstrated verbally and publicly. A lawyer must persuade by the power of logic rather than by force of authority. Business and management are different. Key managerial decisions—"What business are we in?" "Who are our customers?" "Where should we be ten years from now?"—may take months or even years to answer.

The fact that the business manager's time frame reduces the pressure for immediate answers makes management education different from physician education in other ways. Physicians are required to absorb countless facts on anatomy, disease symptoms, and drug side effects. Confronted with 20 patients a day, the physician has no time to consult references and so must rely on memory instead. The manager can look up information, given the longer time horizon of decision making in business. Therefore, managerial education focuses more on problem-solving techniques than on memorization of data.

Not all business schools have endorsed the case method of teaching. At one time the University of Chicago Business School faculty rarely used cases and focused on teaching the "science" of economics, human behavior, operations research and other relevant disciplines. The faculty are concerned with theory building, hypothesis testing, statistical methodology, and the social sciences. Other business schools have used about half social sciences and half case method. Each school is convinced that its teaching philosophy is best and believes others to be misguided. Conceptually, the debate can be broken into two aspects: science versus professionalism, and active versus passive learning.

There is little question that active student involvement in learning is better than passive listening to lectures. The case method is one of many approaches to increasing student participation. However, a skilled instructor can stimulate a lively discussion, for example, by social sciences students on the theoretical assumptions, methodological problems, and use or abuse of statistical analysis in an *American Journal of Sociology* assignment.

Academic science is not overly concerned with the practical problems of the world, but professionals are and professional education should be. The lawyer, physician, and manager cannot wait for perfect knowledge. They have to make decisions "in the face of uncertainty." Science can help with these decisions to varying degrees. To the extent that scientific theories have the power to predict and explain, they can be used by professionals. In the jargon of statistics: the higher the percentage of variance explained, the more useful the scientific theory, the smaller the role for clinical or professional judgment, and the greater the role for case method teaching as opposed to, for example, mathematical problem-solving.

It can be argued that the professional will always be working at the frontier of the limits of scientific prediction. When science is the perfect predictor, then often the problem is solved, or the application is delegated to computers or technicians, or, as in some branches of engineering, professional skills focus on the manipulation of accurate but complex mathematical equations.

Scientific medicine now understands smallpox so well that it no longer exists. Physicians spend most of their time on problems that are not solved: cancer, heart disease, or the common complaints of living that bring most people to doctors. In management, the budget cycle, personnel position control, sterile operating room environment, and maintenance of the business office ledgers are handled routinely by organizational members and usually do not consume the attention of the chief executive officer. In law, the known formulations become the "boiler plate" of contracts.

The debate between business schools over the use of cases illustrates the difference in belief in the power of the social sciences in the business environment. Teaching modes related to science and judgment will always be in uneasy balance with each other, shifting with time and place. A few innovative medical schools have moved away from the scientific lectures in the preclinical years and toward a case problem-solving mode (e.g., the University of Limburg in Maastricht, The Netherlands). On the other side of the coin, a quiet revolution is being waged in clinical reasoning. The principles of statistics, epidemiology, and economics, filtered through the techniques of decision analysis, cost-effectiveness analysis, computer modeling, and artificial intelligence, are making the Cabot Case Record approach less useful

for clinical reasoning. Scientific methods of clinical reasoning are beginning to replace aspects of professional or clinical judgment in medicine.[16]

This change can be observed in the periodic, "Clinical Problem-Solving" sections in the *New England Journal of Medicine*, which started with the editorship of Jerome Kasirer, MD, who helped develop the field of clinical decision analysis.[17]

This does not mean that the professional aspect of medicine will be eliminated by computer-based science. Rather, the frontiers, the unknown areas calling for professional judgment, will shift to new areas, such as the development of socio-emotional rapport with patients—what used to be called "the bedside manner."

The cases that follow are derived from the business school style of case teaching. As such they do not have answers. The cases can be used to apply management concepts to practical problems. However, these concepts (scientific theory seems too strong a term to apply to them) may help solve these case problems but will not yield the "one right answer." They all leave much room for debate.

Notes

1. Harold J. Cook, *The Decline of the Old Medical Regime in Stuart London* (Ithaca: Cornell University Press, 1986).
2. Thorstein Veblen, *The Theory of the Leisure Class* (1899; reprinted New York: Mentor, 1953).
3. Michel Foucault, *The Birth of the Clinic* (New York: Vintage, 1973).
4. C.C. Langdell, *Cases and Contracts* (1871), cited in *The Law at Harvard,* by Arthur E. Sutherland (Cambridge, MA: Harvard University Press, 1967), p. 174.
5. Charles Eliot, "The Inductive Method Applied to Medicine," *Boston Medical and Surgical Journal* 142, no. 22 (May 24, 1900): 557
6. Saul Benison, A. Clifford Barger, and Elin L. Wolfe, *Walter B. Cannon, The Life and Times of a Young Scientist* (Cambridge, MA: Harvard University Press, 1987), pp. 65–75, 417–18.
7. W.B. Cannon, "The Case Method of Teaching Systematic Medicare," *The Boston Medical and Surgical Journal* 142, no. 2 (January 11, 1900): 31–36; and "The Case System in Medicine," 142, no. 22 (May 24, 1900): 563–64.
8. Benison op. cit., p. 66.
9. Alan M. Chesney, *The Johns Hopkins Hospital and the Johns Hopkins University School of Medicine, Vol. II* 1893–1905 (Baltimore: The Johns Hopkins Press, 1958), pp. 125–28.
10. Benison op. cit., p. 418.
11. Although not the first hospital-based social worker to work with Cabot, his best known social worker colleague was Walter Cannon's sister, Ida Cannon. Benison op. cit., p. 145.