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Agrarian Ideology Remnants and Rural Healthcare Organizational Behavior: Observations and Research Opportunities

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Abstract

Rural health facilities, especially hospitals and critical access hospitals, have a troubled history, a challenging today, and a problematic future—a reality that is well documented. Despite public policy support and affiliation tactics, these entities continue to face conversion or closure threats. An enduring question is why these organizations continually struggle. Leading to a hypothesized answer, information gathered during participant-observer turnaround interventions in five rural facilities is categorized, labeled, and interpreted. Five clusters of organizational behaviors were identified. Each cluster is defined in terms of its agrarian root and discussed as a present-day remnant—a rural outlook or mindset. Each behavior cluster is considered in terms of its adverse impact on facility performance. This inductive study points to follow-up studies to: 1) operationalize the rural outlook with a survey tool and a large sample of rural facilities; 2) assess the rural outlook's association with facility fiscal performance; 3) develop and test an economic behavior theory of the rural healthcare firm; and 4) establish a typology of rural agriculture-based communities. The root cause explanatory value of the rural outlook mindset and the proposed research are discussed in terms of strengthening rural health facilities.

Keywords

rural hospitals, agrarian ideology, organizational behavior

1. Introduction

Rural life is often characterized as a collection of difficulties. This reality is vividly captured in two essays on rural challenges. Wood's (2008) *Survival of Rural American* defines demographic trends and the attendant agricultural and economic consequences for rural residents and their communities. Egan's (2006) essay on the history of the middle and high plains—*The Worst Hard Time*—portrays the life

experiences of survivors of the 1930's dust bowl. Both authors capture the idealized character and integrity of rural residents as well as the natural threats and opportunities of rural living.

Within this context, two views of rural health services have emerged. First, managing rural healthcare is considered a difficult undertaking. Trinh (1999) characterizes small hospitals in rural America as perpetually struggling entities. The rural segment of the U.S. system is also buffeted by national trends as well as adverse factors considered unique to rural healthcare. For example, the typical inventory of external threats to healthcare is as follows: 1) scarce resources and competition (Hatten & Connerton, 1986; Hicks & Bopp, 1996; Succi, Lee, & Alexander, 1997), 2) adverse public policy and legislation (Alexander & Succi, 1994; Gianfrancesco, 1990), 3) unequal distribution of providers (Henderson & Taylor, 2003), 4) access to capital for technology and building, 5) shortages of essential personnel (Acosta, 2000), 6) population out migration (Rho & Moon, 2005; Wood, 2008), 7) increased dependence upon Medicare (Dalton, Slifkin, Poley, & Fruhbeis, 2003; Ricketts, 2004; Dalton, Slifkin, & Howard, 2000), 8) low patient volumes (Adams & Wright, 1991), 9) inadequate information technology, 10) shift toward specialty care and away from primary care (Harmata & Bogue, 1997), 11) demographic changes (Goody, 1993), 12) declining revenues and increasing operating expenses (Chang & Tuckman, 1991; Stensland, Moscovice, & Christianson, 2002), and 13) unrealistic local economic development expectations (Wood, 2008).

Initially, the persistence and confluence of these forces defined rural hospitals as victims of their circumstances—organizations beset by threats creating the looming specter of closure or conversion. The increased rate of rural hospital closures between 1980 and 1996 was testimony to the vulnerable status of these facilities (Roher, 1989; Drain, Godkin, & Valentine, 2001). The public policy response to this dilemma is in the Balanced Budget Act of 1997 (BBA) via creation of the Critical Access Hospital (CAH). As a follow-up, the reduced rate of rural hospital closures and conversions now stands as testimony to a resolution of the original challenge of rural health management (Alexander & Succi, 1994). Because 1330 rural hospital converted to CAH status, these facilities became operationally stable and therefore able to maintain access to care (Dalton, Silfkin, Poley, & Fruhbeis, 2003).

A second and current view emerged from the attenuated hospital closure threat and prompted a research emphasis on specifics aspects of facility operations. It has been shown that rural facilities tend to be inefficient (Sinay, 2001; Butler & Li, 2005; Harrison, Ogniewski, & Hoelscher, 2009; Wilson, Kerr, Bastian, & Fulton, 2012), have patient safety issues (Westfall, Fernald, Staton, & NanVorst, 2007; Longo, Hewett, Ce, & Schubert, 2007) and are associated with quality-of-care concerns (Moscovice, Wholey, Klinger, & Knott, 2004; Casey, Prasad, Klinger, & Moscovice, 2013; Moscovice & Rosenblatt, 2004; Joynt, Harris, Orav, & Jha, 2011; Joynt, Orav, & Jha, 2013). In addition, there are continued fiscal performance weaknesses (Holms, Pink, & Friedman, 2013). The emerging concern for operating performance is driven by the fact that the CAH, a Rural Health Clinic (RHC), Emergency Medical Service (EMS) and long-term care facility serve as a community's healthcare safety net (Erman, 1990).

Under the facility performance research umbrella, rural hospital sustainability difficulties have returned

albeit with a different list of compelling threats. The *Save Rural Hospital Act* of 2015 (H. R, 3225, 2015) is the proposed public policy response to intensified closure threats to facilities and access-to-care risks for vulnerable rural populations. The act avers that 238 rural hospitals are "on the brink of closure, 700,000 Americans living in rural areas are on the brink of losing access to the closest emergency room". To address this threat and nine others listed in the legislation, the Act proposes to a) bulwark existing CAHs and b) support the creation of an entity—the Community Outpatient Hospital (COH).

This legislation differs from the 1977 BBA because it attempts to align a COH's scope of services and performance with identified community needs. The Act acknowledges the generally accepted challenges of rural care delivery, yet is focused on addressing these difficulties beyond sustaining a full-service community hospital. Doing so avoids the historical pitfalls of the victim outlook and continues the focus on *performance*, here defined as configuring an organization to meet population-defined needs.

1.1 Problem and Purpose

Once the explanatory value of the victim metaphor became less compelling, the policy, managerial, and research focus shifted to a concern for operating efficiency, fiscal management, quality improvement, and mission effectiveness. Today, the rural healthcare research emphasis is on these four aspects of care delivery. With few exceptions, the literature is descriptive of rural health facility behavior. As such, there is no generally accepted explanation for the historical and emerging performance short falls in either operational sustainability or patient safety or quality of care.

The purpose of this paper is to use a participant observer intervention and detail gathered from five rural health facilities to: a) provide a descriptive overview of observed organizational behaviors in these facilities and b) postulate a rural ideology, mindset, or outlook associated with these behaviors. An additional purpose is to identify follow-up research opportunities regarding the performance of rural healthcare organizations derived from these qualitative observations.

2. Method

This section defines a participant-observer approach to the study's five rural health organizations.

2.1 Facilities

Observational data were gathered from four rural hospitals and one newly funded rural Federally Qualified Health Center (FQHC). Each facility was in a state of the Midwest corridor. The population of the communities' primary service area ranged from 3000 to 10,000. Facility bed size was from 25 to 50. Only one hospital had converted to CAH status. The others had *sole community provider* status and were from 25 to 50 miles from a larger hospital. The four hospitals operated a Rural Health Clinic (RHC) and were considered turnaround facilities because of their 1) declining financial performance, 2) limited market share, 3) narrowed scope of service, and 4) intensified risk of closure or conversion.

The start-up Community Health Center had not hired an Executive Director six months after the Health

Services Research Administration (HRSA) grant was awarded. Therefore, the HRSA deadline for commencing operations was the Director's immediate priority.

2.2 Access, and Intervention

Individually and collectively, the five facilities presented performance improvement opportunities in addition to compelling deadlines. The Chief Executive Officer (CEO) was directed by the trustees to restore each hospital's operating status and standing in the community. For the FQHC, the charge was to meet HRSA's start-up deadlines. Thus, the CEO had unhindered access to all aspect of each facility's operational, personnel, and historical information. Within the first 60 days of employment, the CEO held one-on-one interviews with department heads, supervisors, Medical Staff members, and Board members. Community leaders were "consulted" later. In turn, an operations enhancement plan was developed for trustee approval or endorsement contingent upon amendments.

2.3 Reaction to Implementation

As each intervention was implemented, the organizations' staff displayed an array of behaviors in response to the disruption of the *status quo*. Over time and across the five rural facilities, these behaviors appeared to be similar, yet varying primarily in intensity. Even though the turnaround was a governance directive, the experience became an opportunity to observe these behaviors for understanding and for facilitating a successful intervention outcome. Also, the observation-review process involved three sequential steps as follows:

2.3.1 Step 1—Conceptual "Factor Analysis"

Observations of behaviors and interactions with facility participants led to a "cataloging" of recurrent communications and actions. Thus, it became possible to organize these observations into clusters—each group having a core commonality or unifying theme. This organizing resulted in four groups which appeared anchored in a distinct overarching cognition. This process unfolded as a type of cognitive "factor analysis"; a process whereby a wide array of observed behaviors, interactions, and communications organized themselves into separate clusters or "factors".

2.3.2 Step 2—Seeking Understanding

The resultant four clusters appeared collectively representative of a single theme—a cognitive construct that was a) consistent across facilities and b) associated with organizational performance. This construct also seemed to explain or account for the observed behaviors. Yet, the follow-up question is, "Does this presumed *mindset* have sufficient explanatory weight or is further consideration needed. The Step 2 answer is that an effort needed to be made to identify prior ideological origins of the rural outlook.

2.3.3 Step 3—Naming Cluster Themes

The analysis of each cluster involved providing a cluster title that was deemed descriptive of each cluster's anchoring theme. Theme naming allowed for an expanded narrative of each cluster and provided an opportunity to seek an overarching and unifying ideology for the four clusters. Cluster naming and theme narration led to a consideration of Agrarianism or an agrarian ideology as the

unifying cognitive construct (Hofstadter, 1955; Douglas, 1969; Rohrer & Douglas, 1970; Buttel & Flynn, 1975; McConnell, 1977; Dalecki & Coughenour, 1992; Beus & Dunlap, 1994; Wunderlich, 2000; Wirzba, 2003).

3. Results

Since the observed behaviors tended to cluster around overt themes, the results are organized per: 1) a brief description of each cluster, 2) its unifying theme, and 3) the cluster's postulated agrarian origin. A cluster was labeled based on behaviors that presented as anchored in a central theme; a commonality that unified the identified behaviors. The five clusters have been labeled as follows: 1) Community Centricity; 2) Relationship Ascendency; 3) Longevity Exemption; 4) Regulatory Flexibility; and 5) Performance Independence. Table 1 summarizes each cluster and its observed impact on facility performance. This information is also an outline of the following review of results.

Table 1. Rural Outlook Clusters and Organizational Impact Features

Theme	Organizational Impact
Community Centricity	+ Governance by "oral tradition"
	+ Problems causes are defined as external to the organization
	+ An acceptance-avoidance of unresolved personnel difficulties
	+ Limited capacity to plan, organize, and implement strategies
	+ Marketing and public relation activities are not linked to Vision and Mission Goals
Relationship Ascendency	+ Operating decisions are not always made in best interest of the facility
	+ Compensation policies are not administered in equitable manner
	+ Conflicts of interest hinder decisions and uses of resources
	+ Financial outcomes are weakened because of a permissive environment
	+ Poorly defined lines of authority and leadership responsibility
Longevity Exemption	+ Proliferation of non-essential work driving higher than needed staff levels
	+ Individuals identified as *the* problem instead of seeking pragmatic solutions
	+ Information flow is largely informal
	+ An acceptance-avoidance of unresolved personnel difficulties
Regulatory Optionality	+ Facility has exposure to sanctions and fines for compliance lapses
	+ Documentation shortfalls occur throughout limiting ability to defend actions
	+ Facility gains a reputation for follow-through and implementation weaknesses

	+ Corrective actions are frequently imposed by external 3rd party actors
	+ Measured declines in operating and fiscal performance
	+ Policies and transaction documentations are frequently limited.
Performance	+ Teamwork is weak when needed for cross-functional projects
Independence	+ Medical staff practice actions may deviate from standards of care
	+ Behavioral idiosyncrasies are overlooked or worked around
	+ Medical Staff resistance to peer review protocols
	+ Work is self-directed, not organizationally determined

3.1 Community Centricity Cluster

A base assumption is that the historical primacy of agriculture has shifted—within each rural community—to the centricity of the town itself. The outlook drives a view that the community and its survival are an ascendant priority. This is especially true of those community elements that are or are presumed to bulwark this intent. Further, this expectation has migrated to the local-rural health services structure. Health services are presumed to be the vanguard of a community's economic development. As such, physicians and staff members are afforded considerable latitude in their personal and professional conduct. Yet, often, health services are viewed as centrist to the current and long-term welfare of a rural community. The hospital also stands as a symbol of community self-sufficiency and as a refuge from adverse life realities.

Since sustaining the existence of health services is the priority, organizations may not respond strategically or adaptively when external forces challenge the hospital's status quo. Equally so, this outlook presumes that external support or regulatory oversight can be allowed provided neither intrudes upon the status quo and independence. The evidence indicates also that rural communities are reluctant, to the point of resistant, to consider alternative business models for providing health services—even when objective measures signal impending distress.

3.1.1 Agrarian Origin

As originally stated, Agrarianism believed that agriculture was foundational to the security of democracy and the advancement of America as a nation. As farming goes, so goes the country—so much so that Jefferson (1784), in his *Notes on the State of Virginia*, posed that, "The small land holders are the most precious part of the state". The argument was fostered that the welfare of the forming nation depended upon the enduring success of agriculture. Thus, the government had an obligation to ensure support and protection for American agriculture and the *yeoman farmer* who had unique standing, e.g.,

> "The yeoman, who owned a small farm and worked it with the aid of his family, was the incarnation of the simple, honest, independent, healthy, happy human being. His well-being was not merely physical, it was moral; it was not merely personal, it was the central source of civic virtue; it was not merely secular but religious, for God had

> made the land and called man to cultivate it. Since the yeoman was believed to be both happy and honest, and since he had a secure propertied stake in society in the form of his own land, he was held to be the best and most reliable sort of citizen" (p. 25).

This original element of the agrarian ideology has transitioned in rural communities to a centrist mind set about the role of health care among health service personnel. As it was with agriculture, sustaining rural health services is preeminent over adjusting to market, population, and outcome realities of U.S. health care (Beus & Dunlap, 1994).

3.2 Relationship Ascendency Cluster

The *relationship ascendency* cluster captures the organizational process of substituting *authority* for *relationships*. Even though each facility has a formal organizational chart, an equally informal "organizational chart" existed as a collection of relationships among all stake holders—Board members, senior managers, supervisors, physicians, and staff. This rural outlook is expressed as a governance posture which accepts and participates in the relationship-for-authority substitution. Relationships among field actors are ascendant over the organizational authority inherent in these relationships. The following is a transactional example of the relationship-instead-of-authority feature of the rural outlook:

> The job performance of a hospital's Respiratory Therapy (RT) Manager required the Manager's supervisor to impose a performance improvement plan. In response, the RT Manager protested, "But Debbie, I thought you were my friend!"

Rural boards, administrative staff, and managers frequently govern or supervise based on relationships. Boards set a course for facilities based on relationships that are predominant at the time. In so doing, rural governance groups dilute and distribute their legitimate authority in favor of "relationship power". The governance function becomes part of the organization to the point that its oversight effectiveness is diluted, i.e., an *embedded governance function*. In organizational terms, the conduct and character of the governing body lays a foundation for the facility's behavioral style.

Since such an outlook diminishes the purpose and effectiveness of authority, organizational relationships are confounded. Co*nfounding* is defined as substituting a legitimate role relationship with an interpersonal style that dilutes, distorts the intended intent of these roles. This outlook allows people in rural health organizations to occupy a position without fulfilling the position's accountabilities. Instead, the participants conduct themselves in self-determined ways that contradict their organizational purpose, e.g.,

> A hospital board president befriended the director of nursing because the president was angered by the nurse's husband's alcohol abuse. In turn, the hospital executive was admonished by the president for defining performance expectations for the nurse, e.g., "You're lucky she has enough energy to get her makeup on and make it to work!"

> A hospital's maintenance director operated a small motor repair business out of the hospital's shop. He purchased supplies for "his business" from the local hardware store owned by a hospital board member—who was fully aware of the director's in-house business.
>
> During an extensive hospital building project, the hospital executive developed a relationship with the general contractor. In turn, roofing materials used for the hospital "mysteriously" matched the materials used to repair the roof of the executive's house.

The propensity to confound relationships detracts from an organization's mission effectiveness. Independent of the ethical issues in these examples, confounded relationships are disruptive to the organization's mission, its operational effectiveness, and its ability to engender trust.

3.2.1 Agrarian Origin

Agrarianism as expressed in farming considered agriculture to be independent of and exempt from outside economic market forces—especially competition. The honest, independent, self-sufficient yeoman farmer adhered to a spirit of equality—a view that determined his exchanges with others. The premise and outworking of the agrarian tenant of economic independence of the farmer reinforced the value of industry and self-sufficiency. Since a community's farmers were independent, honest and self-sufficient, it was possible to minimize social stratification. Thus, a rural agriculturally-based community emerged as a collection of relationships among equals.

Arguing from this agrarian premise of the eschewing interpersonal hierarchies, the present-day observation of substituting relationships for authority in rural health facilities is and understandable extension and translation. While a logical extension of the agrarian ideology, this organizational culture remnant is counterproductive and has a negative impact on facility performance (Beus & Dunlap, 1994).

3.3 Longevity Exemption Cluster

There was an observed direct correlation between an employee's tenure with the organization and the employee's progressive exemption from performance expectations. The longer a person was employed by a facility, the greater the extent of independence from regulatory compliance, policy adherence, and performance standards. This attribute appears to exist on a continuum that ends with long-term staff evolving into self-directed autonomous participants. In addition, long-term employees are accorded informal leadership or advocate status by board members, physicians, and staff. The *longevity exemption* is expressed as follows:

> A 20-year RN emerged as the informal nursing executive and was accorded considerable latitude with on-duty hours and direct patient care responsibility. At one point in the turnaround, the board's strategic plan required an expansion of surgical services. This initiative was defeated because the informal executive lobbied each board member to vote against recruiting another surgeon, remodeling the surgical

> suites, and securing expanded anesthesia coverage—because the nurses didn't "feel comfortable" expanding the surgical program.
>
> The 18-year Human Resources (HR) director evolved into the self-appointed employee advocate devoting each day to personal phone time, employee visits, and a self-directed work schedule. As the turnaround gained momentum, it was discovered that: a) HR policies had not been updated, b) the facility did not have a compensation structure or compensation policies, c) personnel files were not organized, d) there was no performance management system, and e) the employee benefit program was unmanaged. None these revelations led to an effort to amend the director's self-determined routine.

3.3.1 Agrarian Origin

An essential tenant of Agrarianism was related to land holding and property rights. The longer one occupied land and generated productivity from his holdings, the more establish one's ownership of the land became. In turn, ownership enhanced one's standing in the community and the ability to operate in an increasingly independent and informally influential manner. Hofstadter (1955) captures this process as follows, "The application of the natural-rights philosophy to land tenure became especially popular in America … what Jefferson called 'the fundamental right to labour the earth'; that since the occupancy and use of land are the true criteria of valid ownership, labor expended in cultivating the earth confers title to it" (p. 27).

In like manner, once an employee has longevity in a position, it is presumed that the individual has *title* to the position and enjoys the freedom associated with that title. The present-day translation of agrarianism within an organization enables an employee to redefine his/her job description as well as the extent of effort put forth (Roher, 1970).

3.4 Regulatory Flexibility Cluster

Frequently operating standards are determined by oral tradition and sustained by individuals having presumptive or arrogated authority. In addition, leaders appear to have limited concern when challenging or minimizing directives from an external authority, especially in matters of regulatory compliance. This approach expresses itself as a belief that state and federal regulations lose their force of law almost in proportion to the geographical distance from the originating source.

Another expression of this position is the view that whosoever wishes has a right to know *who* is in the hospital and *why* they were admitted. Conversely, staff members often believe that sharing Protected Health Information (PHI) within the community is a form of public service, e.g., "We're really just family here". Conversely, rural publics believe that they have a right to immediate access of a community member's health information, e.g.,

> A neighbor's friend was brought to the hospital's ER. The neighbor soon presented in the ER demanding to know the medical status of his friend. When informed of HIPAA constraints, the neighbor's vigorous retort was, "Those laws were made in

Washington, not out here!!"

Further, anyone who upholds confidentiality regulations is targeted with the accusation, "You don't understand small towns very well—do you!" The observed flexibility regarding confidentiality contributes to the erosion of trust and diminishes a facility's effectiveness in its own market.

> Shortly after the turnaround started, the state's department of health conducted the scheduled Medicare Conditions of Participation (CoP) survey. The reviews' exit conference and written report identified several compelling deficiencies coupled with admonitions of expected resolutions before the six-month re-survey. Once the surveyors left, the nurse executive commented that she would talk to the lead surveyor next week, "He's a friend of mine—we don't have anything to worry about". In keeping with this stance, the nurse executive did not willingly participate in a resolution of the cited patient care deficiencies.
>
> There was an observed tendency not to prepare for scheduled regulatory surveys or to conduct on-going compliance self-studies. This posture was augmented by a willingness to argue with adverse survey findings—because the organization's mission priority is to sustain itself in the community, not be buffeted by external forces.

3.4.1 Agrarian Origin

The idea of community is a core feature of Agrarianism. There was limited privacy within a community because it was generally well known what each community participant was doing. Also, this awareness was limited to a knowledge of a community neighbor's conduct, yet was absent any intrusion into an individual's activities—save during a time of trouble. The farmer was free to conduct his operations as he saw fit and expected no external meddling in his farming. However, the need for help during difficult times presumed the fulfillment of a supportive role from others. Yet, *help* did not presume the latitude to tell anyone what or how to do things because the goal of help was to restore one's self-sufficiency (Singer & Freire de Sousa, 1983).

3.5 Performance Independence Cluster

A consistent observation was the extent to which physician providers pursued independence as a priority. Consider the following example:

> A hospital board opted to remodel its 1950 facility *and* build a new patient-care wing. Since cash reserves were available, the project could have started immediately with no debt financing. To foster a participative environment, the board invited the medical staff to every facility planning-meeting. However, it was necessary to individualize an invitation for each physician. Even by complying with this requirement, the board could not capture physician input. Two years later, the board had not created a preliminary design. During this time, the board's cash reserves declined thereby losing the debt-free financing option.

In another situation, the medical staff bylaws needed to be updated. In response, the medical staff

refused to revise the outdated bylaws and threatened the board with litigation if an effort was made to impose a set of revised bylaws. In two other situations, the medical staff refused to allow Emergency Room coverage to be a bylaws condition of Medical Staff membership. The overarching argument was always that the medical staff is self-governing body that is independent of governance oversight and free from administrative supervision.

Goode's (1960) classic article defining a *profession* has explanatory value for understanding the observed organizational behavior of these rural providers. Goode (1960) and later Freidson (1970a) identified the core characteristics of a *profession*. Specifically, a profession is a group 1) that determines its own standards of education and training, 2) whose practice is legally regulated by licensure, 3) whose licensing boards consist of members of the profession, and 4) that is relatively free of lay evaluation. That is, the concept of *professional dominance* (Freidson, 1970a, 1970b) readily accounts for the collective behaviors noted among the facility's physician medical staff members. Scott (2000) argues that some physicians became uncomfortable in the urban transition to managed care and moved to rural settings in which they enjoyed the freedom of a *client-driven* practice. The confluence of rural independence and professional dominance motivated them to maximize professional and economic autonomy in this ideological good-fit arena.

3.5.1 Agrarian Origin

The hallmark of agrarianism is self-sufficiency and independent productivity. Yet, it further assumes that in difficult times internal and/or external sources should come to the aid of agriculture. The foundational importance of agriculture requires this. However, a corollary presumption is that the supporting source is not to exert control over or direct the behavior of the farmer. Also, the local expectation is that outside support is temporary until the supported entity can restore its self-sufficiency (Singer & Freire de Sousa, 1983). Given this root agrarian element, it is not surprising that rural healthcare players are want to challenge authority, even when it exercises legitimate authority.

4. Discussion—The Rural Outlook as Residual Agrarianism

There is an agrarian ideology literature within agricultural history and rural sociology. Many publications link agrarianism to agriculture and the behavior of farmers. A review of these sources also shows a diminished interest in Agrarianism coincident with the decline of the family farm and out-migration to urban centers—so much so that the *decline* (McConnell, 1977) and *end* (Soth, 2001) of agrarianism have been declared. Also, Hofstadter (1955) commented, "The United States was born in the country and has moved to the city" (p. 23)—such that the U.S. population is now 75 percent urban and 98 percent nonagricultural. The assumption is that the agrarian ideology is minimally a factor in rural America and less a topic of academic interest.

As an alternative view, Singer and de Sousa (1983) consider that agrarianism has relevance albeit in areas other than the farm, e.g., "Instead of interpreting agrarianism's persistence as a function of the *lack* of total economic development, it may well be that agrarianism's persistence, at least actually,

stems from social-cultural sources largely independent of changes in economic relations. Any attempt to reduce agrarianism to a specific political or economic program is likely to be doomed" (p. 304).

Further, Rohrer and Douglas (1969) contend that "Agrarianism is rooted deeply in the American experience … The deep roots have nourished a growth so vigorous that, with the passage of time, agrarianism has transcended the bounds of agriculture and has come to be applied to nonfarm contexts … We were impressed by the ease with which agrarianism was applied to nonagricultural situations" (pp. 3-4). Table 2 shows the original premise of agrarianism and the hypothesized present-day transition of each premise from agriculture to rural life. Table 2 is an adaptation of Flinn & Johnson's (1974) survey study of an agrarian outlook among Wisconsin farmers.

Table 2. Agrarianism Tenets Translation Grid

Tenet	Founding Definition*	Modern Translation
1	Farming is the basic occupation on which all other economic pursuits depend for raw materials and food.	The basic occupation presumption has been extended in the form of a rural exceptionalism. Even though the farm is not the economic foundation of a community, the participants retain an exceptionalism in their view point, yet believe that externals should support them as needed on their terms.
2	Agricultural life is the natural life for man; therefore, being natural, it is good while city life is artificial and evil.	The originality of the natural life has been translated to an oppositional view of input or influences from urban-based entities.
3	Amplifies the complete economic independence of the farmer. "*Dependence begets subservience and venality, suffocates the germs of virtue, and prepares fit tools for the designs of ambitions*".** The agrarian tradition upholds simple agricultural communities in which an approximate equality of wealth prevails and in which social stratification is minimized.*	a) Authority is substituted for relationships within organizations and throughout the community; b) Longevity is directly correlated with exemption from performance;
4	The farmer should work hard to demonstrate his virtue, which is made possible only through an orderly society. There is a pride, a certain nobility, in what man accomplishes by the sweat of his brow. There is	The absence of the independent family farm has caused the associated competition to move "in doors" in the form of interpersonal competition. Further, since organizational problems are inevitable, a pronounced tendency exists to define

	a suspicion about a man who makes a living by using his head and not his hands—too much education is not good.	the problem in terms of an individual. In turn, problem solving becomes a matter of criticizing individuals rather than addressing the root problem.
5	Highlights the family farm as embodying independence and self-sufficiency and stands as a standard bearer of American democracy. "*The small land holders are the most precious part of a state*". ** In this view, political independence depends upon social equality and economic security with the small farm existing as the surest foundation.	Standards, principles and policies are largely self-determined because of the presumed independence of the participants from external influences. There is a pronounced tendency to eschew accountability to external regulators or compliance with established standards of care. Often policies are a matter of oral tradition that are sustained via longevity of the collective participants.

* Flinn, W. L., & Johnson, D. E. (1974). Agrarianism among Wisconsin farmers. *Rural Sociology*, *39*(2), 187-204.

** Thomas Jefferson.

From this participant observer study, there appears to be a *Rural Outlook* (RO) or mindset that exists as a remnant of an agrarian ideology. Further, the original tenets of Agrarianism can be translated into present-day elements capable of explaining observed behaviors. The RO is a mindset or belief that a rural community, its citizens, and its organizations are not necessarily bound by the constraints governing other environments. Rural actors seem to consider themselves *exempt* from the world view generally accepted elsewhere. A rural hospital, for example, is not strictly obligated to comply with accepted health-industry standards and regulations. The operating manifestation, in turn, causes rural facilities to be a challenge for boards, administrators, communities, and patients. Further, the RO is considered to have standalone explanatory value plus it allows one to anticipate organizational behaviors and the performance of rural organizations.

4.1 Follow-up Research Opportunities

A participant observer study suffers the limitations of an inductive qualitative methodology. Yet, the resultant observational findings point to needed follow-up studies—each of which considers unaddressed concerns about the performance of rural healthcare organizations. Also, results from the proposed studies will identify operational strengthening-sustainability tactics and specify public policy support for rural health organizations. The goal is to pursue quantitative studies that measure (operationally define) the RO construct and asses its impact on the performance of rural organizations.

4.1.1 Rural Outlook and Living Questionnaire

Prior efforts to measure an agrarian outlook have focused on an outlook presuming a relevance only to agriculture in Midwestern states (Flinn & Johnson, 1974; Rohrer, 1970; Carlson & MacLeod, 1978; Beus & Dunlap, 1994). These survey studies are the foundation for pursuing the hypothesis that a

remnant of agrarianism exists, yet is not attached exclusively to agriculture. What is needed is a questionnaire for assessing the presence and intensity of the hypothesized rural outlook. This requires building a *Rural Outlook and Living Questionnaire* comprised of items reflective of agrarian elements that have migrated from agriculture as shown in Table 3.

Table 3. Rural Outlook and Questionnaire Item Focus

Cluster	Questionnaire Focus
Community Centricity	+ Living in a rural community has advantages over living in a larger urban setting. + Health care services in our community have become the major strength for us—much the way agriculture was. + Our community continues to be strongly influenced by the farming and agricultural activities in the area. + The Federal government should work to keep health services in rural communities—at all cost. + A rural community remains an ideal place to raise a family. + One reason we hear so much about crime and corruption is because the U.S. is becoming increasingly urbanized. + Closing some rural health facilities (hospitals, clinics, health departments) will not create a hardship because residents can travel a few miles to a larger, nearby town for care. + Health service organizations in a rural community play a vital role in the area's economic development opportunities. + Many of our country's problems could be solved if people relocated back to rural communities. + Clean air, no traffic congestion, clear skies and closeness to nature helps rural residents to be value-focused, happy and productive. + Rural residents should be willing to pay local taxes to ensure that health services are supported and remain in the community.
Relationship Ascendency	+ The people who work in rural health care facilities are special people and should be treated as such. + Rural hospitals Boards of Directors should hire/promote current staff members to leadership roles rather than bring in new staff from outside the area. + People living in rural communities are more religious than urban/large city residents. + In rural health organizations, relationships and equality are more important than titles and supervision. + It is difficult for hospital Board members to remain objective when making decisions

	about staff members.
Longevity Exemption	+ One measure of loyalty and commitment to our community is how long a person has lived and/or worked in town. + Long-time employees have a right to a degree of performance freedom from some expectations. + It is acceptable to allow long-term employees to become informal leaders with real authority.
Regulatory Optionality	+ Often the regulations coming from Washington regarding health services do not help or apply to rural health care. + Rural organizations find it difficult to adapt to changes created by new or amended regulations. + Medicare and Medicaid reimbursement rules are not supportive of rural health care providers. + During required inspections, Federal and State survey teams should give rural facilities credit for trying to comply.
Performance Independence	+ Members of the Active Medical Staff should not be required to serve in the Emergency Department as a condition of Medical Staff membership. + Even though rural towns are losing population; these communities are important the American way of life. + Keeping health services in rural communities will ensure that resident receive essential care at reasonable prices. + A primary goal of local health services is to make a profit each year and to buy new technology. + Rural health organizations should be operated as a business, not as a mission or service. + Rural health service professionals should be free to take care of patient and not be concerned about hospital-clinic profit-and-loss outcomes. + In rural organizations, formal organizational charts, policies and chain of command are not as necessary as they are in city companies.

The observed behavior clusters define topic areas around which questionnaire items will be designed. Further, as the psychometric strength of the *Rural Outlook & Living Questionnaire* survey it is possible to pursue a research question and corollary hypotheses. These follow-up opportunities link directly to a hypothesized relationship between the RO and the organizational performance of rural health facilities. At this juncture, the research question involves the existence of the RO as a measurable mind set among rural health service workers, community residents, and board members. A corollary question is whether the RO manifests itself along a continuum of intensity. That is, does the RO express itself in

gradations of intensity from high to low? The participant observer findings give rise to the following testable hypotheses:

1. The RO, as measured by the *Rural Outlook & Living Questionnaire*, is inversely correlated with organizational performance of rural health facilities.

2 The intensity of the RO as measured by the *Rural Outlook & Living Questionnaire* is associated with the quality of life found in the respective rural communities.

4.1.2 A Theory of the Rural Health Firm

Given prior research on rural health facilities, it is possible to describe how such entities perform. Current detail also allows one to define what a rural hospital isn't in economic terms, e.g., profit maximizer, technically efficient, strategic (Trinh & O'Connor, 2000). The evidence is that a rural facility does not fit into a classical economic theory of the firm. However, no effort has been made to articulate a theory of the rural firm coupled with the ability to predict organizational performance under various conditions. The working challenge to build a behavior theory of the rural firm that can be tested against the performance of these organizations.

The RO, as an active mindset or mental schema, is hypothesized to have a direct impact on the organizational behavior of rural healthcare professionals. This reality, in turn, provides an opportunity for the development of a behavioral theory of the rural healthcare firm (Cyert & March, 1992; Greening & Gray, 1994; Dew, Read, Sarasvathy, & Wiltbank, 2008). Heretofore, no such theory has been put forth because the evidence argues that neo-classical economic theories of the firm are not able to explain the behavior of rural health firms. Thus, policy and academic responses to distress among rural facilities must use a retrospective or *post facto* analytic view. The postulated RO and its associated organizational behaviors provide a missing element needed for articulating a behavioral theory of the firm; one with the ability to: a) explain historical outcomes and b) anticipate future performance.

4.1.3 Rural Community Typologies

An additional research opportunity exists in the form of a dilemma. There is a community typology literature that has not been extended to rural communities (Stimson, Baum, Mullins, & O'Connor, 2001; Crow & Allan, 1995). There is a methodology—hierarchical cluster analysis—that has been used for identifying distinct types within a population of communities (Saint-Arnaud & Bernard, 2003; Hill, Brennan, & Wolman, 1998; Seiler & Summers, 1974; Warnecke & Zeller, 1973). Thus, there is a conceptual and methodological environment for demonstrating the nature and extent of distinct community typologies, especially in states with significant rural segments. This situation gives rise to a multivariate research design. Specifically, what is the impact of a community's type on the performance of its health facility? Also, does a level of the RO account for variance in organizational performance within various community types?

5. Summary

Even though a research interest in agrarianism has diminished, there is qualitative evidence that agrarian ideology remnants influence health service organizational behavior, especially in facilities located in states with significant rural segments. This RO motivates unique behaviors that directly impact organizational performance. Further, given the challenges confronting rural health facilities, it is essential that research answers are pursued in the best interests of rural residents and their access to health services.

Rural health services are at a crossroads regarding a best way to ensure access to care for rural residents. Yet, the question over why rural facilities individually and collectively struggle endures. Research continues to be descriptive of the externals challenging these facilities. Public policy responses have been designed to buffer rural hospitals from these difficulties. However, the agrarian ideology remnant mind set hypotheses and its follow-up research opportunities provide a root cause explanatory approach to understanding rural health services behavior. Accomplishing this outcome provides the needed understanding and ability to enhance organizational performance.

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