



UNIVERSITY
OF NATAL

ISR
DURBAN

A THEORETICAL APPROACH TO THE STUDY OF THE HOSPITAL AS A SOCIAL ORGANISATION.

Lawrence Schlemmer and Nelida Lamond

AN OCCASIONAL PAPER OF THE

INSTITUTE FOR SOCIAL RESEARCH

1968 – OCCASIONAL PAPER No. 12

A THEORETICAL APPROACH TO THE STUDY OF THE

HOSPITAL AS A SOCIAL ORGANISATION.

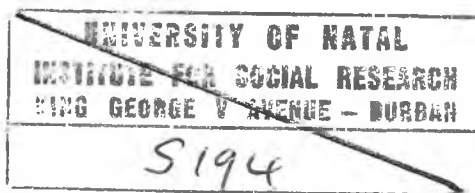
LAWRENCE SCHLEMMER

Senior Research Fellow in the
Institute for Social Research,
University of Natal,
Durban.

and

NELIDA LAMOND

Senior Lecturer in Nursing in the
Department of Sociology and Social
Work,
University of Natal,
Durban.



C O N T E N T S

ACKNOWLEDGEMENTS	(i)
I. SOCIAL RESEARCH AND THE HOSPITAL	1
II. THE RESEARCH APPROACH - PITFALLS AND DIRECTIONS	4
III. REACTIONS TO RESEARCH - HOSPITALS VERSUS INDUSTRY	9
IV. TOWARD A THEORY OF THE HOSPITAL AS AN ORGANISATION	15
V. THE BREAKDOWN OF RATIONALITY - 'NON-FUNCTIONAL DYSFUNCTION'	33
VI. CONCLUSION	39
BIBLIOGRAPHY	41

ACKNOWLEDGEMENTS

The writers wish to thank the following persons for their advice and assistance in the preparation of this paper.

Professors Hamish Dickie-Clark and James Irving, who read the initial draft and whose criticisms and comments made it possible to improve the text in many important ways.

Mrs. Anne McGhee whose comments on hospitals based on her own research did much to stimulate our interest in the topic and also provided valuable insights.

Mrs. Patricia Schlemmer and a number of other senior and junior members of the nursing profession, whose informal yet informed comments on hospitals led directly to the initial conceptualisation of the problem.

Professor Hilstan Watts, Director of the Institute for Social Research, whose guidance and encouragement is much appreciated.

Mrs. Nancy Pratt, Secretary of the Institute and Miss Livinia Slogrove, who typed the drafts and the final article respectively, under considerable pressure of work.

I. SOCIAL RESEARCH AND THE HOSPITAL:

Quite recently there have been convincing indications that hospital services in South Africa are beset by problems of some magnitude. Frequent statements have appeared in the press attesting to the presence of pressing staff shortages among nursing personnel and high rates of wastage among student nurses. The existence of serious problems has been confirmed by the appointment of a government commission of enquiry into matters affecting nursing services in the Republic.

Commissions of enquiry tend to be more suited to investigations in breadth rather than depth. As such they are essential in indicating broad guide lines for the solving of problems. However, they are not always suited to providing specific and detailed approaches to solving problems in social settings.

What does seem to be indicated is that sooner or later effective applied research will have to be conducted in hospitals, so as to provide specific, systematic, and objective data on personnel relations within these organisations. Inevitably it is within the employing organisation itself that staffing problems have some of their most important causes. The type of objective data required is seldom accessible to commissions of enquiry, depending as they do on the testimony of individuals who are themselves incumbents of positions within the organisation, and whose very attitudes and opinions may be aspects of the problems being studied.

The need for such research has been recognised by others, notably L.S. Gillis, Head of the Department of Psychiatry at Groote Schuur Hospital in Cape Town, who, in a recent article^{1]} said, - „Ons moet die saak ondersoek. Ons moet hospitale as klein gemeenskappe sien en die saak sosiologies en psigologies ontleed... ek wil graag u aandag vestig op die feit dat die groep-dinamika in hospitale bestudeer en verbeter kan word. Die nywerhede en die handel neem deskundiges vir hierdie doel in diens - waarom nie hospitale nie?"

The problem which prompted Gillis to make this plea for research, is the high rate of wastage of student nurses which takes place in South African hospitals. Gillis quotes reliable figures which show that upwards of 40% of all trainee nurses fail to complete their professional courses and hence are lost to the hospital service^{2]}. Gillis isolates the true nature of the problem by revealing that virtually 40% of a total of 1,564 girls leaving the service in 13 hospitals framed their reasons for leaving in such vague terms as "personal" and "domestic" or even gave no comment at all. It is important to note that this figure excludes those (18%) who leave to get married. Revans^{3]} has shown, by relating this class of vaguely worded reason for

-
- 1] L.S. Gillis, „Sielkundige Oorsake van die Verlies aan Leerling algemene verpleegsters", South African Nursing Journal, Vol. 32, Nos. 6 & 7, June 1965, p. 21. (No. 7)
- 2] Ibid. p. 7. (No. 6)
- 3] R.W. Revans, Standards for Morale: Cause and Effect in Hospitals, Oxford University Press, 1964, p. 3.

leaving to rates of sickness and absenteeism in five British hospitals, that underlying the platitudes offered as explanation for leaving, is a fundamental breakdown in adjustment to hospital life. This appears to delimit a major part of the problem to breakdowns in either the rewards of nursing or ability to cope with the trainee situation.

The problem is more crucial in some hospitals than in others. In fact, in a major training hospital in one coastal city in South Africa, the problem was serious enough to cause a 75% wastage among students in 1964^{1]}.

What does appear to be conclusive is that the reasons for staff dissatisfaction and the breakdown of morale within hospitals should be studied systematically. It is not suggested that factors existing within hospitals are solely responsible for the problems mentioned. Part of the cause of the problems may lie in inadequate selection of student recruits. Nevertheless, the hospital as a social organisation should remain an important focus of attention.

1] Quoted by N.K. Lamond et. al. in a student report. Miss Lamond obtained the data from hospital records. See N.K. Lamond et. al. : "Reasons for non-completion of training among student nurses." Unpublished report for a 3rd year undergraduate project, University of Natal.

II. THE RESEARCH APPROACH - PITFALLS AND DIRECTIONS:

The type of research that seems to be indicated in this context, is the type of study of personnel relations that has been conducted in myriad factories and business organisations the world over. In such studies, the causes of dissatisfaction, low productivity and low morale among staff are sought in the rewards or frustrations brought about by, among other things, communication processes, type of supervision, status divisions, and the quality of primary and secondary group interaction in the work situation. This type of research of the "human relations" school has been successful in indicating means of alleviating stresses in industry and, on the surface, no reason seems to exist as to why the same approach cannot be employed in the hospital setting.

However, when considering the differences between hospitals and factories, certain reservations concerning this approach spring to mind. The enthusiastic entry of social scientists into the hospital setting equipped with trite models of applied research in specific factories can, in the long run, do more harm than good, both to the hospitals themselves, and to the reputation of the social sciences.

Such research might be concentrated solely or largely on areas of obvious friction and stress, such as the attitudes, rewards and frustrations of student nurses, and it will most certainly uncover causal or related phenomena in patterns of supervision, rules, regulations,

formal and informal communication of expectations, and the like. The temptation will be great to recommend that certain features of say, the supervision of nurses be altered, since this might appear obvious as a solution. Beneficial effects might accrue and persist until new stresses arise among other groups of staff, brought about by the very changes recommended. Sooner or later these new stresses will resolve themselves into a resurgence of the same frustrations for the lower echelons of staff as existed before. The reasons why we believe this danger to be less salient in industry will become apparent later on in this paper. Suffice to say, at this stage, that it appears to us that research in a hospital setting requires a more comprehensive approach than research directed at similar problems in industry, because of the fundamentally important ways in which a hospital organisation differs in characteristic features from factory organisation. This point of view would suggest that the present fashionable problem-orientated "human relations" approach to research in organisations might not be applicable in unmodified form to research in hospitals.

Two other fairly recent developments would also suggest that the "human relations" approach might need to be broadened and modified in order to cope even with the variety of organisational features found in industry:

(a) Foremost investigators in Britain and U.S.A. have reached the conclusion that action research in industry directed at problems of employee morale has to take into account not only human relations within the organisation,

but also the effects of the organisation of work and production engineering^{1]}. Joan Woodward^{2]} states : "The climate of industrial relations in a firm no longer depends entirely on management's ability to develop sound personnel policies and the kind of procedures which encourage responsible behaviour on both sides (management and staff). Employees at both supervisory and operator level are also involved in a system of work organisation and control. This involvement has a more direct and powerful effect on the pattern of behaviour in the firm than have attitudes to the firm itself".

Georgopoulos and Mann^{3]}, after an intensive investigation of ten hospitals in the United States, also concluded that the "human relations" approach needed considerable refinement in the hospital setting. Briefly stated, these two investigators conclude that while patterns of supervision which are supportive and democratic do much to make the nurses more willing to work, they do not materially improve the actual quality of nursing care or the type of co-ordination among members of staff which is essential for the overall efficiency of the hospital as an organisation.

-
- 1] Tom Lupton, On the Shop Floor, Pergamon, 1963.
Lisl Klein, Multiproducts (Ltd.): a case study on the Social Effects of Rationalised Production, H.M.S.O. 1964. L. Sayles, Behaviour of Industrial Work Groups: Prediction and Control, New York: Wiley, 1958.
- 2] Joan Woodward, "Industrial Behaviour: Is there a Science", New Society, 8th October, 1964. P.13.
- 3] B.S. Georgopoulos and F.C. Mann, The Community General Hospital, New York: MacMillan, 1962.

In the hospital setting, this point of view would imply that considerable attention be directed to the effects on overall efficiency in the organisation and on nurses' morale, confidence and performance, of shift work, types and patterns of duties, pace of work, division of labour, and the reactions of patients. Certainly, it would also mean that the nurse's attitudes to her work should also be taken into account. Nursing is undoubtedly more emotionally demanding and also involves more personal commitment than work on the factory floor.

(b) Secondly, as Tom Lupton^{1]} has suggested in Britain, the human relations approach generally has to be broadened to read not "man in group in organisation", but "man in group in organisation in environment". The reactions of the employee must be analysed not only in relation to his organisation and smaller groups within it, but also in relation to the community he goes home to, and all its concomitant domestic, social, economic, legal and recreational pressures and opportunities. When a man goes on strike, or resigns, or stays at home ill, he has to account not only to his firm, but to his wife, the law, his pocket, and his friends. Many years ago D.H. Lawrence made the observation in his well-known novels that very often the womenfolk in the mining communities were the restless inciters behind the "bolshivism" of early industrial protest.

1] Tom Lupton, "Social Science and the Manager", New Society, 8th April, 1965.

It does seem, therefore, that a new and broader formula must guide our attempts to uncover principles of action in organisations, if we are to avoid making glib generalisations which time and again, fail to hold true under all circumstances, like: "its all a matter of good communications", or "piecework is bad", or "profit sharing promotes a sense of common interest", or "leadership and supervision must be democratic". Tentatively, the definition of personnel in hospitals should read "nurses with personality characteristics, at work, in group, in organisation, in environment".

III. REACTIONS TO RESEARCH - HOSPITALS VERSUS INDUSTRY:

In pleading for a more comprehensive approach, we must also plead for a more comprehensive view of the hospital as an organisation, as has been mentioned earlier. It was stated that the differences between the hospital and the factory as organisations make this essential. It might be useful to enlarge on this point:

Much of the research conducted in industry has been directed at discovering solutions to problems very much like those facing the nursing profession in South Africa today; problems like high rates of wastage among trainees, high labour turnover and absenteeism. However, a good deal of the attention of social scientists in industry has also turned to problems of productivity, and organised labour protest. These latter problems are obviously not relevant to research within the ambit of the hospital. On the surface it would appear that this difference would simplify research approaches within the hospital. Certainly, since productivity and organised protest do not have to be taken into account, the element of risk in introducing changes would seem to be less severe to "management" in hospitals than in industry. Yet the very absence of problems of productivity and worker protest (or, rather, the neglect of the first and the absence of the second), might make research in the hospital an even more complex undertaking than similar research in industry; and also points to a fundamental difference between hospitals and factories which is of crucial importance to research.

Social research became fashionable in industry at a time when enlightened managers were beginning to realise that classical management theory (the assumption that efficient organisation of tasks and rational deployment of staff whose duties were governed by precise rules and regulations) was not the sine qua non of productivity. With the advent of the seemingly dramatic results of the human relations experiments at Hawthorne in the U.S.A. and elsewhere^{1]}, came the realisation of how artificial the attitudes of typical management were, and how great a need existed for the re-education of executives.

Those managers who had the flexibility to allow social scientists within the inner temple of their production systems, were, however, very keen to learn. They were naturally very keen to try anything that might bring about increased production and greater co-operation from the employees. Their own institutional values and the profit motive made them keen to learn. Factors like the satisfaction and high morale of staff, low absenteeism and rates of staff wastage were also regarded by the managers as being very important in so far as they could be related to increased profits^{2]}. The goal of increased production permeates

1] F.J. Roethlisberger and W.J. Dickson, Management and the Worker. Harvard, 1939.

2] This does not apply to all industrial managers, and certainly is not without exception in South Africa, where low wages for Non-White operatives and considerable government surveillance of industry do alleviate many of the risks and anxieties faced by overseas industrialists.

the whole of the structure of industry down to the first line level of supervision, since all standards of performance are assessed in terms of production.

The effects of this are that when social scientists make recommendations in factories there is a tendency for large sections of the organisation to support and adjust to the innovations quite consciously and deliberately, especially when productivity is increased. The fact that increased productivity in a factory tends to redound to the credit of most foremen, supervisors, and managers, does, we believe, operate as a tremendous incentive to flexibility. When changes are introduced into an organisation, this flexibility is essential, and without it changes in patterns of interaction or supervision can be disruptive, especially in close-knit structures like a factory. An excellent example of the type of response which supports changes occurring in an industrial organisation is the long-term 'Glacier Metals' project^{1]} in Britain. Here, after a number of years in which the original models have been refined, the result has been the formulation of the 'glacier system', of which the management can be justifiably proud. One gains the impression from many other studies that industrial management has often played as large a part as the social scientist in making innovations effective, by supporting change and introducing many

1] Wilfred Brown and Elliot Jaques, Glacier Project Papers. London: Heinemann, 1965.

secondary innovations to ensure the stability of the initial changes recommended by the social scientist.

A hospital, on the other hand, is a somewhat different proposition. Organised labour protest in hospitals is not a function of unions, but rather of staff or professional associations, and the butt of any protest is not usually any group in the organisation itself, but external institutions like government or community councils. Distinct interest groups among labour in hospitals do not arise easily since myriad distinctions in status tend to fragment the identity of groups. Above all, nobody ever seems to think of the productivity of the nursing staff as a whole. The effectiveness of the service is usually accredited to medical science. Can one roundly state that the administration and supervision in a hospital are productivity orientated? We would submit that they are not^{1]}. Their true orientations are extremely crucial in understanding a hospital, and any social scientist should take cognisance of these orientations before proceeding to even define the problem. The orientations and values

1] The word 'productivity' will probably never be entirely appropriate in regard to the type of work done by nurses. It could only be used if made analogous to standards in the care of the 'whole' patient. This approach to assessing standards in nursing would require somewhat of a revolution in outlook in hospitals. Nursing would have to become recognised as a profession in its own right. Only then will nursing become more patient orientated rather than 'doctor orientated', enabling standards to be set for nursing which would be independent of the achievements in medical science.

of management might well be the industrial sociologists greatest aids, but in hospital administration these may prove to be his greatest handicap.

One cannot assume that the administrative, executive, and supervisory levels in hospital organisation will react to support innovations suggested by social scientists. For example, changes introduced to lessen the frustrations of say, the student nurses, or even sisters, might operate to introduce unanticipated frustrations for ward sisters without bringing them any increased credit for an improved nursing service (since the latter may never be measured). If this were to be so, who could expect the ward sister to support and bolster the changed procedures? In view of this real possibility, the social scientist needs a clear and comprehensive framework within which to assess the possibilities of what reactions and secondary changes will occur in a hospital in response to the modification of specific aspects of its organisation.

This conclusion is certainly not new. Many authors have pointed to the need to study the hospital as a total organisation even when fairly specific problems have to be investigated. Revans^{1]}, for example, says: "As we have looked at these [many] different aspects of the hospital, we have gradually come round more and more to realise the need for taking a synoptic view of the whole hospital In my opinion, you cannot study the

1] R.W. Revans, "How should a Hospital be Judged?" Hospital Service Finance, Vol. 9 : 1960 pp. 34-48.

efficiency of any particular branch of the hospital unless you are prepared to study the hospital as a total entity. Similarly, Georgopoulos and Mann^{1]} conclude that the hospital can best be studied as a whole organisation and they also provide proof of the high degree of interdependence of the various aspects of the hospital service.

1] B.S. Georgopoulos and F.C. Mann, op.cit.

IV. TOWARD A THEORY OF THE HOSPITAL AS AN ORGANISATION:

The social scientist in a hospital does need a comprehensive theory. The efforts of social scientists in industry might have produced excellent paradigms and categories of measurement in relation to formal and informal communication, formal and informal control, characteristics of supervision, and the like, but as argued earlier, there has been no real need to formulate a theory which would refer as much to the role of the managing director as to that of the unskilled labourer.

A certain amount of observation of and reading about hospitals has led us to believe that the theory of bureaucracy might be applied, albeit in modified form, to the hospital as an organisation. This theory was originally formulated by Max Weber^{1]}, and has subsequently been reconsidered and revised by many others^{2]}. It would be useful at this stage to briefly outline the

-
- 1] See H.H. Gerth and C.W. Mills, From Max Weber: Essays in Sociology, New York: Oxford University Press, 1946.
- 2] Including Robert Michels, Zur Soziologie des Partiewesens in der Modernen Demokratie, Leipzig: 1912. Robert Merton, "The Unanticipated Consequences of Purposive Social Action", American Sociological Review, Vol. 2, 1936, pp. 894-904; and "Bureaucratic Structure and Personality", in Personality and Social Systems by Smelser and Smelser, New York: Wiley, 1963. Peter Blau and W. Richard Scott, Formal Organisations, San Francisco: Chandler, 1961. Alvin Gouldner, Patterns of Industrial Bureaucracy, The Free Press of Glencoe, 1954. Michel Crozier, The Bureaucratic Phenomenon, Tavistock, 1964. Phillip Selznick, "Foundations of the Theory of Organisations", American Sociological Review, Vol. 13, 1948, pp. 25-35.

dominant characteristics of a typical bureaucracy before hypothetically considering the hospital in the light of this theory. In describing the characteristics of a bureaucracy we will follow Merton and Crozier very closely, and some passages are in effect a summary of their expositions with slight modification.

Crozier defines a bureaucracy as "an organisation that cannot correct its behaviour by learning from its errors"^{1]}. Even less flattering descriptions have been offered to describe the characteristics of individuals in a bureaucracy. Veblen coined the phrase: "trained incapacity"; Dewey: "occupational psychosis", and Warnotte: "professional deformation". A colleague of ours, after a brush with a government department could not help seeing evidence of an "occupational death-wish" in many civil servants.

We would not for one moment imply that conclusions of this nature are applicable to all hospitals. They are useful, however, in that they serve to caricature certain salient tendencies in bureaucracies which might be looked for in hospitals.

Ironically enough, the most rationally coherent and potentially efficient organisation is the bureaucracy, involving a clear-cut division of integrated activities which are regarded as duties inherent in the office.

1] M. Crozier, op. cit., p. 187.

Roles are hierarchically arranged within regulated and official status divisions, and the assignment of individuals to these roles occurs on the basis of technical qualifications, examinations, or seniority. The tasks of officials are prescribed and regulated by general, abstract, and clearly defined rules which preclude the necessity of issuing specific instructions in each case. The generality of rules requires the constant use of categorisation whereby individual clients or cases are classified according to designated criteria, and are treated accordingly.

The important thing about the regulations is that they cause a complete depersonalisation of objects or clients, since the latter can never be treated on their individual merits.

The formality of regulations is mirrored in the patterns of interaction between members of the organisation, where prescribed modes of conduct and contact totally obscure private attitudes to one another. In this way friction between members is reduced by restricting interaction to formal and mutually accepted patterns. Informal interaction is thereby limited to those individuals, where, by virtue of exact similarity of status and role, the rules do not apply. Informal feedback from junior to senior personnel is difficult or impossible.

These characteristics of the bureaucratic structure exert a constant pressure on individuals to be methodical, prudent and disciplined, and to conform to a very

high degree. This produces very exacting demands on the individual, but, on the other hand frees him of the risk of making mistakes, and hence makes him invulnerable to criticism.

Two mechanisms operate to help ensure that a high degree of conformity is obtained. Firstly, rules are overstressed, and secondly, instrumental values tend to become terminal values; means become ends, and rules become absolutes. Incentives to conformity are provided by a system of rewards involving status-rises, badges, and all the additional rewards of promotion. Lack of conformity is heavily sanctioned and discouraged by strong emotionalised disapproval. A characteristic of particularly the older bureaucracies was the fact that participants were imbued with strong sentiments, often similar to religious ideologies, in order to produce devoted adherence to rules and customs.

Another salient characteristic of a bureaucracy is the tendency for extreme centralisation of authority to develop. The decisions are made at a level where those making the decisions are protected from the personal pressures engendered in the day-to-day activities. One of the negative effects of this is that, because those making the decisions are less acquainted with the relevant facts, a great deal of rigidity results.

Very important characteristics of a bureaucracy are certain typical dysfunctions or pathological aspects of its functioning. The fact that rules prescribe duties of participants so narrowly and rigidly, means

that adaptation to the tasks can never be really effective. This causes the participants carrying out the tasks to take refuge in the rules, as it were, causing the rules to become even more rigidly adhered to. Thus fear of failure and inability to adapt to real life situations causes greater rigidity and hence even less possibility of adapting.

The frustrations caused by the rigidity in performing tasks require that participants be closely and narrowly supervised. The need for close supervision is rationalised by the disparaging and stereotyping of the lower-status participants as being irresponsible and inefficient; this causes blockage in communication between supervisors and those supervised, and also increases the frustration of those carrying out the particular service.

At the level of personality, these frustrations tend to produce ritualism and retreatism. Ritualism can be the only alternative in the face of stifling rules and the need to avoid ever-ready criticism from supervisors. Retreatism involves effective emotional withdrawal from the situation, sometimes resulting in a total lack of involvement, in order to reduce the ill-effects of frustration and tension on the individual personality. Any responsibility is likely to be avoided since it renders one vulnerable to punitive criticisms. The most comfortable alternative is always to simply lose interest and to do no more than carry out instructions.

The central tendency in a bureaucracy is for these effects on the personality of more junior members to reduce the efficiency of the service and to make them incapable of responding to effective needs in performing their tasks. This requires that efforts be made by more senior personnel to combat inefficiency, resulting in still greater centralisation and more rules and regulations. A self-reinforcing vicious circle results where mistakes simply breed even more of the negative effects that make inefficiency inevitable in the first place.

In the course of ineffectual performance of tasks, serious anxieties are generated which cause those performing the tasks to seek emotional protection. Rules and regulations - a perpetuation of the very factors which cause the anxiety - become the only refuge for the trapped participants. Anxiety is indeed a keynote in bureaucracies, particularly anxiety with regard to status, and anxiety over the correctness of duties performed. Protection against this anxiety is bought at the price of reality.

Much has been made of the various dysfunctions of a bureaucracy. In theory, however, these dysfunctions need not always be present to a degree where the morale of members of staff or the efficiency of the particular service is seriously undermined. We would suggest, however, that in any organisation where the type of tasks performed require flexibility and adaptation, and where the members of staff receive some independent academic or professional training, the type of negative effects

described are more or less inevitable. This would be particularly true of a hospital, especially since the uncertainty inherent in dealing with disease would tend to aggravate the more "normal" bureaucratic features of the organisation. The anxieties generated by the disease - pain - death situation would tend to polarise the goals of professional medicine and nursing on the one hand, and the bureaucratic goals of the organisation on the other, in such a way as to make serious conflict in the organisation inevitable.

It should not be assumed that we wish to describe hospitals in precisely the terms used in our description of the bureaucracy. What the theory of bureaucracy does offer in a general sense, is a way of looking at an organisation which takes into account the ever-present possibility of circular effects, of self-reinforcing rigidities which permeate the entire system, and of processes to alleviate anxiety which serve ultimately to increase the anxiety. It is a framework which takes into account that any changes in specific aspects of the functioning of an organisation can generate side-effects throughout its structure. It thereby encourages a global view of the organisation as well as sensitising the investigator to the negative and dysfunctional characteristics that an organisation can possess. As such the theory of bureaucracy is useful for our purposes.

Indeed, we may go even further and seek some specific similarities between hospitals and bureaucracies. In the light of some convincing empirical evidence presented in

Britain and the United States this would appear to be justified.

We have called attention to the anxiety which is characteristic of bureaucracies. Staff in hospitals, because they deal with illness, have much more justification for being anxious, but the end results might be similar to these in a bureaucracy. Revans^{1]}, after a very thorough and systematic analysis of several British hospitals, was able to say: "The hospital is an organisation characterised by anxiety -- enhanced by uncertainty. Uncertainty is magnified by communication failure. Unrealistic ideas about one's own role, knowledge, intelligence, status, and other features of self will increase the difficulty in communicating and being communicated with. Anxiety will inhibit communication through fear of threatening circumstances. A regenerative process may start, anxiety, uncertainty, communication blockage, (more) anxiety, uncertainty, communication blockage ---, (and) the very communication difficulties will prevent the organisation from assessing its own vision". Or, to revert to Crozier's definition, will make the organisation unable to "learn from its errors". Revans relates these general characteristics to wastage of students and to length of stay of patients using strictly empirical methods. In doing so he points to even more specific aspects of the hospitals he studied which bear remarkable similarity to the bureaucracy we

1] Revans, R.W., Standards for Morale: Cause and Effect in Hospitals. op. cit., pp. 91, 92, 93.

described earlier. He refers to ^{1]} "some incurable preoccupation with rank and status throughout the (nursing) profession", but concedes that the rigidities in status may be due to "failures of morale due to some internal malfunction". This is very reminiscent of the dysfunctional rigidities of the typical bureaucracy indeed. Revans^{2]}, says: "in some hospitals, the system of authority, rigid but insecure, must continually strive to protect itself against -- undermining challenges, and sooner than admit the weaknesses of its human foundations will deny the opportunity to call them into question".

As typical in a bureaucracy, Revans finds that the reaction to anxiety is close supervision and domination, with adverse effects. He states: "In the opinion of the team, such (domineering and hostile) attitudes of supervisors, more than any other factor, were responsible for student wastage".

Isobel Menzies^{3]}, after an intensive study of a large British teaching hospital, sees the stress and anxiety in hospitals to be particularly connected with reactions to the disease in the ward, and with human factors in the patients. She sees the stresses and

1] Ibid. p. 67.

2] Ibid. p. 65, 66.

3] Isobel Menzies, "A Case Study in the Functioning of Social Systems as a Defence against Anxiety", Human Relations, 1960. Vol. 13, No. 2. Isobel Menzies, "Nurses Under Stress", Nursing Times, Vol. 13, No. 2, 1961.

anxieties as having produced an institutionalised defensive system which is self-perpetuating and self-reinforcing. The results of this process are startlingly similar to the characteristics of a bureaucracy. The results she mentions are the following:

- a) Need to depersonalise patients.
- b) Ritualised performance of tasks involving check-lists of duties and "patient-centred tasks".
- c) Rigid regulations which make adaptations to the real needs of patients very difficult and cause frustrations for nurses.
- d) Delegation of authority upwards and hence removing responsibility for making decisions from where the day-to-day needs of patients can exert an effect.
- e) Diffused and ineffectual responsibility based on chronological seniority and status. Co-ordinating roles too far removed from the pressures of the ward situation.
- f) Reduced weight of decision-making by checks and counter-checks: inability to take personal decisions.
- g) Personal satisfactions for the nurse reduced because of the lack of real responsibility and a splitting of the nurse-patient relationship, resulting in frustration.
- h) The ensuing reaction of "retreatism"; adopting a don't-care attitude via emotional withdrawal.
- i) Guilt because of periodic under-employment.
- j) Conflicts due to lack of real responsibility while being continually exhorted to exercise more responsibility and discretion in terms of undemanding and punctillious rules.
- k) Close and detailed supervision.
- l) Derogatory attitudes of supervisors; attitudes of blame and criticisms.
- m) No opportunity for personal expression and real rewards of work.

Each one of the aspects mentioned above tends ultimately to reinforce itself, producing the typically bureaucratic vicious circle, with ever increasing rigidity and lack of communication producing more and more tension and uncertainty.

Others in Britain^{1]} have noted this same tendency in hospitals as well. In the United States, Georgopoulos and Mann^{2]}, although they do not specifically use the term "bureaucracy", state that: "It is our impression that many hospitals tend to resolve most of their co-ordinative difficulties mainly through corrective co-ordination, thus missing the opportunity to improve their overall co-ordination through promotive or preventive efforts." It is clear from their findings that the terms "corrective co-ordination" refers to rigidly applied rules and regulations of a type associated with bureaucracies. Mary Goss^{3]} freely admits that the typical hospital is always

-
- 1] E. Skellern, Report on the Practical Application Toward Administration of Modern Methods in the Instruction and Handling of Staff and Student Nurses. Royal College of Nursing, 1953. C. Soler, "Reactions to Administrative Change: A Study of Staff Relations in Three British Hospitals", Human Relations, Vol. 8, pp. 291-316. A.T.M. Wilson, "Hospital Nursing Auxilliaries", Human Relations, Vol. 3, pp. 1-32. Report on the Study Group on Recruiting and Training of Nurses, Ministry of Health, London, 1947.
- 2] B.S. Georgopoulos and F.C. Mann, op. cit. p. 605.
- 3] Mary E.W. Goss, "Patterns of Bureaucracy among Hospital Staff Physicians", in E. Freidson (Ed.), The Hospital in Modern Society, The Free Press of Glencoe, 1963, pp. 170-195.

a bureaucracy in some sense or another but finds that the professional norms of hospital physicians do ameliorate some of the bureaucratic patterns as far as the medical staff are concerned. (She coins the phrase "advisory" bureaucracy to apply to the medical staff in hospitals.)

Glaser's comparisons of American hospitals with hospitals elsewhere^{1]} does give the impression that American hospitals conform less to the model of the classical bureaucracy than do their European counterparts. Freidson^{2]} suggests that this difference might be due to the greater professional independence of American hospital doctors and to the competing career opportunities for hospital staff in America generally. This does draw attention to the importance of the environment of the hospital as a focus of study; a point made earlier in this paper. Coser^{3]}, points out that some of the patterns of bureaucratic organisation in an American hospital restrict effective communication, and hence limit the "role sets" of nurses and produce a good deal of alienation. However, she does draw attention to the fact that not all types of wards are equally bureaucratic in their organisation.

In the light of these findings it seems obvious

-
- 1] W.A. Glaser, "American and Foreign Hospitals", in Freidson, op. cit., pp. 37-72.
 2] E. Freidson, op. cit., Preface.
 3] Rose Laub Coser, "Alienation and the Social Structure", in Freidson, op. cit. pp. 231-265.

that bureaucratic theory applies quite closely to the hospital as an organisation, provided that when specific postulates are made, the theory is flexible enough to allow for differences in degree between various types of wards and between hospitals in different social environments. However, we have been able to refer only to overseas findings. The position in South African hospitals is considerably less-publicised; so this necessitates that any speculation on the local scene be largely hypothetical.

From a good deal of observation (mainly that of the co-author), and from discussions with informed members of the nursing profession in Natal, the impression has been gained that while some South African hospitals may be less bureaucratic than others, the general patterns are quite markedly similar to those encountered in hospitals in Britain and the United States.

Many features would appear to be present in South African hospitals which are characteristic of some of the important dysfunctions of a bureaucracy. An impression is gained of typical status consciousness and a rigid stratification system. There would appear not to be very much democratic interaction between junior and senior ward-staff, which is necessary in order to integrate functions effectively. There also seems to be the tendency for instrumental goals to become ends in

themselves, such as "ward bookkeeping" for example, and also ritualisation of task performance. Rules and regulations are stressed to a considerable degree, as are discipline and standards of conduct and performance among junior nurses which are not effectively related to nursing the patients in the true sense of the word, (except in certain specialised wards like obstetrics and operating theatres).

Anxiety and tension would appear to be as characteristic of South African hospitals as of their British counterparts, but no comment can be made on specific effects at this stage, other than to mention the strong possibility that nurses and particularly student nurses become somewhat too impersonal in their reactions to patients, and possibly also become petty and withdrawn, stifling the spirit of camaraderie among peers which can be so effective as an emotional support for staff^{1]}.

This anxiety and tension as well as certain other dysfunctions seem to be the cause of frustration and the resultant apathy among student nurses. Certainly these factors appear to be very reminiscent of the lack of effective communication which is characteristic of a bureaucracy. The student nurse is exposed to a dual system of authority. On the one hand she is subject to

1] One of the causes of tension and anxiety among student nurses which has been mentioned locally is the very rapid turnover of patients in the modern hospital. In many cases nurses are unable to get to know the names of patients, or even to acquaint themselves thoroughly with the ailments. This is undoubtedly a situation which would facilitate the type of withdrawal we have been discussing.

the rules and demands of her training and the expectations of her tutors, and on the other hand she is treated as little more than an extra pair of hands while on ward-duty. Particularly at the initial stages she is exposed to emotional and technical challenges far in advance of her training and cannot hope to cope adequately. She therefore can easily become the butt of severe criticism in her role in the wards. Many ward sisters do not accept responsibility for training and guiding the recruits on the wards. Their recourse is to close supervision of automatically performed duties. The discrepancy between the goals of training and the actual characteristics of ward-activity cause conflicts in the student nurse. This conflict, combined with the frustrations of close supervision and the anxiety aroused by the illness in the ward can combine to produce apathy and withdrawal. This withdrawal is countered by even more stringent rules and regulations, producing the characteristic vicious circle found in a bureaucracy^{1]}.

Crozier^{2]} devotes a good deal of attention to what he terms "parallel power relationships" within a bureaucracy - dual systems of authority operating which allow certain specialised roles to gain a high degree of independence within what is otherwise a very rigid system.

1] A matron in one large training hospital in South Africa has drawn attention to the fact that the requirements of a nurse's training deprive her of much of the meaningful ward experience. Often it is auxilliary nurses who have most opportunity to make effective contacts with the patients on the ward.

2] M. Crozier, op. cit., pp. 192, 193.

In discussions with hospital personnel, we have gained the impression that much the same phenomenon exists in South African hospitals. One system of fairly rigid authority is characteristic of the nursing hierarchy, while other systems of authority exist for the specialised roles: the medical personnel and consultants, and the paramedical personnel (radiographers, physiotherapists, etc.)^{1]}. To a certain degree a different type of authority might also exist for the teaching personnel in teaching hospitals -- the sister tutors. As said before, what does seem apparent is that there is a conflict of institutional goals between the ward personnel and the teaching personnel; the former system being geared to task performance on the wards, and the latter to the technical and applied skills of the (ideal) nursing role. As Crozier describes it, the systems of authority of the specialised sub-organisations appear to be considerably less rigid than the central organisation. Furthermore by virtue of not being fully integrated into the central system of authority, specialised staff are able to usurp and reject, or at least ignore the nuances of status among the nursing personnel. This produces great conflict for both senior and student nurses. Senior nurses find their status threatened and probably react by emphasizing their authority over junior nurses. Student nurses find themselves faced with conflicting authority figures who, while not affecting their overt

1] This has been noted by investigators overseas, particularly in American hospitals; see Mary E.W. Goss: op. cit. In British hospitals, the fact that all hospital staff are responsible to a lay administrator possibly results in a more uniform system of authority.

behaviour, might prevent them from successfully internalising the authority system of the wards. In a hospital the problem might be more acute than in other large organisations because of the professional interdependence of nursing and specialised personnel. The result of this might well be a tendency for student nurses to fail to commit themselves to full participation in the rituals of the organisation -- yet another type of retreatism and withdrawal to strengthen the vicious circle.

Another possible cause of bureaucratic rigidity in the South African hospital is the role and status conflict which can occur at very senior levels. The twin power-roles of matron and medical superintendent might be the focus of serious conflict. In the uncertainty that results, the matron might strive to reduce the uncertainties within her own area of control by imposing rigid requirements which she can justify on rational grounds. Strict adherence to these regulations on the part of assistant matrons, ward sisters and staff would ensure that any conflicts which might arise could be justified more easily, making the matron less vulnerable to attack from the specialised staff through the superintendent. Conflict between the matron and the provincial head office might also produce much the same consequences^{1]}.

1] The impression is gained that relationships between provincial government administrations and hospitals constitute a further important but separate area of problems which profoundly influences the entire functioning of hospitals.

These ideas are largely speculative and might not always hold true. However, even if many of the specific features of a bureaucracy do not exist in South African hospitals, we would maintain that bureaucratic theory is nonetheless very useful as a tool of analysis, because of the fact that it forces us to consider the interdependences of all parts in the total system, and reminds us that improvements in one area can produce greater tension in another and undermine the initial improvements.

V. THE BREAKDOWN OF RATIONALITY - 'NON-FUNCTIONAL DYSFUNCTION':

Bureaucratic theory, or any other theory of the complete organisation, assumes, for its static models, a form of homeostasis where dysfunctions protect the structure of the organisation even though they might adversely effect the attainment of goals -- the standards of service rendered. Where models of change are formulated, they presuppose either innovation from some marginal role, or dysfunctions which threaten the organisation to such an extent as to make it necessary to readjust to preserve the structure.

Hospitals are changing. In previous times they probably represented almost military-like bureaucracies while today the analogy has to be more subtle. Innovation has undoubtedly played an important part, springing from new technical and professional standards of academic training for nurses, from medical personnel, and probably also from the examples of private hospitals where paying patients have to be kept happy for financial reasons.

In South Africa, as elsewhere, further change might be caused by dysfunctions which are ultimately destructive. The wastage of students, absenteeism, and general shortages of personnel are the surface manifestations of the pathologies within the organisations.

Why should this type of dysfunction exist when the bureaucratic type of organisation does, in ideal form,

achieve an equilibrium, albeit tenuous? Two points made early on in this paper should be called to mind here:- First: The nature of the tasks that nurses have to perform (the equivalent of production engineering in a factory) does not allow them to achieve the functional disinterest of the petty bureaucrat. Forty-seven per cent of Ann Cartwright's^{1]} 700 ex-patient informants felt that patients generally made unfair demands on nurses. It is therefore unlikely that nurses are always able to keep the required emotional distance for the perfect bureaucratic defence system to operate adequately. Especially among the younger student nurses, it would be very difficult to conceive of a complete depersonalisation of patients^{2]}. Bearing in mind the fact that the actual nursing of patients as complete individuals might not be of cardinal importance in the formal system of expectations on the ward, (indeed, it might be functionally impossible) we can see that this situation would produce considerable conflict, which for some of the staff would be impossible to resolve. A breakdown of morale might ensue, with examination failure or resignation being a reflection of the problem.

-
- 1] Ann Cartwright, Human Relations and Hospital Care, London: Routledge and Kegan Paul, 1964.
- 2] In a discussion with an experienced informant, it was suggested that student nurses are happier when nursing status equals, or persons of roughly similar age. This, if true, would tend to support the notion that a depersonalisation of the patient is not easy for the student nurse.

The multiple systems of authority mentioned earlier might be another factor. It is our belief that in most bureaucracies, the younger (and therefore less well-socialised) personnel are protected from the conflict of authority at higher levels. However, in the hospital, the student nurse is fully exposed to the requirements of doctors, paramedical personnel and to the academic expectations of tutors. Dagmar Brodt^{1]} studying an American hospital found considerable differences in the expectations that supervisors on the one hand, and instructors on the other, held of student nurses: "In actual practice, no school of nursing can hope to prepare students to meet all the expectations of every hospital." These conflicting demands and opposed reference groups could easily cause a breakdown in the type of socialisation process with which an organisation prepares new recruits for integrated role performance.

In bureaucracies, the informal interaction between colleagues of equal status in small peer groups tends to serve a very important purpose in reducing tensions. In the face of impersonal demands and occupational anxieties, the personnel are supported emotionally and morally by colleagues of similar status with whom they have primary group contacts. Earlier on we noted that student nurses in South African hospitals might tend to become too withdrawn and impersonal to make effective contacts with informal primary groups. The fact that groups of

1] Dagmar Brodt, "The Neophyte Nurse - A Role-expectation Study", Nursing Research, Vol. 13, No. 3, 1964. p. 259.

students are very small and are often broken up and separated on the wards might also be an aggravating factor. Without effective primary group support it would be little wonder if morale suffered.

All the possibilities mentioned above relate directly or indirectly to the effects of the organisation of labour on the ward and in the hospital generally.

Second: A second major factor is of almost equal importance. This has also been discussed earlier when we dealt with the evidence that the environment of an organisation might contribute to its problems. If we consider the environment of the hospital in its broadest sense, including the effects of community values and pressures on recruits, we must concede that the hospital cannot be seen in isolation.

Community beliefs and expectations with regard to nursing might cause the new recruit to be too idealistic with regard to the nurse's role, causing her to suffer disillusionment when exposed to the actual practices and experience on the wards; or even to the rigours of training. Kibrick^{1]} found in an American hospital that the nurses who were most idealistically inclined or most unrealistic by nature were less likely to stay in the nursing profession than the more realistic individuals, who could perhaps adjust less painfully to the bureaucratic demands of the hospital.

1] A.K. Kibrick, "Dropout in Schools of Nursing", Nursing Research, Vol. 12, No. 3, p. 140.

Bureaucracies, it seems to us, either involve a complete identification of the individual participant with the organisation (as in the army or in say, a Jesuit order), or presuppose that the individual can dichotomise his life, withdraw emotionally, and escape from involvement at the end of the day, or at the close of office hours. Humorous stories of civil servants stopping a typewritten sentence or some task in the middle when the clock strikes five are common. With student nurses neither can apply. They do not withdraw from the world, nor can they withdraw from the hospital, partly, one would assume, because of the irregular hours of work and the demands of study. Therefore we must consider another aspect of the environment of the hospital: the extent to which the nurses' private roles impinge on her occupational roles, and vice versa. We must be prepared to look at the nurse as a mother, wife, girlfriend, beauty queen, wallflower, sportswoman, member of clubs and so on, and the extent to which these roles affect or are affected by adjustment to the ward.

In considering the outside environment we should also think of the student nurse's perceptions of alternative employment in the community, and the pressures exerted on her by friends and relatives in this regard.

Finally, let us not forget that in South Africa, the public hospitals are administered by provincial government bureaucracies, with, we believe, their own set of autocratic regulations and demands. We should consider the position of the matron and the superintendent

not only in relation to pressures from within, but also with due regard to pressures from the totally uninvolved outside government administration.

VI. IN CONCLUSION:

Revans^{1]}, in suggesting ways in which the extent of dysfunction within the hospital can be reduced, makes a plea for an "autotherapeutic" process, whereby all the staff of the hospital become more aware of how they affect and are affected by their colleagues and the work situation. This makes sound sense and we would agree with it whole-heartedly, in view of the preceding discussions. However, one word of caution is necessary. Any autotherapeutic process should be guided by a knowledge of the whole organisation, and should also embrace the whole organisation - even the matron, medical superintendent and the officials who affect the liaison between government administration and the hospital. As mentioned often before, it is our view that in hospitals particularly, alleviating tensions and frictions at the junior levels can easily disrupt the often delicately balanced protective and defence mechanisms among less-junior staff. Under such circumstances the junior staff will be the first to suffer renewed frustrations.

We have to concede that a possible solution to the problems facing hospitals is to select staff and recruits who, by virtue of certain personality traits (tough-mindedness, realism, low frustration thresholds, high ego integration, etc.), might more easily survive the stresses concomitant with their role. However, there is a nationwide shortage of pupils leaving school with

1] R.W. Revans, op. cit., p. 91 onwards.

the necessary qualifications, and therefore there is little likelihood of hospitals being able to pick and choose. Another reason is to our minds more important. If personalities are selected for their ability to adjust to the dysfunctions which exist in hospitals, this solution will do nothing to improve the quality of nursing care for the patient as a total personality. Those with whom we have discussed the problems of hospitals are unanimous in declaring that sympathetic and supportive care for the patient as a complete human being does not enjoy high priority in the wards at present. Since Revans^{1]} so effectively demonstrates that opportunities for nursing the total patient are connected with staff morale and enthusiasm, we have no alternative but to plead for the autotherapeutic process, and for the research which will make this process really effective.

1] Revans, R.W., op. cit., pp. 13-19.

BIBLIOGRAPHY

- Blau, Peter and W. Richard Scott, Formal Organisations, San Francisco: Chandler, 1961.
- Brodts, Dagmar "The Neophyte Nurse - A Role-expectation Study, Nursing Research, Vol. 13, No. 3, 1964, p. 259.
- Brown, Wilfred and Elliot Jaques, Glacier Project Papers, London: Heinemann, 1965.
- Cartwright, Ann Human Relations and Hospital Care, London: Routledge and Kegan Paul, 1964.
- Coser, Rose Laub "Alienation and the Social Structure", in Friedson (Ed.), pp. 231-265. (Below)
- Crozier, Michel The Bureaucratic Phenomenon, Tavistock, 1964. pp. 187, 192, 193.
- Friedson, E. (Ed.) The Hospital in Modern Society, The Free Press of Glencoe, 1963, Preface.
- Georgopoulos, B.S. and F.C. Mann, The Community General Hospital, New York: MacMillan, 1962. p. 605.
- Gerth, H.H. and C.W. Mills, From Max Weber: Essays in Sociology: New York: Oxford University Press, 1946.
- Gillis, L.S. „Sielkundige Oorsake van die Verlies aan Leerling algemene verpleegsters", South African Nursing Journal, Vol. 32, Nos. 6 & 7, June 1965. (No. 6) p. 7, (No. 7) p. 21.
- Glaser, W.A. "American and Foreign Hospitals", in Friedson (Ed.) pp. 37-72. (Above)

- Goss, Mary E.W. "Patterns of Bureaucracy among Hospital Staff Physicians", in E. Friedson (Ed.), The Hospital in Modern Society, The Free Press of Glencoe, 1963, pp. 170-195.
- Gouldner, Alvin Patterns of Industrial Bureaucracy, The Free Press of Glencoe, 1954.
- Kibrick, A.K. "Dropout in Schools in Nursing", Nursing Research, Vol. 12, No. 3, p. 140.
- Klein, Lisl Multiproducts (Ltd.): A Case Study on the Social Effects of Rationalised Production, H.M.S.O. 1964.
- Lamond, N.K., et. al. "Reasons for non-completion of training among student nurses". Unpublished Report for a 3rd year undergraduate project, University of Natal.
- Lupton, Tom On the Shop Floor, Pergamon, 1963.
- "Social Science and the Manager", New Society, 8th April, 1965.
- Menzies, Isobel "A Case Study in the Functioning of Social Systems as a Defence against Anxiety", Human Relations, 1960. Vol. 13, No. 2.
- "Nurses Under Stress", Nursing Times, Vol. 13, No. 2, 1961.
- Merton, Robert "The Unanticipated Consequences of Purposive Social Action", American Sociological Review, Vol. 2, 1936, pp. 894-904.
- "Bureaucratic Structure and Personality", in Neil J. Smelser and William T. Smelser (Eds.) Personality and Social Systems, New York: Wiley, 1963.

- Michels, Robert Zur Soziologie des Partiewesens in der Modernen Demokratie, Leipzig: 1912.
- Revans, R.W. Standards for Morale : Cause and Effect in Hospitals, Oxford University Press, 1964. pp. 3, 13-19, 65, 66, 67, 91 onwards.
- "How should a Hospital be Judged?" Hospital Service Finance, Vol. 9 : 1960, pp. 34-48.
- Roethlisberger, F.J. and W.J. Dickson, Management and the Worker, Harvard, 1939.
- Sayles, L. Behaviour of Industrial Work Groups: Prediction and Control, New York: Wiley, 1958.
- Selznick, Phillip "Foundations of the Theory of Organisations", American Sociological Review, Vol. 13, 1948, pp. 25-35.
- Skellern, E. Report on the Practical Application Toward Administration of Modern Methods in the Instruction and Handling of Staff and Student Nurses, Royal College of Nursing, 1953.
- Soler, C. "Reactions to Administrative Change : A Study of Staff Relations in Three British Hospitals", Human Relations, Vol. 8, pp. 291-316.
- Wilson, A.T.M. "Hospital Nursing Auxilliaries": Human Relations, Vol. 3, pp. 1-32. Report on the Study Group on Recruiting and Training of Nurses, Ministry of Health, London, 1947.
- Woodward, Joan "Industrial Behaviour: Is there a Science", New Society, 8th October, 1964. p. 13.



This work is licensed under a
Creative Commons
Attribution – NonCommercial - NoDerivs 3.0 License.

To view a copy of the license please see:
<http://creativecommons.org/licenses/by-nc-nd/3.0/>

This is a download from the BLDS Digital Library on OpenDocs
<http://opendocs.ids.ac.uk/opendocs/>