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MANAGING SYSTEMS IN A BRITISH MENTAL HOSPITAL

In 1957, the Tavistock Institute of Human Relations was approached by Banstead Hospital and asked to conduct an appraisal of the Hospital's structure and function, and the scope for possible development. Two staff members of the Tavistock Institute, Miss Isabel Menzies and the author conducted the study which was small in scale but distributed over about nine months, with further discussions spread over another (18 months). It is hoped that a further paper may be publisheddealing with the course of the study and with therapeutic policy and staff skills. One aspect of the work is of general theoretical interest, and forms the subject matter of this paper.

The Problem

For the four years or so preceeding the study, the Hospital had been engaged on a radical revision of its therapeutic methods and policy. The Hospital, and in particular that part of it with which the study was concerned (the Female Division) had transformed itself from a custodial retreat on the fringe of society into an active residential treatment unit highly connected with its surrounding community and 'catchment' area. The use of physical methods of treatment had been vastly increased, and the systems of ward organization and the therapeutic outlook of staff had been changed. There was a new spirit of purpose and achievement abroad.

There existed in the hospital both this newer outlook and aim, and the remnants of the older, traditional, custodial outlook and aim. They were embodied in different individuals and groups but also appeared as conflicts within individuals, where for instance the bereavement associated with letting a patient leave one's ward, existed together with the sense of achievement and success that one's own efforts had done something.

Alongside changes in feeling and aim, there were changes in social structure, and it is these which are to be examined here. The formal structure of the Hospital was fairly clear and fairly typical, but it is to be expected in any organization or society that the informal or actual structure departs from the formal in some respects, and that the two might be quite far apart if changes in function were rapid.

As we discussed with the staff the changes in their jobs, and

their relation with other jobs, certain clusters of attitudes and relations emerged which could be interpreted structurally, that is as deriving from the individual's or group' position in the structure and not directly arising from the impact of changed procedures and policies upon them personally. Again, discussion with staff about the success or otherwise of various kinds of group meetings held among the staff, could also be interpreted in structural terms, and not only in terms of the skills, insights and intentions of staff involved.

The emphasis in this analysis was placed upon the governmental or management aspects of the structure, and an attempt made to look at the Hospital as an organized system of tasks performed by the staff in relation to the patients. Many analyses have been made of hospital structure and administration and we attempted here to develop the work of Sofer (1) Hospital Paper), along lines suggested by Rice in his studies of the organization of work and management in industry (2. Ahmedabad book). It is not usual to think of hospital organization in straightforward management terms, but Rice's derivation of structure from the detected primary task of the organization affers a valuable approach.

Here I shall describe the organization in conventional terms, then select illustrative research material to point up structural problems, which then will be analysed in terms of primary task, and managing and operating systems.

I. FORMAL ORGANIZATION

The Formal Organization of the Hospital

The Hospital is part of the National Health Service, and is controlled by one of the Regional Hospital Boards through its own Hospital Management Committee. Regional Boards control all hospital services within their regions, which in this case included S-W Metropolitan London, Ken, and parts of Surrey and Sussex (check). They are part-time mixed lay and professional groups, who have great financial control over hospitals, appoint all medical staff, and other staff above a certain salary level. They have the advice in psychiatric matters of a full time Regional Psychiatrist.

Hospital Management Committees are part-time mixed groups, broadly representative of local sectional interests. They are appointed by

the Regional Hospital Boards and have powers of approval over internal policy matters, and over disposal of the Budget allowed them by the Regional Board. They are the legal employers of all staff not employed directly by the Regional Hospital Board. Appointments are made on the recommendation of the Physician Superindent. This hospital, like most mental hospitals was large enough to have its own Management Committee.

Within the Hospital, the Physician Superintendent had greatest power and had invested in him legal responsibility for all the certified patients, who were compulsorily detained with deprivation of civil liberties. He might suspend at his discretion any member of the staff. He was a powerful figure, and the equivalent of the Chief Executive or General Manager but he did not as great a power as his predecessors had before the advent of the National Health Service. This Hospital used to be one of the London County Council's, and as Sofer has shown the responsibilities of the Secretary have increased. The Physician Superintendent in this Hospital had two contracts, one as part-time $(\frac{2}{11})$ Superintendant with the H.M.C. and one as part-time $(\frac{9}{11})$ consultant with the Regional Board. He therefore had two roles, the lower status one by virtue of a contract with the higher authority.

The Secretary had two roles, one as Secretary to the H.M.C. which made him the official channel through which all communications and decisions reached the Hospital from the Committee, and one as Hospital Secretary in which he was the subordinate of the Physician Superintendent, and in charge of the clerical and administration departments of the Hospital.

Matron was responsible to the Physician Superintendent for the female nursing services of the Hospital, and for nursing training. She had the right to attend H.M.C. meetings when nursing affairs were discussed. The position of the Chief Male Nurse was similar with respect to the Male nursing staff, though traditionally his position was of slightly lower prestige status than that of the Matron.

The 4 senior managers of the Hospital thus had double roles resulting in a sort of leap-frogging hierarchy. General management of the three 'functions' of the Hospital was traditionally exercised by the Physician Superintendent, though formally it was exercised only by the Management Committee with some legal and emergency functions rested in the Physician Superintendent.

The working compromise which had been reached in the Hospital between the traditional, the official, and the effective system put the Physician Superintendant substantially in the position of Chief Executive. His Deputy, the Matron and Chief Male Nurse, the Hospital Secretary, the Chief Engineer and the Catering Officer were his immediate 'command' group, or as he put it, his 'cabinet'. The Hospital Management Committee took a position midway between that of a controlling group and an advisory body. Many policy and executive decisions were taken by the Superintendant with the cognisance and support of the Secretary, in anticipation of ratification by the committee. The Superintendant's position was not equivalent to that taken by full-time senior executives in publically-controlled organizations such as County Councils. Here the executive is officially deprived of policy-making powers, but is expected to execute policy decisions and comes to bear a policy advisory role with skill in anticipating decisions by the Committee. The Physician Superintendant was in a strongerposition than this, by virtue of his traditional powers, his professional prestige, his legal responsibilities, and his contacts with authorities higher than the Management Committee. We shall re-examine his role in relation to the Committee at a later stage of the analysis.

The medical and nursing activities of the hospital were divided into three main divisions. The Male Division was under the charge of a consultant psychiatrist. The Chief Male Nurse was primarily concerned with this division. There were between 800 and 875 patients. The Female Division (1200-1500)patients) was again under the control of a consultant psychiatrist who was also the Deputy Physician Superintendant. The Matron was primarily concerned with nursing services in this division. The third division was the non-statutory neurosis hospital, known as the Downview Hospital. This was formally not a mental hospital, and did not accept certifie patients. It was under the direct control of the Physician Superintendant in his role as consultant in the hospital. Nursing services were provided by Matron. There were about 50 men and 50 women patients. A subdivision of the Male division catered especially for tubercular patients and was run with a relatively high degree of autonomy. It was known as the Freedown Hospital.

There were other departments and services organised centrally, and not explicitly included within any of the main divisions. The Nursing training school was run by a Sister Tutor, responsible to Matron. The financial, clerical and secretarial services were controlled directly by the Hospital Secretary. The artisan services (building, carpentry, electricity, painting, locksmiths, etc.) were controlled by the Chief Engineer, whose accountability was a little obscure. Formerly (before 1948) responsible to the L.C.C.'s engineering department, and to the Physician Superintendant, he now was formally responsible to the Hospital Secretary and to a large extent, de facto, to the Physician Superintendant. Catering Services were organized by the Catering Officer, again responsible in fact to the Physician Superintendant, though traditionally this came within Matron's area of control. Laundry and needlework services were under the control of Matron. The Gardener seemed to be responsible directly to the Physician Superintendant.

Medical service departments operated centrally though some staff or services were specifically allocated to divisions. These departments were the Psychology, Psychiatric Social Work, and Occupational Therapy departments, the heads of each being responsible to the Physician Superintendant.

There were thus thirteen roles subordinate to that of the Physician Superintendent, although only eleven people were actually responsible to him as both he and his Deputy also acted as consultants in charge of a main division. There was a division into medical, nursing, medical service, and administrative operations, into subdivisions of these, and the heads of all subdivisions were responsible to thePhysician Superintendent, although his regular 'cabinet' did not include the whole of this group of subordinates.

This sort of organization is not unusual in mental hospitals, although the balance between Physician Superintendent, Matron and Secretary may vary. It should be stated at this point that the system worked although it may seem ungainly and there were points at which it could be improved. Considerable space has been taken to describe the 'top management', but further description will be limited to the Female Division. This, as we have seen, was the largest, and had as its head the Deputy Physician Superintendent. It was

also the one where the impact of change was reputed to be greatest, and the one where, for these reasons, the study was concentrated.

The Formal Organization of the Female Division

The main hospital building was large and housed the central services and the Male andFemale Divisions. The plan of the building was something like two combs placed parallel with their 'prongs' facing outwards, and the two combs joined at one end. The joining section held the central offices and the wings held the divisions, females on one side, males on the other. Branching off the long main corridors 'the backs of the combs) were ward blocks. These were three storey buildings, each floor being a ward and consisting of several inter-connecting rooms, dayroom and dormitories, individual 'side' bedrooms, offices, bath, kitchen etc. The organization of the Division hinged around this layout.

Within the Female Division, each medical officer was in charge of several wards, not necessarily all in the same ward block at the beginning of the study. Each doctor had one 'reception' or short stay ward, in which the majority of new patients stayed for the whole of their treatment. He also had a number of other wards, either of 'long-stay' or chronic psychotic patients, or of 'sick and senile' patients. Four junior medical staff and the consultant worked mostly in this division. Four or five others, including the S.H.M.O. took some part in the work of the division, usually taking one or two of the long-stay female wards in addition to their major committments in other parts of the hospital. In this way the extra numbers of patients in the Female Division were covered, and each doctor had a varied case-load.

extra to what?

The nursing services of the Division were administered by Matron. The first division was into night staff and day staff. The Deputy Matron, and Matron herself worked during the say, and a Senior Assistant Matron controlled the night staff, which was much smaller than the day staff and consisted of student nurses doing their prescribed period of night duty (usually three months) with some staff nurses who were often ex-sisters who preferred for personal and domestic reasons to work part-time and at nights. There were usually two nurses on medical wards, and one on others, though some blocks were looked after by a single nurse, depending on the amount of care and attention thought necessary during the night.

The day nursing staff was divided into two shifts. On each

shift, four Assistant Matrons worked, and each looked after two ward blocks. She had an opposite number on the other shift, and duty times overlapped by half an hour in the middle of the day. All the Assistant Matrons shared one office in the central buildings.

Each ward was under the charge of two sisters, or a sister and staff nurse, working on opposite shifts, and all other members of ward staff, i.e. staff nurses, student nurses, assistant nurses and domestic staff worked the same shift system. Shifts alternated week by week and days off were covered by working one long day (twelve hours) in each week, so that staff members regularly worked with their opposite numbers. – meaning?

II - CHANGE AND CHANNELS OF CONTACT

The central focus of the study mf was the changes in therapeutic aim in the hospital, the effects these had had upon people's jobs, and lines of possible future development. Enough must be described here to provide material for analysis of the systems of organization, though, as has been stated, these topics are to be dealt with in another publication.

Over several years, but with greatly accelerated rapidity within the x two or three preceding the study, great changes had been effected. Use of physical methods of treatment had increased, in particular of E.C.T. and tranquillising drugs. Wards which were previously mostly locked were opened, leaving only a few 'closed' wards. The railings which previously surrounded and confined the ground adjacent to each ward block were removed. An active policy was pursued to break up long-standing stable 'communities' of chronic patients and to discharge as many as possible. New admissions were treated actively, and in most cases left the hospital within two months of entry.

At each step there had been doubts and prediction of catastrophe from various sections of the staff, but the overall soundness of the administrative decisions taken, and the good fortune attending them had produced on the whole a high level of confidence, optimism and trust in the senior medical staff. There were of course, those among the medical staff who disagreed with the theoretical orientation of the treatment policy, and those among many grades of staff who felt that treatmentx methods or the discharge policy, were pushed too far for them or the patients. During the period of active change, many of the dissidents left the staff through the normal processes of retirement, transfer, yz and promotion, so that a change in the climate of opinion resulted both from the experiences of staff members, and froma process of social selection, part systematic and deliberate part spontaneous.

At the time of the study, a hospital policy was discernible which w consistent and clear and which enjoyed a considerable dd degree of support from the staff.

With such rapid changes in the tasks of the staff, the atmosphere of the hospital, and the actual composition of the staff, it is to be expected that a rigid system of precedent, protocol and procedure wo

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not persist without change. There was in fact a series of channels of contact through which decisions, teaching, consultation, discipline, appeals and representation took place. Some of these were conventional and formal, some unconventional or informal. Examination of the salient ones can illustrate the impact of change and the sources of some confusions which existed. This is not an exposition of all interactions between staff members, but of those channels through which people were primarily influenced in the direction of their work, and through which they exercised influence upon other people's work or reactions to them.

The Medical Channel

Within this channel were combined executive, consultative, training and appeal functions. The Superintendant or his Deputy were the two most closely concerned with decisions on clinical policy and met the rest of the medical staff frequently. Apart from ad hoc meetings during the course of work, there were two regular meetings each week with the whole of the hospital medical staff. At these meetings, not only were technical matters discussed (case conferences, treatment practices) but information about the workings of the hospital was passed on and shared. To some extent they were used as training meetings where the experience and skill of senior staff could be communicated to juniors. Again, there was a large consultative element in the work at the meetings, as proposed changes in ward organisation, departures in treatment practice, relations with outside agencies and the community were discussed. Doctors had a chance to bring up points of dissatisfaction or puzzlement, and to make their views known to their superiors. The doctors meetings can be seen as multi-functional, but primarily concerned with establishing and maintaining a common, shared mode or range of modes of professional and technical practice.

These functions were not limited to formally designated meetings, but were discharged continually through casual meetings and through the important institution of the doctors' house. This was a house in which resident, unmarried members lived, and in which lunches were provided for a large proportion of the rest of the staff. The meetings over lunch-tables had no agenda, but commonly included a good deal of 'shop' talk about particular patients and ward events through which doctors sought the opinion and advice of

their colleagues, and so came to share their views and knowledge. In many ways these informal meetings, and the 'gossip' which took place at them were very important exploratory and consolidating processes.

Within the female division there was continual contact during working times between the consultant in charge and his medical staff. Much of the actual training in understanding and skill took place on the wards between the consultant and a junion. He took considerable pains to keep his staff informed of his intentions and of the influence of the outside world upon their activities. A preliminary analysis of his working time over a period of three weeks showed that over half his time was spent on wards, on clinical, managerial and training duties. Over a third was spent on strictly administrative and managerial work in his office and in contact with people outside the hospital. The remainder (about a tenth) was spent on research and formal teaching.

Both the consultant and his medical staff came closely into contact with the work of the Assistant Matron and sisters. Perhaps to a greater extent than in other hospitals, it was explicitly stated that the M.O. in charge of a ward was the person who took decisions about the handling of patients and the provisions made for them. This meant that the ward sisters and nurses might well be given instructions about nursing procedures by a medical officer, and would be expected to carry them out. Such instructions were not universally given or accepted. It tended to be the consultant who gave active direction, with the junion doctors participating less. All the medical staff payed great attention to the sisters' and nurses' judgments, and these latter were consequently allowed wide discretion. This varied according to the type of ward, for on the reception or short-stay wards, medical intervention was at its greatest intensity, while on some of the long-stay wards, the active work was more consistently under the control of the sisters.

The point being made here is that a sister might well find herself receiving guidance and instruction from both Assistant Matrons and medical staff, and that it could not be assumed that the two sets of superiors would necessarily be dealing with separate issues. As the role of the medical officers became increasingly active, so they came into increasing contact with patients and, at least (with) some medical officers, (they) became increasingly concerned with issues which might be considered traditionally nursing matters.

The Nursing Channel

The second major channel of contact had undergone perhaps the greatest changes of all. Whereas the work of medical officers had changed, and their interaction had increased, the nature of their contacts had changed less than was the case with the nurses. With them there were changes not only in jobs, but in the distribution of authority and prestige, and in the nature of contacts made.

A number of regular meetings were held between members of the senior nursing staff, with the main functions of reporting upwards to Matron, and planning nursing deployment. Matron had her contacts to maintain outside the nursing hierarchy, at committee meetings and discussions with senior medical staff, and one of the tasks she shared with her Deputy and of the Senior Assistant Matron was to ensure that one of them was available for ~~ix~~ internal duties every day during day shift hours. The three met in the morning to plan any necessary changes in shift times and allocation of nursing staff. The Matron met the Assistant Matron on each shift daily, and received reports on ward events, as well as arranging deployment moves with them. She also provided a half hour period on each shift when she or her Deputy was available to any member of the nursing or domestic staff. Personal requests for leave or off-duty times, complaints, quarrels, observations, personal problems, were all brought. Matron was here providing an appeal channel other than that directly up the hierarchy, and was providing a personal counselling service - both valuable 'personnel' functions.

This whole senior group did not meet for meals. Matron ate in her own quarters (as did the Physician Superintendent, usually), and the Deputy and Senior Assistant ate with the Sister Tutor. The Assistant Matrons were very much more close-knit as they all based their operations on a shared room, although they ate in the canteen with the rest of the staff of the whole hospital. Between them passed a great deal of information and advice and many minor deployment changes were effected informally between them without involving their three seniors. Their room was by way of being a central information exchange where senior nurses, sisters, nurses, doctors, visitors and patients were wont to seek advice on each others activities and whereabouts.

Assistant Matrons made frequent contact with ward sisters. Each was in charge of a number of wards, in the same ward block. Their function can be described as primarily one of facilitating ward work by handling questions of nursing availability, and the provision to the ward of services, equipment, transport for patients etc. Only to a limited extent did they discharge a management or leadership role, although they did do so, and did a certain amount of informal training, and a considerable amount of communication upwards, either for or about, the nursing staff. They were not the only people regularly or frequently to meet and work with sisters. As has been described, medical officers were increasingly doing so, and Matron held meetings three-monthly with all the sisters for, as far as could be detected, a mixed consultative and appeal purpose.

The role of all the senior nurses had changed as the nature of ward life changed. Their function of ensuring that the whereabouts and condition of each patient and item of stores was as expected, and that any deviation should be reported upwards, became increasingly attenuated. As the division moved away from the preservation of a steady state to the attainment of a succession of dynamic equilibria, the structure of the nursing hierarchy came under increasing strain.

The strain appeared most clearly at the level of the Assistant Matrons. As locked doors diminished, so did the need for people to keep them, and in fact the number of Assistant Matrons had declined. Even so, they were the object of some puzzlement in the senior medical staff who wondered what was happening to their role, of gratitude from junior medical staff who found them mines of experience, wisdom and know-how, and of a range of feeling from toleration to resentment from the sisters. Sisters tended to look to the senior medical staff rather than 6to the Assistant Matrons, though they themsxlves included representatives of both the newer outlook on therapeutic policy, and of the older retentive-custodial policy.

The junior nurses and domestic staff came into contact day by day with the ward sisters, who were thus very important figures for them. It varied from ward to ward how much they met the medical staff. On some, such as the admission or active treatment wards, the contact was frequent. There were both student nurses and assistant nurses but very few staff nurses, as they were promoted to decrease the shortage of sisters. Student nurses

had an extra contact with the sister tutor and medical staff through the training school, where they spent study days each week in addition to their 'block' preliminary training. Considerable attention had been paid to the training and support of nursing staff, with, it seemed, considerable success. Junior nurses had little contact with the senior nursing staff, and that usually forappeal, personal request or disciplinary reasons. Assistant Matrons appeared on wards, but their role was often not clear to nurses.

Figures 1 and 2 show the interaction between these two channels within the Female Division. The contacts made by the Consultant have been shown separately to make for visual clarity, and because they are by way of constituting an occasional or 'emergency' system, operating at times of change or need for decisions taken personally by the Consultant without delegation to any subordinate.

III - SYSTEM ANALYSIS

Hierarchy of Tasks of the Hospital

The concepts used in this analysis are current within the Tavistock Institute of Human Relations where they have been developed in relation to the study of socio-technical systems. There hasx been an attempt to study the technological aspects of, say, a manufacturing company, in relation to the social system it uses, and to the economic system. The notions most directly applicable here are those of the 'enterprise' viewed firms as an open system, of the definition of its primary task in relation to its environment, and of the internal grouping of tasks into managing and operating systems according to the criteria of technology, territory and time.

The term 'enterprise' denotes an "organization of men and materials about some common endeavour"[1] and as such applies to a hospital as much as a factory, trading company or research institute. When viewed as an open system[2] it is assumed that it maintains its identity in relation to the environment, and that there is a continuous importx and export of what may be called material. The materials of a hospitals imports and exports are patients, staff, goods, and money. When materials are within the system, then some operation or conversion is practised upon them. Thus patients are admitted, are treated in some way or other for a longer or shorter time, and are discharged, whether better, worse, or dead. Staff join, are trained or otherwise change, however,minimally, receive pay, food etc. and leave. Goods are imported, turned into meals, office files, arranged into key rings, libraries, uniforms, etc. and wear out, are taken away, eaten, used up or written off. So with money, converted into pay cheques and notes, food, goods.

This notion is a simple one, but leads to a useful organization of analytical questions when other concepts are related to it. It carries the implication that the internal activities of the enterprise cannot be analysed by themselves without reference to the constraints and demands of its environment and of its own directed impetus towards some goal in relation to its environment. There will certainly be tendencies within the system mk to maintain a steady

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1. Definition used by Emery (527)

2. Rice, ...

state, but adaptation to external change is not an extraneous encumbrance but a necessary derivative of the nature of the system, for it is never isolated from its environment, but continuously taking from and adding to it.

The enterprise will need to carry out certain day to day tasks in order to achieve its day to day survival. These necessary conditions of survival do not define fully the activities of the enterprise, although there seem to be some enterprises where the conditions for survival have so cramped their 'enterprise' that they are in danger of becoming moribund. One danger of unenlightened and inefficient bureaucratic administration is that the lower orders of the system may become thus 'regulation-bound'.

Where the enterprise can rise above the social equivalent of annihilation anxiety, a variety of goals may present themselves for choice. The choice will not be free for those in the enterprise because each possibility will carry with it different degrees of difficulty in terms of internal resources, and of environmental demand, support, or opposition. If the system were closed, these considerations would not apply. Some mental hospitals twenty years ago might have looked like closed systems, but could probably be better defined as moribund open systems trying to look closed. Banstead Hospital at the time of the study was increasingly becoming open, in that the rates of imports and export were rising. It was becoming in that sense more dependent upon its environment, but rising well above the 'survival' level and facing choices of goal.

My colleague Emery has likened the range of possible goals to a hierarchy of which one will become primary according to the balance of forces operating (cf. Maslowe's hierarchy of motives). The dominant goal is the 'primary task of the enterprise'. What was happening at Banstead was the redefinition of the primary task of the hospital in accordance with 'technological' changes 'newer treatment methods).

The primary task within at least the Female and Downview (non-statutory) Divisions could be said to be the treatment of acutely disturbed patients received from the community and returned to the community as soon as practicable, using criteria of social capability, not 'cure'. This implies an increased turnover of patients, more active participation by the staff, and a greater contact with the resettling of patients in the community. The fences were coming down figuratively as well as literally, and although the study did not

see much progress with the last of these implications, considerable innovations have since been attempted[2].

Other tasks in the hierarchy were not dormant but were operating alongside the ~~pm~~ primary task. The secondary task could be said to be the retention of chronic patients. This is what used to be the primary task, and the aim of this paper is to display the impact of this change upon the internal ~~xtm~~ steady state of the system. This secondary aim was subject to redefinition and shift in emphasis as the notion gained ground of the provision of a 'hostel and sheltered workshop' for patients unable to cope in the community. This whole task was viewed as diminishing in importance and open to ~~futx~~ possible future abandonment.

The tertiary task was to provide a residential centre for sick and senile old people. Many of these patients would not be considered markedly psychotic, and could be cared for in their families, if these were in existence, willing and able; or in other kinds of institution. As it is, the mental hospital is one of the few places available to them. In spite of the unpromising setting, a service of understanding care had been built up in the hospital. An attempt was being made to discharge as many long-term old patients as possible back to their families, and to ensure that as few as possible new admissions of age 60 and over became 'long stay'. The problems presented by sick and senile patients are different from those presented by younger and more disturbed patients, and while the treatment of many new admissions could be regarded as a part of the primary task of the hospital, there were many patients for whom the hospital would have to be their palce to spend their last days. In this respect the tertiary task of the hospital could be described as the provision of a 'pre-moritorium'.

There remains a further task, less obvious and demanding in extent than the three already mentioned, but not derived from then and sufficiently important to be listed. This, the quaternary task of the hospital, was to train staff to occupy roles outside the hospital.

It is of the essence of the concept of primary task that all activities in the enterprise can be derived from it and contribute to it, or otherwise can be seen as unconstructive and a hindrance to it. Where there are several tasks in the hierarchy of possibilities all extant and operating simultaneously, the possibility of conflict between them arises. The three tasks of highest

priority described here need not necessarily conflict, if the division of work within the hospital could be made to accord with them, and this is a possibility *a priori* because each involves handling different patients. Conflict would arise if there were confusion between the tasks and simultaneous attempts made to work according to more than one with the same patients. Effective work would come from defining the tasks of different sub-structures differently so that their parallel operation produced a total contribution to the hierarchy.

The fourth task described does not include all training in the hospital, as the necessity for most of it can be derived from the others. As defined, it emphasises one relation the hospital has with its environment, as all tasks or goals of an enterprise are definitions of such relations. It immediately raises the possibility of conflict between the needs of the patients and of the hospital in meeting them, and the needs of staff defined according to external criteria, such as the examination requirements of the D.P.M. or of the General Nursing Council. Such conflict is not assumed to exist at this stage, but the possibility must be examined.

Managing and Operating Systems

Having examined the goals towards which the hospital was working, it is possible to examine its organization in terms of consonance or dissonance with them. In general terms, a distinction is made between managing systems and operating systems[1].

The operations of an enterprise may be seen as import, conversion and export, or in terms of patients and a hospital, admission, treatment and discharge. Some of the sub-systems within the hospital (units, divisions departments) will be concerned with one or other aspect of these operations. They are concerned with the direct execution of the task of the enterprise. These are called operating systems, as distinct from managing systems. A managing system emerges when the work of a system becomes too complexion for its direction, coordination and control to be undifferentiated, that is carried out by people working directly on the operations of the system. When certain roles emerge which are not part of any one operating system, but concerned with control, service, coordination and direction, they constitute a managing system.

1. Rice, pps. 40-47.

A complex organization will consist of several orders of sub-system (Fig. 3). The first order managing system will consist of the head or heads of the total enterprise and the heads of each operating system, together with the staff of any service function controlled at that level (say personnel, research and development). Each of the first order operating systems may be differentiated itself into a managing system and a number of second order operating systems. The head of this system will be a member of the first order managing system as well as the head of a first order operating system. He will be head of a second order managing system, but not of any of the second order operating systems. The division can continue until a primary working unit is reached where management is internal, that is, the head of the unit is a member of it, and there are no subdivisions.

We may begin now to examine the first order systems of the hospital. This would seem to be a simple matter.

The First-order Systems of the Hospital

The first order analysis can best be approached by considering the routes through which patients entered, passed through and left the hospital (Fig. 4). Most of the analysis will be of the organization of work in relationx to patients, not in relation to other imports and exports such as staff, money, and materials, although they will be mentioned where relevant.

Patients entered the hospital by way of routes. One was through outpatient clinics held by the medical staff in general and other hospitals in the 'catchment' area, which included the boroughs on both banks of the Thames from Kensington westwards to Richmond and Barnes. A second route of entry was direct through domiciliary visits paid by hospital staff, in response to requests from general practioners, ex-patients, and various health service agencies. A third route was by transfer from other mental hospitals. A fourth was direct, by application for admission as voluntary patients, referral by medical sources, as non-statutory patients, admission as certified patients, or short-term emergency admission (for three days) under Section 20 of the Mental Health Act.

These routes are arranged not in order of frequency or importance, but a proximately in order of the degree of control exercised by the hospital. Legally, the Physician Superintendent xx possessed complete authority to control admissions. Pressure would be very great on him to accept an emergency admission under a 'three day order', designed to place an acutely disturbed

patient under observation rapidly, but in fact some control could be and was exercised over all admissions.

Patients passed through the hospital in one of its main divisions, Female, Male and Downview (non-statutory) or Freedown (tubercular) or were treated at outpatient clinics. The area labelled 'Domiciliary Support' in Fig. 2. refers to treatment in homes, visits by nurses, P.S.W. or medical staff, and the 'meals on wheels' service begun by the hoppital for old people in the locality. All patients were discharged or would inevitably be discharged, and again the Physician Superintendent controlled discharges.

The first order operating systems of the hospital included all these routes, but the way in which they were differentiated did not correspond exactly with the routes. Before examining their differentiation it is now possible, having considered the aggregate of operations, to analyse the first order managing system.

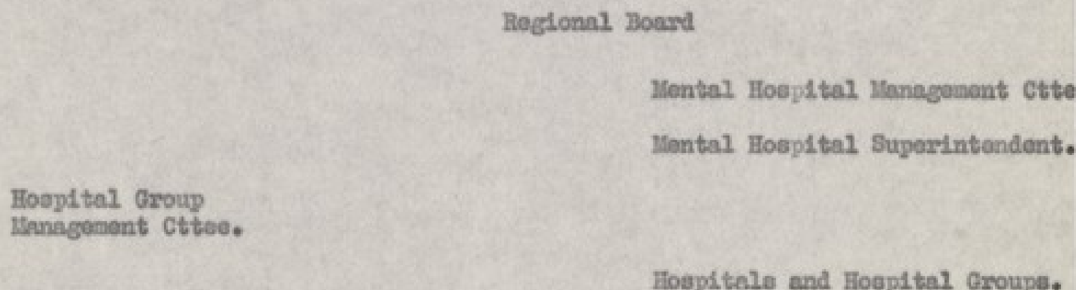
First Order Managing System

Already we have seen that the Physician Superintendent was by virtue of his legal position in charge of all contacts with patients. As a first step we can set up the managing system as controlling all the operations and with the Physician Superintendent at its head. The position of the Hospital Management Committee must be examined. It would seem that it forms the topmost management of the hospital, and should thus be included in the Physician Superintendent area in Fig. 3. Reference to the control of imports, conversion and exports immediately xxxxx throws doubt on the extent to which the Management Committee does in fact manage the activities of the hospital. A medical officer working at an out-patient clinic is not undertaking a separate part-time contract with the hospital visited. It is not quite clear to what extent his responsibility to the Physician Superintendent differs from what it is in the hospital, but it does seem clear that the Management Committee has no control at all, especially as it does not employ him. Similarly, domiciliary and community work outside the hospital does not seem to be controlled by the Hospital Management Committee. Apart from any question of its constitution and frequency of meeting, it cannot on this count really be considered the Management Committee. The Regional Board is the effective next level in the National Health Service hierarchy, but from the point of view of the hospital as an enterprise and an open system it must be considered part of the environment

of the total system, not part of the first order managing system.[1]

If the Management Committee is not the top management group, what is it? To some extent it is in the environment of the hospital as a part of the higher order managing system headed by the Regional Board. If the whole Hospital Region is regarded as a system, then hospital and hospital groups become 1st and 2nd order operating systems. The Hospital Management Committee would thus be a control and service function within the managing system area, and not the head of the hospital area (Fig. 4). It should be noted that in hospital groups other than Mental Hospitals, the Hospital Group Management Committee may well be in fact the management of the hospital.

Fig. 5. Possible Higher Order System



Further, to some extent the H.M.C. seemed to act as something of an advisory group for the Physician Superintendent, giving him some further contact with the environment. When it appointed administrative staff it could be viewed albeit 'unconstitutionally' and contrary to formal requirements, as acting in fact as part of the Physician Superintendent's managing system, that is, as a control and service function within the hospital.

The roles of Physician Superintendent, Deputy Physician Superintendent, and three consultants in charge of divisions, were held by three people. As both the Physician Superintendent and Deputy were each in charge of divisions, it was inevitable that the activities of the two divisions were more closely associated with overall hospital policy considerations.

An attempt to divide the hospital's senior roles into the heads of service and control functions within the managing system and the heads of first

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1. If the whole Hospital Region is regarded as a system, then hospitals and hospitalx groups become second and third order operating systems.

order operating systems immediately shows that the organization is confused. That is, it is confused according to current functional requirements, but it is quite logical and straightforward when judged according to traditional-historical criteria.

Operating systems can be differentiated by technology, time and territory, as discussed by Miller.[1] The technological criterion is easy to understand in certain industrial situations, where for instance, different departments of a factory handle different products or carry out different processes such as forging, machining and assembling. It has been suggested by other writers that other criteria are needed to account for all differentiations, e.g. by chart and purpose (?). For the purpose of this paper, 'technology' is interpreted widely enough to include differences in technique (e.g. nursing and medical treatments) and differences in the kind of patients dealt with (e.g. by age, type and severity of illness). A nurse moving from an active treatment reception ward to a sick and senile ward is, for our purposes here, meeting different technological requirements, as well as changing her territory, and maybe the definition of her task by time (shift hours).

Miller has argued that division between operating systems work more effectively when the criteria of division follows a natural line of cleavage in the total task - by territory, time or technology - and especially if two or more of these coincide. If units are grouped together in a way which violates the functional relation, the effectiveness of their management will suffer.

It would appear that the medical and nursing services were operating systems differentiated by technology, and that any division according to work-place and work-time were secondary. Thus the two first-order operating systems would be medical and nursing services, with specialist ~~xx~~ and administrative departments acting as service and control functions at hospital level or lower.

Against this interpretation can be placed the tendency in the hospital to regard it as organized into three divisions in the charge of medical officers, with two of these (Female and Downview) more closely linked especially as far as nursing services were concerned, because female nurse s under Matron served both. If this were so, then the Chief Male

Nurse would be an appointment within a division, and Matron would in effect hold three appointments, one at hospital level concerned with training, and one in each of two divisions as executive head of nursing services.

It is suggested that the difficulty in interpretation is not due to the inappropriateness of the interpretative method, but that there existed a real confusion and difficulty over the relations between the medical and nursing services. The problem of the appropriate location of specialist and administrative functions will be left aside as easier of resolution, and attention concentrated on the control of medical and nursing services within the female division. A starting assumption will be made that the first differentiation in the hospital was between medical and nursing services (technological). The second split on the medical side was that between divisions (technology reinforced by territory). The parallel split on the nursing side was obscured by the operation of the night shift, for the night services concerned both Downview and the Female Divisions in one command. This suggests that the split was according to time, but this line of cleavage would be so weak naturally as to indicate that it is inappropriate, or not in fact an operating differentiation at all.

Second Order System - Female Division

The activities of the division were controlled by the Consultant in charge and Matron. The Consultant had responsible to him the medical officers, and Matron to her the Assistant Matrons including the Night Superintendent, and also her Deputy, the Senior Assistant Matron and Sister Tutor. Thus the management of the Division was divided. It could not be said that the one was fully subordinate to the other, formally or in practice, nor that they acted as a pair, discharging shared responsibilities with some division of labour. Some of Matron's subordinates themselves controlled activities outside the Division, but even if her role were divided into 'Hospital Matron' and 'Divisional Matron' it was still by no means clear that she was subordinate to the Consultant.

The split in control ran right through the Division, but lesser-order differentiations were not parallel between the two hierarchies. This was so at the beginning of the study, though they were brought into line later on. Thus, at the beginning, Medical Officers areas of responsibility did not correspond with those of Assistant Matrons. Medical Officers worked single shift days, and Assistant Matrons double shift days, thus introducing an extra criterion of differentiation on the nursing side. It was at the level of the ward, not the group or ward block, that it could be said that a certain doctor and a certain pair of sisters were in charge.

Nurses on a ward worked under the direction of the ward sister with relatively little by-passing contact with more senior people. Sisters, however received directions from the ward medical officer, the assistant matron and directly from the Consultant. They had direct contact too with Matron. The increasing intervention of the medical staff in ward activities followed from their increasing participation in treatment and increasing interest in the social milieu of patients. The role of assistant matrons was changing and they were by then not the only bosses that sisters had.

Figure 6 shows the resulting pattern of control. This should be contrasted with the 'typical' paradigmatic model in Figure 1. Several questions immediately are raised. What is the relation between consultant and Medical Officer - is this truly an executive hierarchy? Similarly, is the Medical Officer truly the executive manager of the ward? What then of the Assistant Matrons and more senior nurses.

? It is at this point, when executive control is discussed, that many medical men seem to shy away. It is not suggested at this stage that wards or similar units should be under the executive control of the doctor, but it is suggested that they are in fact under the executive control of some person or persons, and that various implications arise from the various alternatives possible.

It can be predicted from Figure 5 that a point of strain emerges in the organisation along the boundary

between sisters and assistant matrons.

This is the area of greatest distortion in the organisation, judged by the criterion of the paradigmatic Figure 1. No fewer than four superior influences bear upon sisters, instead of one. The assistant matrons are the only group with neither representation at the top (managing) nor at the bottom (operating) boundaries of the system. It is not that this "land-locked" state is inappropriate for middle executive levels, but rather that if no other group is in this position, forces exist to enhance the isolation and impotence of this group. At the line where the "multi-based" sisters and the "isolated" assistants matrons meet, there is bound to be strain, for this is the line along which executive authority is weakest. If the assistant matrons are by-passed all round, how can their authority remain unimpaired?

It can be seen, too, that it is extremely difficult to say which areas represent managing functions and which operations, that is, who is really in charge of whom.

The diagram looks skewed, as though the medical areas have encroached over the nursing. It is suggested that historically this is precisely what has happened. A straight division between medical and nursing services without overlap would seem to be the simplified starting point of the change, but this is not in fact a possible arrangement for a single enterprise. It is rather the juxtaposition of separate systems. What seems to have been happening in fact, is that alternative forms of organisation were in conflict, as the medical staff moved from service and control towards a management function.

III Analysis of Possibilities

Initial State and Competing Influences

There are in hospitals relics of the mediaeval religious foundations run by nursing orders of nuns. Matron or Mother Superior, and the Sisters retain their titles and are distinguished (on duty) from each other and the "Novices" by their different coloured garbs and head-dresses. It has become ~~a~~ less frequent in the past few years to see the long hood-like head-dress, and nurses are becoming more like other workers in protective closing, but on the female side the influence of the long tradition is plain. Male nurses

are not at all monastic in garb, title or history, and there is no Florence Nightingale tradition. They bear much more resemblance to army stretcher parties and orderlies, and in that sense are close in tradition both to the surgeon and the patients.

Nursing orders of sisters had less pragmatic and prosaic aims and ideals. They ministered to the body because of the soul, but were not fully equipped for all contingencies, needing the more professionalised, privileged and powerful help of the priest and maybe the surgeon. The organisation stemming from this practice was that of a residential institution administered, controlled and operated by the nursing staff, who recognised the pre-eminence of the male visitors, but whose activities could not be said to be under visitors' control.

In modern secular hospitals this organisation persists in some degree where female nurses are concerned, and the organisation of male nursing services is substantially modelled upon the female. Modern nurses may not think of themselves as mediaeval nuns, but the form of organisation which persists from those times may be the source of anomalies and difficulty in some hospitals today. The persistence of the notion of a nurse-directed community was greater in mental hospitals than in general hospitals until recently, but the changes in psychiatric method-policy are likely to produce more fundamental disturbances of this pattern than has occurred in general hospitals. Mediaeval interception has been more active for a longer time in general hospitals. There too, the idea of the dedicated, educated woman acting as the doctor's right-hand woman has gained ground. Perhaps the theatre sister is the popular image of the true nurse, even more than that of the lady with the lamp. Even so, all the greater intervention of doctor with patient, and the greater deviation of nursing techniques from medical, doctors in general hospitals seem recently to be no more likely to be concerned with organisation and management.

A form of nurse-directed community would seem to be the system which

existed at Banstead, and probably other hospitals, before open wards, and active treatment became fashionable. It is referred to here as the "simulated nursing home" for reasons which will become clearer after a closer examination of nursing direction under modern conditions. In the hospital working with this structure, the Physician Superintendent will be the chief executive, and the Matron, Chief Male Nurse, Secretary or Steward and other specialists will all be his subordinates, and act only with his authority. The bulk of the task of operating the hospital devolves upon the nursing staff. It is they who are in daily contact with patients, who know them best, who see to their needs, keep account of their activities and do most of such treatment as there is available. Medico-legal responsibility is rested in the person of the Physician Superintendent, and medical staff act as his aides. Through them he discharges his responsibility, and they, not the nurses, are liable to be called to account in litigation, but their responsibility is proscribed. They have little control over what happens to most patients beyond allocating them to particular wards, taking care of their physical condition, and receiving their cases periodically.

Essentially, the whole medical staff are located in the hospital managing system, and provide, on the authority and on behalf of the Physician Superintendent a service and control function. They do not take full command of operating units. It is common to hear doctors in such a hospital refer to many points of management as being "Matron's province". They"visit"the wards to see their patients, just as a family doctor might visit a family, or a school or factory doctor might visit school or factory. In these latter cases no-one would assume a claim that the doctor was in charge of the patients and the organisation except to a limited extent. Certainly an "old style" mental hospital doctor has more control than this, but the parallels are closer than those with a parent, head teacher or

factory manager. As the primary task of a mental hospital changes, as it did at Banstead, so the organisation changes. In formal, establishment, terms the number of assistant matrons there declined as wards were opened. Even more marked were the changes in managing roles. The intermediate state of organisation described shows signs of the original forms of organisation jostling as it were, for ascendancy with some variety of medical direction, and with the consultant's emergency system described above. Four possible systems will be discussed separately to bring out the implications if any one or pair were to become the resolution of the existing strained system.

Nursing Direction

Under this system, although the hospital would remain under the control of the Physician Superintendent as long as his statutory position remained, the wards, blocks and divisions would be under the control of nurses, sisters and matrons. The whole hospital could logically be under nursing control in which case, the Physician Superintendent would stand in the position described below for other medical staff. Medical staff would occupy roles in control and service functions within the hospital and sub-unit management systems. Rice has pointed out that if such control and service functions are located above the level of system in which they operate, then there is an implied lack of confidence in the management of that system. In this case, if matrons and sisters were to be in charge of their work, then doctors would be attached at the level at which they worked. Thus senior medical staff concerned with hospital policy, such as the Deputy Physician Superintendent, would hold (occupy ?) roles, as now, at hospital level. Consultants with divisional responsibility would be the subordinates of divisional matrons, that is, of the Chief Male Nurse for the Male Division, and of Matron in the other divisions separately.

They would be her consultants. Other medical officers would be similarly attached at block or ward group level, under the appropriate block matrons, that is, roles developed from those of present assistant matrons.

The implications following from this system would be as follows:

1. The executive nursing staff would carry the responsibility for the welfare of patients, and control the donditions under which patients lived. Specific medical responsibility could be retained by doctors, the relation existing being like that between factory doctor and factory manager, or military unit commander and unit medical officer. Inevitably, these responsibilities would be limited in relation to the whole of the life space of patients.

2. As doctors would be advisers to the executives it would not be incumbent upon the executives necessarily to act upon the doctors' advice. Executive nurses, if they were truly in control, would decide for themselves whether or not to accept medical advice in any specific instance, and would be quite entitled to reject it. If advice were mistakenly rejected, and some harm resulted to patients, other staff, or property - that is, if there were some failure with respect to the tasks of the enterprise, then the executive nurse, would be called to account for this failure. If she or he accepted and acted upon bad medical advice, then again she alone would be called to account for the failure, and the doctor could be called to account by her alone for his failure. She would appear in court, not the doctor.

3. The function of doctors would be to advise the executive nurses in charge of the units to which they were attached, and to be responsible to them for the administration of medical treatments to the patients resident in these units. They would not need to be concerned with arranging for staff to be on duty, seeing to curtains, meals, pots and pans, but would

be free to offer advice or request action on these things. They would maintain technical liaison with each other, and would plainly be an extremely powerful group.

4. The consultant attached to the Division would not be in charge of it. Therefore he would not be in charge of junior medical staff. His relation with them would be limited to training, technical consultation and maybe the operation of a second appeal channel. He might well, and would, probably, arrange the deployment of doctors to units, and allocation of patients to doctors, but the postings and allocations would be madeby Matron on her authority. Junior executives might well ask for the substitution of their medical officers, and it would be for Matron to authorize or refrain from authorizing this, even if she delegated this authority to her consultant.

5. The responsibility for the provision of nursing and medical attention for twenty-four hours of the day would rest with nursing executives unless the night shift were organised at hospital level. There is no reason why it should be organised at that level, so the choice of level is between division, ward group and ward. There would be no role at ward level which could carry on twenty-four hour responsibility unless sisters did not work shifts. Even if this were so, the staff group would be too small to allow flexibility, and as in some cases the night nurse looks after more than one ward, difficulty could easily arise. A night staff arranged at divisional level, and responsible to divisional management would imply lack of confidence in group management. The appropriate level would therefore be that of block or ward group. Block, or Group Matrons, could hardly work shifts ân this case. One matron, or possibly an equal-status pair, or a Group Matron and Deputy, would have to carry twenty-four hour responsibility. This is an inevitable implication of being "in charge" of the ward group, and not "partly in charge" for some of the time. They would not necessarily have to work all hours of the day and night, but it wuld be their responsibility to see that

staff were on duty not only by day but by night. They could arrange any series of cross-checks, or any type of handing-over routine as long as it worked, and they would have to arrange for help to be on call. If "on-call" medical help were arranged at divisional or hospital level, the duty doctor would be responsible at that level, but the group executive would be responsible for seeing that he were called when necessary.

There are some features of this system which plainly present great difficulties. It is unlikely that senior doctors would be content with it, though juniors might be, as it might mean relatively few changes in their actual responsibilities in spite of the apparent diminution af in status and authority. The pay scales at present in force would not help the task of finding suitable senior nurses for the executive roles, for these roles would provide highly responsible posts deserving of salaries more akin to medical than to nursing scales. It would be difficult for outside authorities, especially courts of law, to accept that the treatment received by a patient was given on the responsibility of a nurse, and however closed the hospital system might be vis-a-vis its environment, this degree of departure from expectation would conflict with its primary task, be that active treatment or custody and retention.

The system has many features which are not impossible or alien to present practice. The idea that control of nursing staff should be in nursing hands is generally acceptable. It is tempting to think that it would be a rash nurse who went her own way when in disagreement with a doctor, but this possibility is not so far-fetched if one thinks of an experienced, knowledgeable assistant matron who has held an appointment for some years, and a young junior hospital medical officer who knows as yet about as much psychiatry as the gate porter and will probably leave his job in two or three years. If he were in a consultative capacity with

technical support from consultants it might be a saving of embarrassment for it to be clear that he was not expected to be "in charge" of a ward,, but to carry out a medical practice there.

The notion of a nurse-directed community is, however, unlikely to be workable if it includes doctors within it. Under modern conditions it makes more sense to think of a nurse-directed enterprise supporting and providing a setting for the doctor's practice. The nearest working variety of this type of organisation is the nursing home directed by a Matron. Here she is in charge of all the activities of the home. Patients maintain two sets of relations, one with the nursing home and one with their own doctors, who visit them there. The link between home and doctor dervies from the separate contract each makes with the patient. The doctor could withdraw his patient without needing the executive permission of the home. The home provides a service to patient and doctor on its own terms.

The essential characteristic of the nursing home arrangement is that the doctor is not employed within it, and does not occupy a role within it, but is part of the environment of the home. In a mental hospital, only a simulation of this arrangement is possible, in the form of organisation. The simulation of the nursing home pattern is weak, for although wards and ward groups would be nurse-directed and doctors would be in their evnironment, in the first-order managing system, they would not be acting as independent agents but as staff officers for the medical superintendent. They would be responbible to the head of the enterprise, as Matron would be.

With both the "simulated nursing home" and the explicit nurse-directed community, the question arises of the primary task to which they are best ~~mixxxxxx~~ adapted. Neither allows the doctor the

opportunity to direct staff activities in relation to his patients except in a very limited sense. They do not allow the medical group with other colleagues to initiate social change as part of the treatment process. They are essentially adapted to the custodial-retentive task of the enterprise.

Medical direction

Under this arrangement at hospital, divisional and ward group levels the command is vested in medical officers. The arrangement is not, it will be seen, a simple reversal of the pattern of nursing direction, for the ward group is the smallest unit for which there would be available the full-time services of a doctor. The implications of the arrangement are, however, the converse of the implication of nursing direction.

1. The medical officers would be responsible not only for the specific medical treatments administered to patients, but for the control of the environment in which patients lived. Thus doctors would carry responsibility fot the discipline, deployment and work of the nurses under his command.

2. Assistant Matrons or Group Matrons as they might be called, would be advisers to the medical officer. It would not be incumbent upon the medical officers necessarily to act upon the group matron's advice. They would be entitled to direct departures in nursing practice if this scope were allowed to them by their senior, the Consultant-in-Charge. They would be answerable for any incompetence in nursing resulting from their policy.

3. The function of group matrons would be to advise the doctors in charge of the units to which they were attached, and to carry out such executive nursing duties as were delegated to them. It would be expected thatthey would continue to be concerned with nursing, personnel matters such as deployment, discipline, appeal, and with supervision and perhaps training. In all these matters they would be responsible to, and be acting under the direction of the medical officer, not the Matron. Within

each ward group, the managing system would include the medical officer as its head, and the group matron as the head of one operating system - nurses and domestic staff. The other operating system - medical services - would be represented by the medical officer himself. Specialist services might be located at this level if convenient for operation, in which case they would become either a service function to the M.O. or another operating system. Occupational therapy, if operating on wards or within ward groups, would be an operating system parallel to nursing.

4. The division would be under the command of a consultant He would be in charge of junior medical staff, but only through them of group matrons and sisters . The divisional matron, whose role might be taken by the hospital matron or by a more junior matron, would be entirely responsible to the consultant, and would not be in charge of group matrons. She would be his adviser on nusring matters and would be concerned with administrative arrangements and training, and could play a valuable role as a consultant in the literal sense to more junior nurses, and as a person through whom personal appeals could be directed if the first appeal through the executive chain left the appelant aggrieved. In receiving any reports upwards she would be acting as the consultant's assistant or staff officer. She would not carry authority in her own role. Instructions on nursing procedures would be issued by the Consultant, or by the Matron on his behalf, to the medical officers, not by Matron to group matrons. At hospital level Matron's role would again be concerned entirely with the provision of a service to staff, not with direction of an operational hierarchy.

5. The night shift of nurses would be arranged on the responsibility of the medical officer if it were decided to organise it

at that level. Group Matrons could continue to work shifts, though they might be of more service to their medical officers if they did not.

There are features of this system plainly likely to cause difficulty. If the executive hierarchy is occupied by medical officers, it means the abolition of the nursing hierarchy at top level. It is suggested that in the state of affairs existing at the time of the study, this hierarchy was either redundant or maladaptive. The tasks carried out by senior nurses could in fact be carried out by clerical staff, leaving the senior nurses available for involvement in policy planning and control at a far higher level of responsibility. As the most senior and experienced nurse in the hospital, Matron would be expected to carry great influence over nursing matters under any system, but if a system of medical direction were adopted she could not carry executive responsibility, by definition.

Medical officers would carry far greater management responsibility than their training or terms of employment envisage. Here in fact is the greatest defect of such a system. It is highly doubtful that a young psychiatrist could in fact take command of a community of some 100 - 150 patients and 20 - 30 staff. The demands on his time for training in straightforward psychiatry would seriously interfere with his freedom of action as a manager. Further-more, with such short tenure of junior and senior registrarships, he would leave when he was about fit to manage, and be replaced by another novice.

Yet if a medical group wishes to engage p in active community treatment, an effective flexible management structure is required. At Banstead, effective management occurred in spite of the system, and, in fact, in violation of it. Such an unstable equilibrium depends for its survival upon the force exercised by the head of the system. Change the incumbent of the role, and the system becomes open and fluid.

Greater reliability is needed in the very structure itself. So far it seems that a "simulated nursing home" and a pattern of nursing direction are essentially adapted to the wrong primary task, and that a system of medical direction could hardly be staffed in its simple form under present conditions.

There are, however, two remaining possibilities, a modified or partial medical control, and a pattern of joint medical/nursing control with shared responsibility.

<u>Partial Medical Direction</u>

This possibility is distinct from the existing situation in that there would be no ambiguity, but leaves the control of the system in medical hands at a level where the responsibility can be carried.

The hospital and divisions would be under medical direction. Ward groups and wards would be under nursing direction. Nursing staff at divisional and hospital level (matron, deputy, senior assistant, sister tutor, chief male nurse, his senior assistant) would act in advisory capacities, as described under the system of medical direction. Assistant or group matrons, and ward sisters would act in executive capacities, as under the system of nursing direction. Junior medical staff would be on the staff of the seniors in charge of divisions. They would act with the senior's authority, as his medical team. They would assist him in his medical work in the wards he controlled through his executive nursing subordinates. Responsibility for the medical policy and practice would rest with the consultant, who could vary the amount of scope allowed to juniors, and the demands made on them according to their capacities and stage of development. One or more could act, in addition, as his deputy or assistant in technical management. That is, they would stand in for him in his absence, or help him, in his task of running the division through matrons and sisters.

The relations between senior and junior divisional medical staff are not new in medical organisation, as far as responsibility for the treatment of individual patients is concerned. It is simply the relation between consultant and registrar, strictly speaking. What would be new in this system is the division between junior executive nurses and senior advisory nurses. This is the necessary implication of preserving the consultant-registrar relation together with giving the consultant executive managerial responsibility for the wards he works in.

Joint Medical-Nursing Direction

If senior nurses and junior doctors are not to be solely in advisory capacities, yet if neither junior doctors nor assistant matrons are fully capable of taking sole executive charge of ward groups, then shared responsibility is a possible resolution (?). Occupancy of a management role by more than one person is not at all impossible. Pair or group management with collective responsibility is seen partially in cabinet government, tribunes, and some forms of industrial organisation. This is not committee management, nor an arrangement of manager and deputy, or manager and assistant. Both incumbents together are accountable to seniors, and required to discharge certain obligations.

Such an arrangement applied to a mental hospital would place a doctor and a nurse jointly in charge of an operating unit. Taking Banstead again as the example, the hospital would remain under medical direction, although logically it could be under joint direction. The divisions of the hospital could be under joint direction unless, again, an advisory role for divisional level nurses were arranged. Ward groups would be under joint direction, but wards under nursing direction. Joint direction of a ward group by a medical officer and a group matron would carry the following implications.

1. The doctor and matron would be jointly responsible for

the complete running of the ward group in relation to patients. They would share responsibility for the work deployment and discipline of nursing and other staff.

2. Neither would be in advisory capacity to the other. Decisions on action would need to be joint decisions, and both would be held to account if anything went wrong, and would both receive credit if things went well. The doctor would be as responsible as the Matron for what the nurses did, and could not claim that their activities were her affair. It would be open for either of them to appeal to his superior (the divisional consultant or consultant and matron) if he felt that their joint task was being hampered by their inability to agree. Clearly skill would be needed in arranging the pairing, and in working the arrangement. Their seniors would need to adjust to the notion that both juniors were involved in all decisions. This does not mean that they each need, formally, to discuss everything they do with the other, or that advice, requests, demands, congratulations, rebukes or abuse from seniors should be formally passed on to both. They would not be Tweedledum and Tweedledee but what they each did would be required to be in accordance with what they understand as joint policy.

It is to be expected that they would each carry out tasks for which they were best adapted, but in each case the other partner would be the person with whom agreement should first be sought. It is clear that group (assistant) matrons could not work shifts, but that they and doctors should be subject to the smae overall requirements.

3. The same considerations would apply at divisional level if consultant and matron shared responsibility, but if the consultant alone were in charge, he alone would be in a position to direct the activities of the pairs of subordinates. The relation between matron and group matrons would be one of technical liaison and advice. Allocations of group matrons to doctors, and vice-versa, would be made on the authority of divisional management, joint or single, but in either case, both consultant and matron would be involved. Divisional management would be in control of ward

activities only through the ward group pairs.

4. The pair in charge of a division would be required to arrange twenty-four hour service to patients. With two people available it would be easier to oversee shift changes, and for one to be on call or to call in at nights occasionally. If for some reason, one were to work a night shift, the other would be available during the day. Either could carry on when the other was away on divisional or hospital business or at conferences and training courses.

Joint direction would be the most unconventional and unusual of all the possibilities suggested. It does not become unworthy of consideration because of that. Two people in charge of patients' welfare would present the patients with opportunities for splitting. There would probably be great pressure on the pair to split, not only from the patients. The adoption of an explicit policy and practice of shared direction would demand that the pair were alert to such pressure, and it would be their task to deal with it. The opportunity for splitting would certainly be there, but so would the opportuhity for doctor and matron to become aware of it in specific instances and to use their response as a therapeutic aid. Divided control with confused and ambiguous responsibilities and long channels of communication enables patients to maintain splitting mechanisms with impact with contrary reality. If there are the equivalents of father and mother, there is some point in putting them jointly in charge and ensuring that they are not in fact split. The decision about adopting this system might depend to some extent upon the therapeutic orientation of the hospital involved.

Choice of Alternative

It is suggested that the situation described at Banstead, particularly in the Female Division was a simultaneous operation of two incompatible forms of organisation with the occasional addition of a third.

The first was the simulated nursing home with all doctors located in fact in the first order managing system. The second, newer (?), was the system of medical direction and the third, in the Female Division, the "consultant's emergency system" which amounts to a de-differentiation of the division so that at times the hierarchical structure is lost as far down as ward sister level. Four possible resolutions of such a state have been described, in general terms, using Banstead as an example, and some implications have to be pointed out. They are an explicit system of nursing direction, an explicit system of medical direction, a horizontal división between the two with medical direction at senior level and nursing direction at junior, and a fusion between the two. These systems are incompatible and cannot operate simultaneously in the same area, but different systems might apply in different areas. Horizontal division has been mentioned, and there exists too the possibility of vertical division. That is to say, different orders of managing system might be staffed differently, and so might different managing systems of the same order.

Choice of alternative may depend upon overall policy and aim, and upon particular requirements in particular areas. There is one characteristic which all four possibilities share. In each case there is only one hierarchy, and a clear distinction between management and operation. People of different professions may occupy management roles either singly or in pairs, but in each case there is a clear management role. In considering the factors governing choice of alternatives we may consider the requirements of roles at different orders of system and the possibilities of redefinition as therapeutic policy changes, and we may look at the availability of suitably trained people in the medical and nursing professions.

First-Order Management

There is a need for a person or persons to direct the entire activities of the hospital. In mental hospitals this role is defined as

one to be occupied by a management committee and a medical practitioner acting as Physician Superintendent. The constitution and perview of the Management Committee do not predispose it towards being an effective management organ, and it is best regarded, probably, as a control function with regional managing system. It is not logically required that a medical practitioner should be in charge, but in considering alternative arrangements, the need for overall direction is sometimes overlooked. The post of medical superintendent is subject to attack from medical and lay quarters. In hospital administration literature (F.N.I.) and in Parliament (F.N.2) it has been suggested that doctors im should not need to be concerned with "administration" (A & Q in military terms) and that consultants do not readily accept that their activities should be subject to direction by a medical colleague. A lay administrator, it is argued, may do the job better, advised by a medical committee,or the function of a superintendent should be limited and the post held for only a limited time. In arguments like this, there seems to be a confusion between full management and the administration of finance, stores, transport, secretarial and office services, or what would be described in industrial terms as a confusion between general and commercial management. It may well be pointless to expect a senior medical manager to spend much time on petty details of "administration" in the limited sense, but it may fairly be argued that the proportion of his time which should appropriately be spent on management might be anything from 50% to almost 100% depending on how much time he spends himself on the personal treatment of patients. There is a further confusion between the usefulness of a role, and the performance of a role by particular incumbents. Some physician superintendents or medical directors may not be particularly good at delegating responsibility to consultants, but some are, and in two institutions at least (Banstead hospital and the Tavistock Clinic), consultants do not complain on this score. Some physician superintendents

may not in fact be very good at managing at all, so that there is no reason why consultants should regard them as having any pre-eminence. The implication of not recognising a directive is that the whole consultant group be held collectively responsible for the complete activities of the hospital. This is a possible arrangement if the group is viable. (It is the system used by the T.I.H.R.)

Any hospital could be run by any person or group of persons capable of discharging complete management responsibility in what is after all a medical institution. It is suggested here that the mental hospital appointment of a physician superintendent with full authority is the one best adapted to efficient management. It is not necessarily entailed that he retain personal responsibility for each patient. This responsibility can be delegated to whomever is in effective control of treatment, as the new M.H. Bill provides.

Commercial management in the mental hospital is thus inevitably a service and control function either at first order or lower orders. Confusion should arise at first order only from a dual appointment of the same man as hospital and group secretary where there is only one hospital in the group, or more so in the particular hospital in which the dual appointment is made where there are a number of hospitals in the group. If any services in this area were decentralised, then they would become the responsibility of second or third-order management.

The location of senior nursing roles varies according to whether the second order systems are under medical, nursing or joint control, and will be examined later.

Second-Order System

The Manager of a main hospital division must be a general manager in the same way as the hospital manager with some possible exceptions - Nursing training, the administration of staff residential

accommodation, and secretarial and administrative services might be all arranged at hospital level. On grounds of general policy it would be advantageous to locate some of these as near as possible to the scene of operations, in which case the scope of divisional management would increase. At present at Banstead there are four de facto divisions but only three consultants. There would be arguments on technical grounds for subdividing the work of the hospital into more than these divisions, or for subdividing each division into units larger than the existing ward group or block. This possibility is relevant to the consideration of the most suitable appointments to divisional management for it would demand more hierarchical levels of appointment than present nursing scales admit, or a greater preponderance of senior medical staff than at present exists.

Consultants are the only grade of medical staff who have sufficient experience and seniority, and whose salary scales are at all consistent with the management of the larger divisions. Both they and Senior House Medical Officers might manage intermediate subdivisions or smaller divisions, depending upon the size and technical demands of the units. Yet there are not enough consultants to man all the necessary roles.

It is debatable whether or not senior nurses (matron, deputy, senior assistant) could command divisions jointly with consultants, but it seems unlikely that they could command them by themselves. Their salary scales do not provide sufficient remuneration for either of these roles. (Matron's maximum £1.195, Deputy £810, Senior Assistant £685). Joint Managers could not receive widely discrepant salaries, and a manager could not receive less than her subordinate. Furthermore the training and experience of senior nurses does not as a rule prepare them for this sort of responsibility. Earlier it was suggested that full-scale responsibility was incompatible with the newer primary task of the

hospital. These considerations taken together make it clear that divisional management is inevitably under present conditions to be discharged by medical staff of consultant rank.

What then of senior nursing staff? So far in the consideration of alternatives, the points made have seemed to the writer to be legal requirements and inevitable implications of present conditions. More scope for action appears from now on, and it is not the aim of this paper to make recommendations in public to Banstead hospital. The alternatives have been discussed, and are illuminated here in case their examination should illuminate the work of others.

Some nursing functions would seem to be hospital first-order service functions, such as nursing training and the administration of the nurses' home. There is no a priori reason why the latter should not be part of the secretarial and administrative services, but the former seems to be in the natural place. There is need for control of this function and, more so, a need for senior nurses to participate in hospital policy planning.

It is questionable whether or not there need be two parallel nursing hierarchies (Matron's and Chief Male Nurse's), any more than parallel nursing and medical hierarchies. Certain units of the hospital, such as the Male Division and Freedrun (?) Hospital may be staffed by male nurses, but if a unified medical-nursing hierarchy were introduced throughout the hospital it would simply mean that certain nursing posts would be occupied by men and some by women. At hospital level there would need to be a person acting as a chief nursing officer. The incumbent might have a deputy or assistant, who could be of the opposite sex and be next senior in status, but the work might demand only an assistant, not a deputy, of a status about that of a sister. There may not in any case be any advantage in the traditional but ambiguously

defined roles of matron and chief male nurse. At the moment a matron earns more (£1,195) maximum) than a chief male nurse (£1070 maximum), but if this sex-distinction proved to be irrelevant to the structure necessary to fulfill the defined task of the hospital, it might make good sense for the roles of chief nursing officer and, say, the deputy chief nursing officer to be open to either sex.

The role of chief nursing officer discharging a service and central function in the hospital managing system would need to be different from that of conventional matron. It would be akin more to that of an industrial personnel director or technical director. The task would be to provide for the operating units of the hospital or trained and deployable nursing staff, and to advise on the best use to be made of them. This would involve arranging recruitment, ? formal school training, deployment to units for terms of duty, arranging for replacements or exchanges on the request of nurses or executive nurses and doctors and (for they would be responsible for a nurse's activities and would thus be able to dismiss a nurse from their unit subject to the prevailing availability of replacements) devising training and development activities for senior and executive nurses, consulting on promotions, providing technical and professional advice to nurses, providing an alternative appeal channel for nurses and acting continously as the physician superintendent's nursing adviser. The range of activities, power and influence on major matters would probably be greater than under the present "pseudo-executive" arrangement, but the concern with minor details of houskeeping would diminish.

If these services were provided at first order level, and if divisions were medically directed, there arises the question of second-order nursing advisory roles. At present these are discharged, along with quasi-executive divisional functions and hospital function, by matron, chief male nurse, deputies and senior assistants. Only the first,

or perhaps second of these establishments would be required at hospital level, leaving the others available for divisional service. However, what might be needed is a number of appointments of equivalent rank, differing in maximum salary and range according to the particular responsibility involved. The Female Division, being the largest, might profitably use the Chief Male Nurse's appointment, but here again is the persistent conflict between requirement for new conditions and traditionally rooted regulation. A drastic re-scaling of all senior nursing appointments to allow one or two top-grade hospital appointments and a number of "principal" level divisional appointments, both open to either sex, might make good organisational sense in terms of this hospital. The hospital does not have freedom of action here. Its structure is determined by forces in its environment.

Third-Order Systems

At present at Banstead, the third order systems are the ward groups in the main divisions, but in the Female Division the aim is to work towards the establishment of three main clinical sub-divisions, determined by technology - an active treatment unit, geriatric unit, and a diminishing long stay unit. Such sub divisions would be along natural cleavage lines, as they would each be directed to the exclusive pursuit of one primary task. Such units, each with ward groups divided by age or type of treatment, would demand management roles at two levels. If managed medically, it would seem that consultants or senior house medical officers or perhaps senior registrars might command them, but sufficient consultant establishments do not exist. In actual terms, this would mean an increased burden upon the divisional consultant. Neither are there intermediate nursing grades in existence which could provide management help from nurses.

At ward group level, the problem is a little different. Control could be vested in a medical officer if he were sufficiently well treated and had sufficient time available for a long enough period. This

would not apply to junior registrars taking their Diploma in Psychological Medicine, nor to many junior house medical officers. Senior registrars could help, but would be in too great demand for higher-level appointments, and in any case could well be employed as understudies at higher level. Paradoxical though it may seem, the hospital is short of consultants and of juniors, while probably having less of a total shortage than this would imply. The difficulty arises from the short tenure of registrarships, and the heavy training commitments of many juniors. Because of these factors many of the junior doctors are not in fact available for clinical management appointments, which disposes the system towards using joint appointments or executive nursing appointments with the doctors acting strictly as registrars, that is, as staff officers to the (non-existent) consultants in charge.

The people available for executive nursing appointments would seem to be assistant matrons. This would be so if they did not work shifts, and if their pay was higher than that of the sisters they would be intended to control It is identical.

In the short term, using present establishments, the best that might be managed is to use a system of medical direction down as far as the ward group, and to appoint ward group management either from medical or nursing sources, or both jointly, according to the availability of individuals. There would be a need in any system to preserve the mobility of doctors through different kinds of treatment unit. This would be quite possible provided specific dual appointments were made, and it were recognised that a doctor who engaged the services of another in his unit might well be a subordinate of the other in his unit. Doctors on the divisional staff could readily be deployed in different units.

Little has been said in this paper of the possible roles of other professions, as they are concerned with service functions and there

is perhaps less confusion surrounding their roles than those of doctors and nurses. Provided medical care were adequately provided through the"staff officer" system, there might be some point in putting almost any professional person in executive charge of a unit, provided that all the implications outlined earlier were acknowledged.

Conclusion

The hospital had added a new task to its hierarchy of tasks, and that one had become primary in at least one division. An emphasis upon active treatment, rapid turnover, and greater involvement of doctors in the actual lives of patients, began to impose strain upon the system. The system was itself a fairly stable but not necessarily efficient juxtaposition of a nurse-directed community and a group medical practice - what has been described as the simulated nursing home adapted to the retention of patients. The greater activity of doctors led to an unstable equilibrium between the simulated nursing home system, and one of medical direction, with occasional breakdown in differentiation to a system of direct control by the divisional consultant.

The need of a hospital pursuing such a primary task is for a flexible unified system of management, which can continue to change as groupings of patients, and size and function of units change. It seems that neither a nurse-directed nor a medical-directed system would be possible in pure form, but that a system of medical direction at senior levels, with either medical, nursing or joint direction at lower levels, might be possible. The requirement for units at every level is that there should be clearly and unequivocally some person or persons in charge, and that services are provided to them from higher order systems whenever their units are not self-sufficient. Any unified system would seem best to be differentiated into sub-systems according to technological

criteria reinforced by territory, with time differentiation arranged at the lowest convenient level.

Such a unified system would require for its most effective manning a different sort of nursing establishment from that existing, a greater proportion of senior medical staff especially consultants, and a longer tenure of office for junior and senior registrars. There would be, most conveniently, a singly top nursing job, a range of senior establishments to provide divisional and deputy hospital roles, and a true intermediate level between sisters and the seniors.

The hospital is in the position where technological change has affected its relations with its environment, and enabled it to meet new demands from its environment. There are however, severe restraints upon it from environmental forces, which prevent it from adapting with the greatest effect. A mental hospital cannot be reformed from top to bottom without its establishment coming into question. If a new sort of mental hospital is required, there may have to be new ways of running it, with new sorts of relations between traditional jobs.

The problem cannot be solved by shifting the emphasis to treatment in psychiatric wards in general hospitals, for the conventional medical-nursing relations there are even worse adapted to modern psychiatric methods.

Although the latter part of this paper has concentrated upon the seeming impossibility of running Banstead hospital, in fact that hospital does run. It is only because it runs well that disequilibrium has arisen in its structure. That is, it is because it is alive and adapting to new social tasks, that its structure begins to show strain. It is in the nature of unstable equilibrium that they change, and changes have taken place in the Banstead system since the time upon which this analysis is based (specify).

If a system does work, is there any point in raising difficulties about it? In the case of a mental hospital there certainly is, for analysing some of the organisational problems here may help to prepare for future adaptation. Further-more, because a system works, it does not necessarily mean it is working at its most efficient. This hospital was working well, but in spite of its system, and by virtue of the fact that it did not in fact operate its formal system. The various possibilities considered here are not pipe-dreams, but attempts to make explicit some of the actual forms of organisation already existing albeit covertly or inconsistently. This hospital, and most probably, most others, could work as well at far less cost in time, money, number of staff, or alternatively could work far better with the same resources. Its ability to do so is not fully determined by its own activities.

Play down superintendents power.

Doctor must direct in action
treatment sit:

↓ send out [illegible] - dept
[illegible] / direction - communic
- nurse & doctor

New introduction referring to 1959 Act.