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ORGANIZATIONAL RESPONSES TO TASK-RELATED STRESS--
COMPARATIVE CASE STUDIES OF HOSPITAL NURSING UNITS

City University of New York

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ORGANIZATIONAL RESPONSES TO TASK-RELATED STRESS--
COMPARATIVE CASE STUDIES OF HOSPITAL NURSING UNITS

GREGORY A. KUHLMAN

A dissertation submitted to the Graduate
Faculty in Psychology in partial fulfillment of
the requirements for the degree of Doctor of
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1982

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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ABSTRACT

ORGANIZATIONAL RESPONSES TO TASK-RELATED STRESS-- COMPARATIVE CASE STUDIES OF HOSPITAL NURSING UNITS

Gregory A. Kuhlman

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Case studies of two hospital nursing units (an acute care medical unit and an obstetrics unit) were conducted using a methodology adapted from organizational diagnostic methods developed by Levinson (1972) and influenced by the methodological and analytical approach of the "action-research" model described by Miller and Gwynne (1972). Structured individual interviews, eliciting entry experiences, work role experiences, experiences of the relation between work and personal life, and projective material, were conducted with fifty-five Hospital staff members selected from different organizational positions and roles with emphasis on Hospital and nursing unit managers. Observations of work activities and a review of relevant documentation were also conducted. Case study material was comparatively analyzed within a general theoretical model of organizational dynamics and functioning based on both psychoanalytic and open systems theories, including the work of Wilfred Bion (1959), Miller and Rice (1967), Menzies

(1967) and Kernberg (1975).

Many aspects of organizational functioning were found, in part, to form a psychodynamic social defense system relative to particular sources of organizational anxiety, including task-related stress. Similarities and differences in the psychodynamics of the units studied were found to be consistent with similarities and differences in their work environments, including the nature of tasks and activities, staffing constraints, patients, intake and discharge processes, and unit sizes.

Similarities in psychodynamic functioning include the defensive use of professional role standards, idealization of work, emphasis on technology and related role specialization, emphasis on more discrete and distant work tasks, projection of unacceptable feelings and attitudes onto others, and export of feelings and "burnt-out" staff members. The principal difference found in the psychodynamic organization of the units was the relative tendency toward depressive versus hostile expressions of aggressive impulses on the medical and obstetrics units, respectively. The defensive systems of these units were found to be generally effective in controlling organizational anxiety and promoting their effective functioning--the main cost being continual loss of valuable staff resources through excessive turnover.

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INTRODUCTION

This paper presents case studies of two hospital nursing units. It attempts to understand these cases in the light of a general theoretical model of organizational dynamics and functioning based on both psychoanalytic and open systems theories.

It focuses specifically on the organizational responses to task-related stress. It is hypothesized that many aspects of their organizational functioning will be found to be consistent with a psychodynamic social defense system relative to particular sources of organizational anxiety.

While it is beyond the scope of this paper to undertake a comprehensive review of the organizational relations literature, some of the more relevant contributions are discussed, illuminating the theoretical and methodological underpinnings of the research and analytical approach employed. This discussion is followed by a description of the specific research methodology utilized.

In Part Two, the case material and analyses are presented. Material concerning the overall organizational environment of the Hospital is included to provide a context for understanding the functioning of the nursing units.

Part Three presents a comparative discussion of the case analyses. Some conclusions are offered concerning the relationship of these analyses to theories of organizational functioning and the organizational relations literature.

PART ONE

THEORY AND METHOD

THEORETICAL PERSPECTIVE

The theoretical perspective of this paper grows out of both psychoanalytic- and systems-based theories of organizational dynamics and functioning. A key contribution to this perspective is found in the writing of Wilfred Bion (1959) who formulated a psychoanalytic theory of the emotional life of work groups. A large group of theorists have further developed and amplified this work (Slater, 1966; Rioch, 1970; Gustafson, 1976).

A second key underpinning is found in the concept of the organization as an organismic open system in relation to its environment as articulated by Miller and Rice (1967). Rice (1969), Kernberg (1975), Jacques (1955), Menzies (1967), Gustafson and Hausman (1975), Emery and Trist (1960), and Trist (1981) have applied and extended this work.

Bion's theory of work groups describes them in terms of two types of behavior: the work group and the sentient group, which consist of the same set of individuals. This distinction reflects two different levels of needs operation in the group: work needs--which correspond to the task system--and sentient (emotional) needs, which correspond to the human factor of the group's members.

Work group behaviors are those which realistically relate to requirements of the group's task. Sentient group behaviors are those which are motivated by the--often unconscious--emotional needs

of group members.

Bion referred to these sentient group behaviors as those of a "basic assumption group", because the group behaves as if it has made a particular assumption about the basic purpose of the group, preempting the work task. For example, a group with a "fight-flight" basic assumption behaves as if its task were to attack or flee from some source of preeminent danger.

Bion delineated two other basic assumptions, dependency and pairing. Under a dependency basic assumption, a group behaves as if its purpose were to support a leader who will nurture all of its members. A pairing group attempts to couple two members in order to give birth to a savior for the group.

Other theorists have suggested additional basic assumptions, including pseudo-mutuality (Gustafson, 1976) where the group maintains the myth that there are no important differences between its members. The key point is that pressure related to emotional needs can, particularly in situations of stress, distort or even displace work tasks.

On the other hand, sentient group behaviors can also support the work of the group. Such emotional phenomena are involved, for example, when we speak of a group's esprit de corps.

Individuals take on leadership and other roles within the group in response to sentient needs of the group, as well as its work needs. While task-related roles are usually reflected in the formal structure of an organization, emotional roles often are not.

The level of organizational integration in relation to task performance--a measure of organizational health--is determined by

the nature of the fit between the task and sentient systems: that is, the ways, and the extent to which, the organization's emotional life facilitates and impedes its work life, its goals and purposes.

Miller and Rice's (1967) theory describes the organization as an open system in relation to its environment, extending Bion's theory to an intergroup model. As open systems, all organizations perform activities related to the import of resources across an external boundary, the transformation of throughput, and the export of products.

Most organizations are complex systems which require a number of sub-systems of activity related to the primary task of the organization, each with its own boundary within the organization. Each of these task sub-systems takes on an emotional life of its own, according to Bion's theory, as a work and sentient group which interacts with the systemic process of the organization as a whole.

The extended systems theory of organizational behavior encompasses more discrete structural and functional approaches, in addition to the psychological viewpoint. Structural features, such as differentiation, integration, centralization, formalization, and configuration, and functional issues, such as organizational purpose, goals, and tasks, have long been recognized as important factors in organizational behavior. Recognition of the role of individual and group psychological motivations is also longstanding. The work of Miller and Rice brings these system views together with psychodynamic considerations into a coherent framework.

Emery and Trist (1960) emphasize the role of the technological system as a dynamic, interrelated component in the functioning of

-

organizations:

The technological component has been found to play a key mediating role and hence it follows that the open system concept must be referred to the socio-technical system, not simply to the social system of an enterprise. . . . There is . . . an almost constant accomodation of stresses arising from changes in the external environment; the technological component not only sets limits upon what can be done, but also in the process of accomodation creates demands that must be reflected in the internal organization and ends of an enterprise.

Study of a productive system therefore requires detailed attention to both the technological and social components. It is not possible to understand these systems in terms of some arbitrarily selected single aspect of the technology such as the repetitive nature of the work. . . . (p. 87)

Rice (1969) has developed a further articulation of organizational systems theory in which he describes interleaving levels of similar individual, group, and intergroup structures and processes in organizations. These processes concern the regulation, through the exercise of authority, of complex boundary transactions between task and sentient systems and with the environment.

Leadership in a work group and in an organization performs the functions associated with the ego in the individual: It monitors and controls relations across boundaries, both internal (between sub-systems) and external (with the environment).

This is the management function which is critical to successful organizational functioning, since survival depends both on boundary transaction and boundary integrity. Leadership must successfully manage task and sentient systems within the constraints of the environment for organizational survival.

During times of stress, the management of anxiety becomes a key issue in the organization, as in the individual. Psychological processes are used defensively in relation to anxiety-arousing

issues in organizations. Organizational structures, communications, attitudes, relationships, and other processes may all be organized defensively. Leadership may also be influenced by defensive needs.

Kernberg (1975) has described some of the ways in which individual personality and leadership style interact with the defensive needs of organizations. He outlines the relationship between organizational (and group) regression and regression in leadership, including the regressive pull of aggressive, dependency, and sexual needs within the leader, within the work group, and in the relationship between the two:

The general implication is that a breakdown in the effectiveness of work created by various internal factors and relationships between the organization and the environment induces regressive group processes first, and regression in the functioning of leadership later. If these group processes remain undiagnosed, only their end product may be visible, in the form of what appears to be primitive, inadequate leadership and, more specifically, negative effects of the leader's personality on the organization. . . .

It is, of course, possible that serious psychopathology in the leader is, indeed, responsible for the problems of morale, of breakdown of task groups, and the development of regressive group processes. The problem, then, is to differentiate the symptomatic activation of emotional regression in the leader, reflecting problems in the institution, from the deterioration of organizational functioning reflecting psychopathology in the leader. (Part I, pp. 4-5)

He explores some of the specific ways in which particular leadership personality features impact, both positively and negatively, on the functioning of organizations. For instance, with obsessive personality features:

On the positive side, the focus on orderliness, precision, clarity, and control may foster good and stable delegation of authority and clarity in the decision-making process. . . . On the negative side, some dangers are the leader's excessive need for order and precision, to be in control, and the expression of the sadistic components that often go with an obsessive personality. (Part II, pp. 6-7)

Kernberg characterizes the schizoid leader as being insulated from group regressive processes but very available for the projection of distorted fantasies and unable to satisfy the dependency needs of subordinates. Paranoid leaders are a particularly good fit for fight-flight dynamics. Narcissistic leaders may require inappropriately submissive subordinates and, like schizoids, be unable to give, inducing a variety of regressive processes in organizations.

Jacques (1955) gives a cogent description of the impact of primitive psychodynamic processes in the social system of a factory department. In object relations terms, a social system encompassing processes of splitting, projection, and introjection defends against paranoid and depressive anxieties of system members.

Jacques points out the ways in which the social defense system, while allowing the day-to-day work of the department to proceed expeditiously, gives rise to a whole series of (otherwise seemingly inexplicable and contradictory) symptomatic behaviors in relation to organizational change and adaptation which is greatly impeded.

Menzies (1967) describes several ways in which social systems function as defenses against task-related anxiety in a hospital nursing service. In her case study, Menzies argues forcefully that the structure, culture, and mode of functioning of an organization develop, not only in the service of organizational task performance through available technologies, but also to provide for the psychological needs of its members, including the control of anxiety.

Menzies describes the task-related sources of anxiety on

hospital nursing services:

Nurses are confronted with the threat and reality of suffering as few lay people are. Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting, and frightening. Intimate physical contact with patients arouses strong libidinal and erotic wishes and impulses that may be difficult to control. The work situation arouses very strong and mixed feelings in the nurse: pity, compassion, and love; guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy of the care given the patient.

The objective situation confronting the nurse bears a striking resemblance to the phantasy situations that exist in every individual in the deepest and most primitive levels of the mind. The intensity and complexity of the nurse's anxieties are to be attributed primarily to the peculiar capacity of the objective features of her work situation to stimulate afresh these early situations and their accompanying emotions. (p. 284)

A number of specific defensive techniques used by this nursing service are identified by Menzies. Nursing work is broken down into task lists to increase the distance in the relationship of nurses and patients. The significance of individuals is denied (as symbolized by the nurses' uniform) by depersonalizing and categorizing them. Feelings of preference and other emotions are detached and denied.

Individual responsibility for decisions is reduced by ritualized task performance and a system of checks and counter-checks. Irresponsible impulses are split off and projected onto others. Responsibility for some tasks is distributed obscurely or inappropriately delegated to superordinates. The nursing role is idealized, and possibilities for individual development are de-emphasized. The structure of these defenses is rigidified by a resistance to change.

Menzies points out that these defensive structures, in addition to their inadequacy in controlling the primary task-related

anxieties, also arouse a considerable amount of secondary anxiety in and of themselves. These secondary anxieties include: stress related to the inadequacy of nursing service operations, feelings of loss caused by excessive transfer of staff, anxiety and guilt concerning underemployment of staff, and deprivation of individual work and social satisfactions.

Where the means of anxiety control are psychically primitive, much organizational energy is expended, and task efficiency sacrificed, in the maintenance of the social defense system. This organizational investment in the social defense system becomes debilitating when, as in the case of more primitive defenses, it contributes little or nothing to realistic organizational adaptation to the source of anxiety and arouses a great deal of secondary anxiety.

Gustafson and Hausman (1975) describe some of the organizational dynamics of an inpatient psychiatric service. These dynamics center around a process of splitting between patient and therapist roles where the therapists maintain an atmosphere of love and caring by avoiding discomfort associated with aggressive actions. Aggression is experienced exclusively as a negative attribute of the patient role.

One consequence of the need to maintain this split is a diminished capacity on the part of the staff to use appropriate aggressive actions in the service of work. This diminished capacity is reflected in and promoted by undue restrictions on, and a lack of clarity in, the delegation of authority on the service.

In general, some defensive processes and systems are as normal

to group and organizational life as they are to individual life. They become problematical when customary modes of coping are inadequate to control the level of organizational anxiety, and the group begins to function at a more regressed level which exacerbates organizational problems.

A vicious cycle can develop in which regressed, maladaptive functioning fails to cope effectively with anxiety arousing conflicts and problems which lead to further regression and ever poorer functioning. Usually, the organization possesses sufficient ego strength to interrupt this cycle through some realistic adaptation.

Evidence indicates that the stress which may lead to organizational regression can be induced by any combination of a variety of factors. Stressors may include deficits in feasibility of tasks, adequacy of resources, appropriateness of structure to tasks, and effectiveness of leadership, among others.

As in individual psychopathology, organizational symptoms may be misleading indicators of the source of anxiety. A systems analytical approach offers the opportunity to consider the dynamic interaction of a complex matrix of internal and external factors and processes in understanding organizational problems and dilemmas.

Both Menzies and Kernberg suggest that medical and psychiatric organizations, respectively, may be particularly vulnerable to organizational regression. Both base their arguments on the nature of the organizational task--treating human beings in distress (and often in a regressed state). This task is cited as inherently frustrating and anxiety arousing since it involves a high degree of

uncertainty of outcome and touches so closely upon powerful and volatile human emotions and fantasies.

These arguments suggest that the concept of organizational valancy for regression might usefully be explored by examining the group and organizational dynamics of human service enterprises in depth. There may be other stressors in addition to those related to task which would contribute to a predisposition to regression in the organizations.

If this is so, it would be useful to know more about the factors and processes involved in this organizational valancy for regression in human service enterprises. The following section presents briefly some methodological considerations relative to gathering data concerning the structures, processes, and psychodynamic functioning of such organizations.

METHODOLOGY

Methodological Considerations

The methodological approach employed by the researcher in gathering the data which is presented in the following case study reflects the psychoanalytic and systems theoretical base of this research. The case study method is largely adapted from organizational diagnostic methods developed by Levinson (1972). Another major influence on the methodological and analytical approach is the "action-research" model described by Miller and Gwynne (1972).

Levinson's method of organizational diagnosis is aimed at collecting and analyzing data on an organization as an organismic whole. Traditional attempts to collect information on organizations have focused on bureaucratic, role, and communications structures. Levinson's framework includes these areas, but goes beyond them to include a more comprehensive, dynamic overview of the organization, its subsystems, and its environment.

In addition to structural data, this method seeks to elicit information concerning organizational development and crises, perceptions, knowledge, and expressions, and attitudes and relationships. At the level of analysis, the method focuses this information on the organizational-environment boundary, assets and impairments, and level of integration--with formulation of genetic and dynamic analyses of organizational functioning.

Levinson describes several formal instruments which can be utilized to collect data concerning the organization. These instruments include interview and written questionnaires, as well as suggested observations.

The research orientation was extended to include the action-research approach described by Miller and Gwynne (1972). The focus of this approach is on establishing a relationship with the organization beyond that of information collectors.

In the action-research model, this role is extended to include feedback of preliminary findings to system members, mutual discussion of findings and problems, and collaborative development of adaptive organizational change efforts within an on-going relationship. With this method, opportunities for experiencing significant organizational processes are greatly enhanced.

This method is, of course, subjective in nature, requiring the use of the consultant-researcher's experiences and feelings as a research instrument. The dilemmas of becoming involved with the subject organization in this way, including the difficulty of "calibrating" oneself as a research instrument are manifold.

Miller and Gwynne suggest methods for self-calibration including personal psychotherapy, frequent consultation with non-involved colleagues, openness concerning emotional responses of researchers, and inclusion of these responses in data for later analysis.

Even with such safeguards, this method is admittedly problematical in terms of scientific objectivity. As Miller and Gwynne conclude however, it is quite questionable whether such

"objectivity" is achievable in the realm of the social sciences.

With this thought in mind, there are many advantages to having the involvements and reactions of the researcher openly acknowledged and included in the data. Indeed, the sort of information provided in this method, especially concerning transference phenomena, seems unobtainable in more "objective" methods.

Research Method

The Hospital was selected for study because of the interest of its Administrator in research relative to the organizational impacts of technological innovation (specifically, implementation of a computerized Hospital Information System) at the Hospital. Because basic data concerning the functioning of the Hospital was considered central to understanding the effects of any change, the Hospital setting provided an excellent opportunity to obtain this information.

Data concerning the Hospital was collected from three sectors of the organization. First, information was gathered relative to the Hospital at large. Based on this data, including discussions with Hospital and nursing administrators, two nursing units were selected for intensive study.

Two specific research instruments were adapted from Levinson (1972). A general questionnaire (Appendix A), guiding management interviews, was used to obtain basic structural, demographic, and other documentary information on the Hospital and on each nursing unit.

In addition, fifty-five structured individual interviews were conducted with a sample of Hospital staff members to gather

behavioral and attitudinal data from these three sectors over a four month period. Interview subjects were selected from different organizational positions and roles with emphasis on Hospital and nursing unit managers. Within roles, subjects were selected at random from Hospital staff lists.

Interview questions covered topics including entry experiences, work role experiences, information systems, HIS (Hospital Information System) implementation-related experiences, and projective questions. This interview structure is provided in Appendix B, and the interview sample is described by work group and work role in Appendix C.

The open-ended interview structure guided the course of the interview, however the researcher used his judgement to follow-up specifically on topics of interest. Due to time constraints, most but not all questions were asked of each subject. Over ninety-five percent of interviews were recorded on audio tape for later review.

In addition, the researcher kept notes on each interaction with the organization, including observations and reactions to his experiences. These interactions included negotiation of the research contract with representatives of management and staff sectors, making logistical arrangements, observation of various management and staff meetings, and administration of formal research instruments. Informal experiences provided some of the most useful data.

Some brief oral feedback of research findings was provided to Hospital leaders in the course of the study, particularly with respect to the impact of the HIS implementation. Reactions were

noted and included in the research data base.

Information gathered through these methods was reviewed, synthesized, and organized around the case study outline adapted from Levinson. This stage provided an opportunity to gain some distance from earlier emotional responses and cognitive sets relative to the subject organization--a chance to sift and interpret the data from a more removed perspective.

The product of this sifting and refining, along with subsequent analyses, is the basis for the following case material. This case material is presented according to the basic categories of Levinson's case study outline.

PART TWO

CASE STUDY

GENETIC DATA

Identifying Information

Hospital

The Hospital is a private, not-for-profit, acute care referral hospital. The Hospital building is a 630 bed facility and is located adjacent to several other components of the Medical Center of which it is one part. The Medical Center is a part of the University and also includes the Rehabilitation Hospital, School of Medicine facilities, and the Health Care Center, among other institutions.

In addition, the School of Medicine is responsible for the operation of a nearby City hospital. These components all share medical staff and training functions to some extent and the Medical Center provides a variety of central services (personnel, maintenance, etc.) to each of its component institutions.

The Hospital employs approximately twenty-five hundred non-physician staff directly, and another five hundred Medical Center employees (accounting clerks, plumbers, etc.) work at or closely with the Hospital for a significant part of their job. In addition, there are 320 administrative and managerial employees and 265 House Staff Physicians.

Each year the Hospital admits approximately nineteen thousand patients. The occupancy rate exceeds ninety percent. The average patient stay is about eleven days. The Hospital is classified as a

tertiary care facility, and the level of patient acuity is higher than at most similar hospitals because of teaching and research functions and the effect of the cooperative care unit to which less acute, recuperative patients may be transferred before they are ready to go home.

The Hospital serves a relatively affluent patient population, as one might expect, since all admitted are the private patients of the Attending Physicians. Forty-four percent of patients have Blue Cross coverage, ten percent have other private insurance, and forty percent are covered by Medicare. Only three percent are Medicaid or Workers Compensation patients, while an equal number pay their own way. Over a quarter of patients come to the Hospital from outside New York City, and stories of famous patients are frequently encountered.

The Hospital operates on a budget of 120 million dollars annually, and produces a surplus of 1.5 million dollars which supports the operation of the Medical School. Its financial condition is much stronger than most comparable institutions.

Obstetrics Unit

The Obstetrics Unit occupies an entire floor of the Hospital with the Post-Partum care section at one end and the Labor and Delivery and Nursery sections sharing the other end. The Post-Partum section has thirty-six beds.

The nursing staff of the Obstetrics Unit numbers approximately seventy-five for all shifts. Six house staff are assigned to cover this Unit as well as Gynecology. Pediatricians are also involved in

the care of babies in the Nursery. Over sixty attending obstetricians admit patients to the Unit, but a core group of under ten account for most admissions.

The Unit specializes in high-risk patients in the over thirty age group. The average patient stay on the Unit is well below average for the Hospital at about four or five days. The Unit averages 170-180 births each month. In order to accommodate this volume, the Unit operates at an average 120 percent capacity by placing some of its patients in beds on other units.

Medical Unit

The Medical Unit which is one of five medical nursing units at the Hospital occupies half a floor and is divided into two halls--the "high side" and the "low side". There are thirty-six beds, including a four bed intensive care room for particularly acute patients who do not require transfer to the Intensive Care Unit.

The nursing staff of the Medical Unit has approximately fifty members for all shifts. The house staff providing coverage for all five units of the Medicine Service numbers twenty. A large group of attending physicians admit patients to the Unit, but a core group of about thirty routinely admit patients here. Numerous consultants are also active in the treatment of patients here.

The Unit specializes in the treatment of extremely ill patients, many of whom have cancer or heart disease. Average patient stay on this Unit is well above the Hospital average at around twenty days due to the high acuity of the Unit's patients.

Circumstances of the Research StudyHospital Entry

This researcher first became involved with the Hospital in late December 1980. At that time he was invited to sit in on a meeting with the Hospital Administrator and a senior organizational researcher who is an associate of this researcher. He had been negotiating with the Hospital Administrator and the Executive Director of Nursing since Spring 1980 for authorization to conduct a large-scale study of the implementation of a new Hospital Information System (computerized communications, record-keeping, and accounting system) at the Hospital. This researcher was to design and direct the study under the supervision of the senior researcher.

During this meeting, the Hospital Administrator appeared to be generally interested in the idea of a study relative to the HIS implementation, and a number of general ideas about the design of the study were discussed. The study was conceived as an overview of the impact of the HIS implementation on the quality of working life and general functioning of the Hospital. A pre-post implementation design utilizing questionnaire and interview surveys of a large sample of Hospital staff members would be employed.

The Hospital would receive interim reports from time to time focusing on issues that would assist it in the HIS implementation task. Research findings would be presented in professional journals, providing public relations exposure for the Hospital's leadership position in HIS implementation.

During this discussion, the Hospital Administrator expressed some anxiety about whether such a study might stir up latent

resistance to the HIS implementation among some groups, particularly physicians. Physicians had been problematical at other implementation sites and had been particularly resistant to a major cooperative care innovation recently undertaken by the Hospital. Initially, a large proportion of attending physicians had refused to admit their patients to this facility, although they were eventually persuaded to do so. The Administrator also noted that the HIS Task Force was becoming rather anxious about the impending transition from design to implementation.

It was agreed that the Administrator would present the study for formal approval by the Operations Committee early in January. The Administrator stated that he expected this review to be pro forma and requested that the researchers prepare a detailed research schedule.

When the Administrator presented the study to the Operations committee for approval, he was rebuffed by his boss, the Executive Vice President of the Medical Center. At a mid-January meeting with the Executive Director of Nursing and the researcher, the Administrator stated that his boss regarded the study as "risky" and without obvious benefit for the Hospital. The Administrator felt that the decision was open to appeal.

It was decided to prepare a document outlining the potential benefits of the research and the steps which would be taken to minimize any risks (e.g., careful review at each stage of the study). In addition, the senior researcher was to meet with the Executive Vice President to attempt to persuade him not to oppose the research.

Late in February the Executive Vice President agreed to allow the study at the behest of the Administrator and Executive Director of Nursing, but told them that "its your ass, if anything goes wrong."

During March the study received provisional approval from the Hospital Human Subjects Review Committee. In April, this approval was temporarily rescinded when the full committee required changes in proposed letters to prospective survey participants. In May, revised letters were approved by the Committee.

During June, a specific proposal for pilot interview and questionnaire administrations was approved by the Administrator. A meeting was held with the Administrator to obtain a variety of general information about the Hospital and a list of forty Hospital staff for selection of a pilot survey sample.

During July, five pilot interviews were conducted by this researcher and an additional three by the senior researcher. Fourteen pilot questionnaires were distributed. Six were completed and returned over a four week period. In addition, five top Hospital managers were interviewed.

At the end of July, a meeting was held with the Administrator to discuss results of the pilot survey and plans for distribution of the preimplementation questionnaire to a large sample of Hospital staff. Interviews with top Hospital managers continued.

During August, it became known that the Executive Vice President of the Medical Center had resigned to take an executive position with an insurance company. The reasons for his resignation were unknown, and it was widely speculated that his resignation was

precipitated by the appointment of an inexperienced University President who would have to be "broken in". News of his resignation struck the Hospital as something of a bombshell, as he had been the key leader of the Hospital since its move to its current building twenty years previously.

A short time following the announcement of his resignation, it became known that the Provost of the Medical Center had submitted his resignation as well, but would stay on until a new Executive Vice President had been appointed.

Early in September, the Hospital Administrator reported that the Medical Center Vice President for Personnel had vetoed the research study. The reasons given for the cancellation concerned an anticipated unionization drive which was expected to take place among nursing and clerical employees during the fall. The Vice President felt that the focus of the union effort would be the HIS implementation and that a survey in this area would increase the risk of unionization. It was explained that the Vice President's authority to cancel the study was firm, since his past success in preventing unionization of the most Hospital staff was highly regarded.

While the larger scale survey could not be revived again, the Vice President and the Hospital Administrator agreed that a smaller scale study could take place, provided that it focused on two or three nursing units in the Hospital. It was agreed that the data collection would take place by interview and observation. In addition to managerial personnel (team leaders and above), sample size would be limited to five nurses, five physicians, and five aide

and clerical staff on each nursing unit. Interviews with key Hospital managers would continue to follow the HIS implementation and general Hospital functioning relative to the units under study. Selection of nursing units for the research would be subject to approval of the Hospital Administrator.

Nursing Unit Entry

Nursing units to be studied were selected in consultation with the Hospital Administrator, the Executive Director of Nursing, the Director of Nursing, the HIS Project Director, and the Administrative Supervisors and Head Nurses of the units under consideration.

An acute care medical unit and an obstetrics unit were chosen for intensive study. Criteria for selection included differentiation of task (acute care versus healthy process) and HIS implementation status (pre- versus recent implementation).

The initial response to the research of nursing unit managers was notable. After their interview several of the Supervisors and Head Nurses made inquiries at the central Nursing Office as to whether Nursing Administration was aware of the content of interview questions. Several of them expressed concern that they might have been "disloyal" in giving sensitive information to this researcher.

As a result of their inquiries, a meeting with the researcher was requested by an Assistant Director of Nursing. The Assistant Director was provided with the interview structure outline and the general thrust of the research was explained. She agreed to reassure these unit leaders that the research had the approval of

Nursing Administration.

Nursing unit managers agreed to request permission from unit staffs for research observation of meetings on the units. Permission was subsequently obtained. Permission for interviews was sought individually by telephone follow-up to letters describing and authorizing the research. No nursing staff member refused permission for an interview, and only three individuals withheld permission for audio recording of the interview.

Hospital managers were equally cooperative in participating. Resident physicians were generally cooperative, but very hard to track down. Five out of six were interviewed eventually. The sixth cancelled four appointments before leaving for a new rotation at another hospital. Attending physicians were the least cooperative group (particularly obstetricians)--the majority of those solicited declined citing lack of time.

Initial Overall Impressions

Upon entering the Hospital one immediately has the sense of having entered an orderly, well-kept building. The small lobby area is clean and neatly organized with an attended information desk at hand. Resting prominently atop the desk which is otherwise surprisingly clear of papers, one notices a computer terminal.

One soon develops a familiarity with the premium placed on space here: As one makes one's way with difficulty past those who are waiting for an elevator, one sees many others waiting in the adjacent admission area. The area is bustling.

During the months of negotiations and snags in developing the

authorization for the research, the researcher became aware of an underlying emotional tone of anxiety--a continual feeling that the study might be scuttled at any moment should the anxiety level rise too high.

During the initial phases of interviewing on the selected nursing units, the prevailing feeling was that one was rather unimportant: Scheduled interviews might or might not take place depending on other job demands; appointments were continually canceled without notification and had to be rescheduled (particularly on the Obstetrics Unit).

HISTORICAL DATA

Events Leading to the Initiation of the Study

During 1969-70 several vendors proposed installing their computerized hospital information system at the Hospital. It was felt at that time that an HIS might potentially be able to contribute to an improvement in the effectiveness of Hospital information processing. Several studies of the general operational and fiscal feasibility of an HIS at the Hospital were conducted over the next eight years, and the idea was bandied about in top management circles, particularly by the Long Range Planning Department.

The HIS is a computerized medical record-keeping and information transmittal system which replaces most paper information systems. A large central computer is used to store and manipulate data which can be entered and retrieved from terminals throughout the Hospital. Two or three terminals are installed on each nursing unit and ancillary service department along with a printer to generate hard copy for patient charts and other purposes.

Most patient record-keeping and medical ordering is done through the computer. For example, if a physician wants to order a particular blood test for a patient, he enters the order at a terminal screen using his personal authorization code. The computer then uses its printers to notify the appropriate nursing station and laboratory that this work is to be done. If any special

preparations are required, such as dietary restrictions, the appropriate departments are notified. The staff obtains a blood sample, labels it with a label generated by the computer, and sends it to the lab. The lab staff feeds the blood sample to the automated laboratory blood analysis machine which automatically feeds the results to the HIS computer as soon as they are available. The computer enters the results in the patient's medical record and uses its printer to provide a hard copy for the patient's chart at the appropriate nursing station. The physician may check the patient's medical record for the results by using any terminal in the Hospital. In addition, the computer automatically enters a charge for the test on the patient's bill.

In 1978, a contract was concluded with a vendor to install an HIS at the Hospital. Under the contract with the vendor, system design and implementation planning was done by a Project Team within the Hospital. The Project Team included representatives from most Hospital departments and extensive consultation with departments took place over the next two years of design activity. A design freeze was imposed on September 1, 1980, and installation of hardware began on that date.

On-line implementation of HIS began in January, 1981. Training was provided for all affected staff, immediately prior to implementation on their unit. The implementation plans called for bringing the system on-line first in all ancillary departments of the Hospital--e.g., Admitting, Radiology, etc.--so that these services would be available when nursing units were brought on-line gradually, one by one. Nursing unit implementation began in April,

1981 with the Neurology unit. It was expected to continue for approximately one year until all Hospital nursing units were brought on-line.

At the time of this study, about half of all nursing units were up. The Obstetrics Unit was brought on line during August, 1981. The Medical Unit was expected to be brought up in March, 1982. The implementation was proceeding approximately on schedule with some minor delays from time to time.

Problems of the Organization
as Stated by Key Figures

Directly Related to HIS Implementation

A number of problems were experienced in the course of the implementation. The most prominent problem was the frequency of system down time--that is, time when HIS is unavailable to users. While some down time was anticipated (a regular two hour down is planned each night at three a.m. for regular maintenance), the amount and frequency of down time greatly exceeded expectations.

The major cause of this problem was inaccurate allocation of computer memory space for various system functions. Because programmers are not intimately familiar with Hospital routine in every operating area, it is extremely difficult to predict how much different HIS functions will be utilized by different Hospital areas, and thus how much space must be allocated for storage of data relative to those functions. When space allocation is exceeded by greater than anticipated utilization of a given function, data "spills over" into memory areas reserved for other functions resulting in a scrambling of information and disruption of HIS operations.

HIS must then be closed to users so that space can be reallocated, data unscrambled, and the system restored to operating order. During the time that it takes to do this, Hospital staff must make do with manual back-up systems. At the end of the down time, all data from the down period must be entered into HIS to update it on the current status of each patient. Needless to say, this procedure entails considerable frustration for all involved.

Other problems experienced were mainly localized in effect. These problems included various inaccuracies in programming for specific functions--e.g., omitting an automatic ordering capability for a commonly used procedure on a service, so that the procedure must be typed into HIS for each order.

Other problems related to general system limitations with unanticipated effects. For example, Hospital staff were accustomed under manual procedures to being able to thumb through a patient's chart for a particular type of data, recognizing it by the color, typeface, and organization of the standard form. Because of limitations inherent in the type of printers used by HIS, this forms recognition was disrupted. HIS prints all output on the same white paper, using the same typeface with little variation in format. All reports in a patient's chart tend to look alike.

Cumulative reporting provides an additional example of system limitations. Because of standard paper width (printers cannot operate vertically), cumulative laboratory results are printed on one page for the past seven days' only. Under the previous manual system these results were charted by the month, and it was easier to discern long-term trends.

Hospital Problems

A range of problems are cited by key Hospital managers, however none are acute at present. The immediate focus of Hospital managers is primarily on the problems described above relative to HIS implementation. Other problems include maintaining adequate nursing staffing within a nationwide nursing shortage. Maintaining compliance with myriad State and Federal regulations is cited as a preoccupation. The Hospital suffers from a shortage of space and currently plans the construction of a major addition and the renovation of a number of units.

In a day and age when many hospitals are in dire financial straits, it should be noted that fiscal problems are not a prominent focus at the Hospital. Indeed, each year the Hospital produces a substantial budgetary surplus which contributes to the operation of the Medical School.

Obstetrics Unit Problems

Problems cited by key leaders on the Obstetrics Unit include staffing shortages. Because of the nursing shortage, many of the staff nurses available for duty are inexperienced new graduates. This problem is particularly acute over the summer when old staff have left while new graduates are not yet available for hiring. Staffing problems are made particularly acute by the unpredictable nature of obstetrical admissions. At times the Unit has carried a census of up to fifty patients in a thirty-six bed facility.

There is a great deal of variability from day to day with respect to the number of women in labor admitted--on a slow day

three or four women might be admitted, while a busy day sees seven to ten or more admissions. When patients admitted on a busy day require Caesarian section deliveries, this places further demands on staffing patterns. Usually, staff are pulled from the Nursery and Post-Partum units to provide increased coverage in the labor area at peak demand times. The ability to shift staffing in this way is constrained by the training and experience of staff available.

Nurses are affected by this staffing shortage when they cannot have the days and times off that they would prefer. Because of the need for coverage for deliveries and care day and night, there is little flexibility in work schedules. There is a great deal of pressure not to call in sick, for example.

Another problematical area cited by unit leaders is the historical role of obstetrics as a second-class specialty in medicine. Before the Hospital moved into its current building, there was no Obstetrics Unit. Unit leaders describe something of an uphill struggle to gain recognition for the needs and priorities of the unit. For example, the nursing staff on the Obstetrics Unit would like to see an expansion of facilities for rooming-in patients. There are currently only four out of thirty-six beds available for rooming-in.

Some attending physicians complain that the number of residents available to cover the patients in obstetrics and gynecology needs to be increased. Since gynecological patients tend to be more acutely ill (birth being a natural, healthy process) and less routine, house staff attention tends to be dominated by these patients, although the same residents provide coverage on both units.

Leadership issues are frequently cited as a problem on the Obstetrics Unit by staff at all levels. There is the feeling that not all Unit nursing leaders are as capable in relation to patient care as might be expected, and that leaders do not often pitch in to do their share. This impression produces a morale problem, particularly among younger members of the nursing staff who are looking for role models.

Medical Unit Problems

The Medical Unit suffers from many of the same staffing problems as the Obstetrics Unit and other nursing units in the Hospital. While census on the Medical Unit is more predictable and stable than on the Obstetrics Unit, the acuity of the patients is vastly greater. In fact, many of the patients on the unit are dying.

This is a special source of stress, especially for the young, new graduate staff nurses on the Unit who are encountering death for the first time. Almost all of the nurses on this unit state that they take their job home with them to a great degree. The nursing staff on the Unit must also deal with patients' families during their adjustment to patients' illnesses. A special stress group is available for nurses on the unit to help them deal with job demands.

The acutely ill patients on the unit require an extraordinary amount of care. Most nurses feel that the pressure of patient care tasks is such that they are unable to do everything that they would like to do for their patients in terms of making them comfortable and providing emotional support. Time constraints make it necessary to stick mostly to medically required work. Some nurses report

experiencing feelings of guilt in relation to these constraints, taking the responsibility for limitations upon themselves, although most accept their own limitations intellectually.

Space is a problem here as elsewhere in the Hospital. Supplies storage was recently reorganized to accomodate the installation of HIS terminals exacerbating a pre-existing problem. Many supplies and pieces of equipment on the Unit are stored on rolling carts, so they may be kept in the hallways without violating regulations concerning the obstruction of hall areas. Some equipment is stored in the dirty linen room as well.

Developmental History of the Organization

Hospital Background

The Hospital has a long and varied history which is closely intertwined with the other institutions comprising the Medical Center. The University itself was founded in 1831, its Medical School a decade later. The Hospital as an institution came into being when the Post-Graduate Hospital, which had split from the Medical Center in 1882, was re-merged with the Center and became the Hospital. The Hospital moved into its present building adjacent to most other Medical Center components in 1963.

With its move into the present facility, the Hospital acquired a new Administrator who went on to become the Executive Vice President of the Medical Center. He is widely regarded as the spirit behind two decades of Hospital development.

A major watershed during this period was the building and implementation in 1979 of an innovative Cooperative Care facility at

the Hospital. This facility houses patients who are well enough to leave the Hospital but not well enough to go home. In Coop Care, patients are cared for by a care partner until they are ready to live at home again. In effect, this freed the other units of the Hospital to care for more acutely ill patients, and in doing so increase the demands placed upon these other units by raising their average level of patient acuity.

The implementation of HIS is viewed as a second major watershed, shepherded by the Executive Vice President before his recent resignation. Throughout his tenure, the Hospital developed a reputation for innovation which is reflected in the Coop Care and HIS programs, as well as more circumscribed programs like ambulatory surgery and sports medicine.

Obstetrics Unit Background

The Obstetrics Unit first came into being with the move to the current Hospital building in 1963. Few major changes have been reported on the Unit over the years. Development is seen more as a gradual evolution of medical techniques--for example, the practice in recent years of allowing fathers in the delivery rooms. The implementation of HIS is viewed in this context. Although the impact of implementation was more disruptive than that of most other technological change, it has now been absorbed into Unit routine. Obstetrical patients rarely use the Cooperative Care program, so it has had little impact here.

Perhaps the most noticable change has been in the nursing staffing pattern which has undergone the same shifts seen in the

Hospital as a whole. Many more of the nurses are young and inexperienced in recent years and the rate of turnover has increased. The Unit often suffers a nursing staff shortage, especially in the summer months.

Medical Unit Background

The development of the Medical Unit has a number of elements in common with that of the Obstetrics Unit and the Hospital as a whole. Nursing staffing has become problematical here in recent years. Leadership, in contrast, has remained constant. Patient acuity level has increased somewhat since the implementation of the Cooperative Care program. Change here also is seen in terms of medical developments--new disease syndromes and treatment techniques which are seen from time to time.

Service History

Hospital Service

Throughout its development the Hospital has enjoyed a fine reputation for the delivery of quality patient care. This is the top organizational goal within the Hospital. Within the Medical Center this goal is combined with that of providing top flight medical training. The reputation of the Hospital for quality care has enabled it to attract excellent staff and has made it a regional treatment center for a number of specific patient types. It has also been able to attract relatively sophisticated, upper and middle class patients who are able to afford its fees.

Obstetrics Unit Service

Patient care on the Obstetrics Unit is not regarded by most as equal to the outstanding level of care associated with the Hospital in general. While many feel that the quality of care here has improved gradually over recent years, there is the feeling that it is only good to average and lags behind that available elsewhere.

In part, this is attributed to a conservatism felt to be inherent in the institution which has slowed the implementation of new obstetrical techniques such as birthing chairs and the presence of fathers at cesarian section deliveries. In particular, the quality of post-partum care for mothers is felt to be only average.

Medical Unit Service

Medical care here is felt to be among the best available anywhere--one of the top units in one of the best hospitals. This particular Unit is felt to be rated as slightly better than the other excellent medical units in the hospital, mainly because of its experienced nursing leadership. In spite of feelings on the part of some nurses that they do not have time to do all for patients that they would like, most believe that patient care is the top priority and that, in general, no better care is available anywhere.

STRUCTURAL DATA

Formal Organization

Hospital Organization

The gross formal organization of the Hospital is, in part, described by two organizational charts for Hospital administration, and Nursing Department administration presented in Chart 1 and Chart 2, respectively. Top management decision-making at the Hospital takes place in a number of committees composed of key Hospital administrators. Decision-making is mainly by consensus. Changes which are opposed by major management groups are not implemented.

The central management committee in this respect is that composed of the Vice Presidents of various Medical Center components. Most major decisions come before this group for disposition. Depending on the nature of the decision (i.e., who will be affected), it may be referred to a number of other groups for consideration.

These groups include executive committees of the Hospital medical staff, the Medical School faculty, and so forth. Some decisions are referred to sub-committees of these bodies for study. For example, the HIS implementation is monitored by a special inter-group task force. The Board of Trustees of the Medical Center must approve major budgetary moves, capital expenditures, faculty appointments, and the like.

Chart 1

Hospital Administration Organization

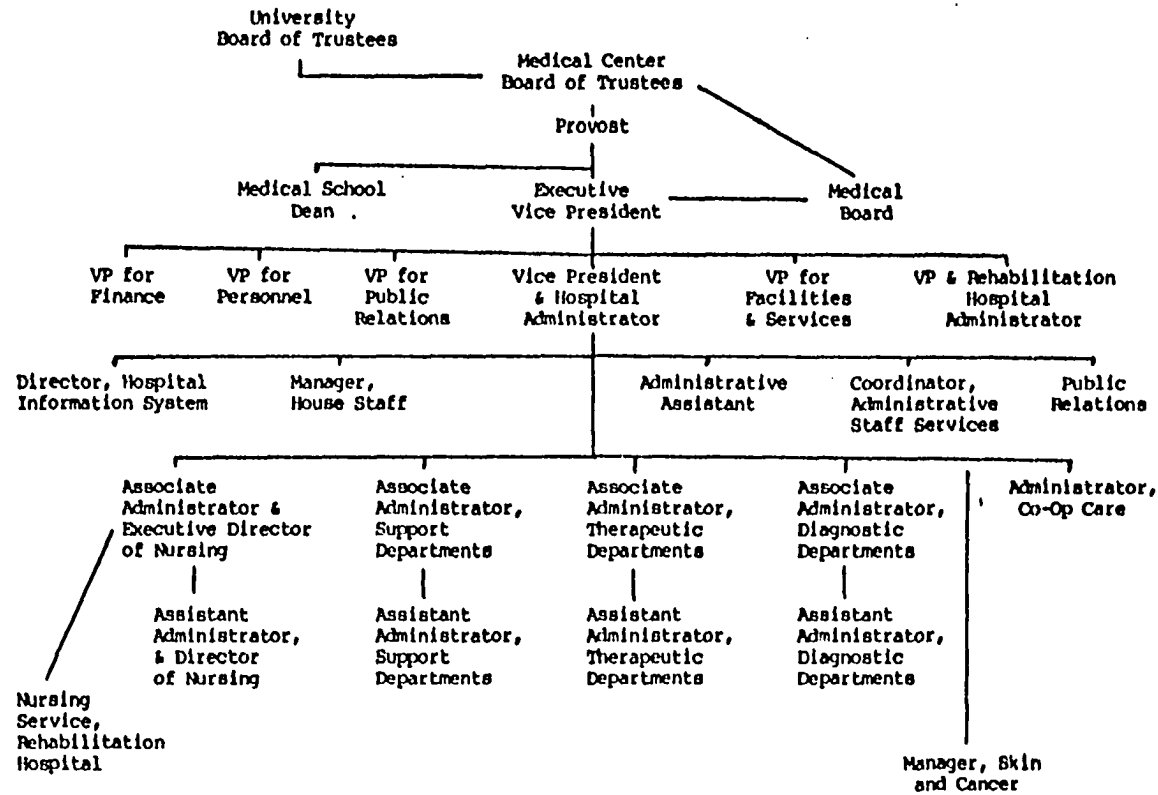
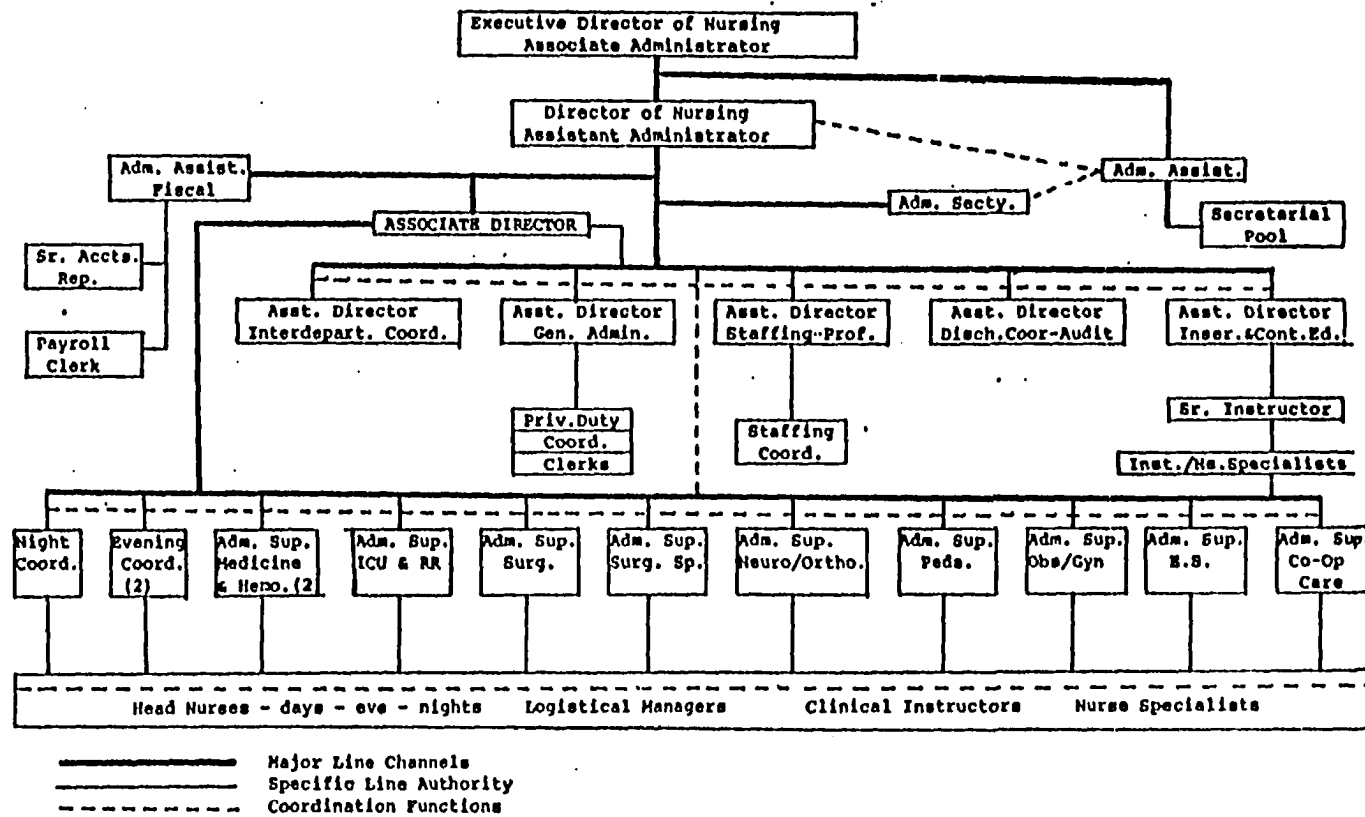


Chart 2

Nursing Department Organization



Roles within the Hospital organization tend to be highly formalized with detailed job descriptions governing responsibilities and authority. This tendency reflects the great number of regulations governing professionals employed in the Hospital setting and governing hospital procedures in general, as well as the task demands of a complex organization.

Obstetrics Unit Organization

The Obstetrics Unit is somewhat larger than most nursing units in the Hospital, and its structure reflects a somewhat greater degree of complexity required by its size and tasks. The top manager of the Unit for nursing staff is the Administrative Supervisor for Obstetrics and Gynecology who reports to the central Nursing Department. Each of the three sub-units (Labor and Delivery, Nursery, and Post-Partum) are managed by head nurses who are supported by assistant head nurses (night coverage) and team leaders.

Operationally, the nursing staff takes direction from the nurse in charge of the sub-unit at any given time (usually one of the leadership personnel listed above, though occasionally a staff nurse) and also from physicians treating patients on the Unit. licensed practical nurses and nursing aides take direction from the nursing staff.

The house staff on the Unit is organized into teams or firms. Each firm is headed by a chief attending physician and includes an experienced resident, other residents and medical students.

Operationally, the attending physician treating a patient supervises

all medical activity relative to that patient with residents providing coverage. Each medical service has an overall Chief who is a senior faculty member of the Medical School.

Medical Unit Organization

Medical Unit structure is similar to that of the Obstetrics Unit, but a bit simpler. Here the Head Nurse is considered the top manager of the unit reporting to the Administrative Co-Supervisor for Medicine.

Assistant head nurses and team leaders report to the head nurse and supervise staff nurses. LPNs and nursing aides take direction from the nursing staff. Medical personnel are organized similarly to those on the Obstetrics Unit.

Plant and Equipment

Conditions throughout the Hospital are crowded, and the Obstetrics Unit and Medical Unit are alike in this respect. Small to tiny offices are shared by staff at all levels, and privacy is difficult to find. Many spaces serve multiple functions--nursing staff lounges are also lunch rooms, medical meeting rooms, etc.

What space there is appears to be clean, well-organized, and well-equipped. Supplies and equipment are more available than at most hospitals, although some specific items are in short supply (isolation carts, for instances). The Hospital prides itself on having the most up-to-date medical equipment and supplies.

Ecology of the Organization

One of the most striking aspects of Hospital ecology is the

physical mobility of its staff. Viewed in macrocosm, the Hospital is a sea of swirling activity, constantly in motion. Most key personnel, managers, and physicians carry radio page beepers, so they can be contacted, not just in emergencies, but routinely as well. If one wishes to get in touch with most of these people, it is necessary to page them.

The exception to this rule is the nursing staff whose activities are by and large confined to a circumscribed set of rooms on their unit. Nurses can for the most part be located by phoning their unit or calling out their name in the hall of their unit.

Nurses, though, are subject to a temporal mobility in their work. They have different days off each week on an unpredictable schedule that they may not know until a few days in advance. In addition, staff nurses rotate among night, evening, and day shifts as often as every three weeks and are frequently requested to work double shifts to cover for absent co-workers. This rigorous scheduling is one of the most prominent complaints by nurses about their working conditions.

The nursing staff is unique in its localization, among patient-care personnel. This characteristic is both a function of the nursing task and determinant of that task. Because nurses are the most available, they tend to be the coordinators of medical care even though they lack the authority to make final decisions. When new tasks arise, they tend to be delegated to nurses because they are available.

Because nurses have the most constant, consistent contact with patients, they tend to be more subject to emotional effects of

working with patients. Nurses tend to deal with patients as whole people to a greater extent than specialized staff--oncologists who treat the patient's cancer, laboratory technicians who work with the patient's blood, dieticians who attend to the patient's diet.

Financial Structure

As noted under Genetic Data, the financial structure of the Hospital is dominated by the fact that income is predominantly derived from third-party (insurance) payments. Since 1978, the State has controlled inpatient hospital charges other than those covered by Medicare which are controlled federally. Appeal of rate regulations is a three year process which plays havoc with cash flow even if successful.

The Hospital is felt to suffer particularly under this system because of its uniquely complicated and acute patient population which tends to make its costs appear higher than those of institutions treating more conventional populations. So far, the Hospital continues to produce a small operating surplus which is used to support the operations of the Medical School.

Personnel

The Hospital employs approximately twenty-five hundred non-physician staff directly, and another five hundred Medical Center employees (accounting clerks, plumbers, etc.) work at or closely with the Hospital for a significant part of their job. In addition, there are 320 administrative and managerial employees. There are 4.4 staff members per bed.

Physician staffing is provided by approximately one thousand

attending physicians of whom about two hundred are considered active (with patients frequently admitted). Attending physicians receive private compensation from their patients for their services and are not employees of the Hospital although they have a formal relationship with it. Many attendings receive compensation from the School of Medicine for teaching or research activities which may be carried out in part at the Hospital. Resident physicians in training compose the 265 member house staff. In addition, students from the Medical School are much in evidence at the Hospital where they do clerkships.

The nursing staff, which includes registered nurses, licensed practical nurses, aides, and unit clerks, numbers about one thousand. Ancillary services like Laboratories, Admitting, and Pharmacy employ some 225 technicians and clerks. The remainder of the staff are affiliated with Housekeeping, Security, and the like. In addition, students from nursing and other professional schools are at the Hospital for field placements.

A detailed analysis of staff demographics at the Hospital is beyond the scope of this study, however a number of trends may be noted. In general, the number of minority employees is markedly greater in lower level positions--housekeeping staff, aides, etc. The nursing staff is predominantly female, particularly at the professional level where it is also predominantly young and white. Aides and LPNs tend to be minorities, older, and of much longer tenure. The medical staff is predominantly white and, to a lesser extent, male.

The group with the shortest tenure is the professional nursing

staff with an average tenure of one year. Typically, the Hospital attracts recent graduates of nursing schools who seek an advanced training experience before settling into a more comfortable job.

Demographic trends on the nursing units studied were consistent with those noted in the Hospital at large.

Personnel Structure

Personnel structures at the Hospital are fairly standard. There is little variation between units.

Recruitment. For most positions recruitment is through advertisement, reputation, and personal contacts. Recruitment of professional nursing staff is the biggest recruitment problem as noted in previous discussion. Benefits and other compensation for this group are continually being updated and improved to remain competitive with those offered by other New York area hospitals. Many new graduate nurses are attracted to the Hospital because of its reputation as a high quality training institution, some after having done school placements at the Hospital.

Orientation. Most nursing employees receive formal orientation training specific to the unit on which they will work. For nurses the orientation period lasts a month which is divided between patient care courses and on-the-job training. On the other hand, house staff at the Hospital receives no formalized orientation. They are usually given a brief tour by a more experienced physician and then learn the ropes as they go.

Training. Advanced training likewise varies from group to

group. House staff are supervised routinely by more experienced physicians and participate in a very formalized training program. A variety of in-service training events are available to professional nursing staff--though participation depends on individual interest and the pressure of staffing demands. The Hospital provides release time for professional nursing staff to attend conferences. For other nursing staff there is little or no formal training available, and this is the source of some resentment on the part of some LPNs and aides.

Promotion. Job advancement opportunities vary widely between groups. Certain promotions take place automatically within the nursing staff. LPNs become staff nurses if they pass the examination for registered nurse. staff nurses tend to be promoted to staff nurse senior after a year or so on the job. Advancement opportunity beyond staff nurse senior tends to be more limited. For nursing aides there is essentially no advancement available.

Compensation. Salaries at the Hospital for most groups are comparable to those offered in similar institutions elsewhere. Salaries are not viewed as the primary source of employee motivation. Particularly for those on the professional nursing staff, there is an awareness that working conditions and pay might be better in other settings. Compensation for nurses lags behind that of comparable male-dominated professions--pharmacists, for example, receive higher salaries. Many are motivated by their own need for a period of intensive training and hospital experience before seeking other positions.

The Hospital does make a special effort to keep nursing compensation and benefits equivalent to that offered by other hospitals because of the chronic nursing shortage. This effort includes special benefits and programs such as reimbursement for education and four day work week.

It should be noted that attending physicians are in a unique position among Hospital staff as regards compensation. They receive no compensation from the Hospital whatsoever. Although some receive a salary through the Medical School, the primary source of income is patient fees.

Evaluation and Supervision. Hospital employees receive a formal written evaluation from their supervisor at least once annually. The view of these evaluations is mixed. While some find them helpful, others feel that they are really pro forma. Promotions are felt to depend on a number of factors in addition to job performance, including "how well liked you are by leadership". These more informal factors are felt to weigh more heavily by many of the Obstetrics Unit nursing staff. The attitudes of many are reflected in the observation of one nurse that "they can always find something wrong if they want". For the purpose of learning, day-to-day clinical supervision is felt to be more helpful by most nurses.

Some house staff, on the other hand, feel stifled by their supervisory relationships. After experiences in other hospital placements of having primary responsibility for patient care decisions, it is difficult for many of the residents to accept a

secondary role to the attendings as is usual at the Hospital because of the private status of patients.

One resident described the situation:

Sometimes the nurses can really boss the residents around because these patients are not really yours, and you can't make any final decisions. So the nurses can call you up and say, "You have to come over here right now. You have to do this, and you have to do that. This is the attending calling in and I'm passing on the message." I can't stand the way the attendings call up the nurses rather than me for a change in their therapy, relaying messages through the nurses. That gets me mad. . . . Then you have no way to discuss it. If you disagree, you don't have any say in the matter. It makes you feel below the nurses.

Labor Relations. Employees of the Hospital are only partially unionized. Service employees, aides, patient unit clerks, technicians, and many ancillary service employees belong to Local 1199. Nurses, most clerical employees, administration, interns and residents are not unionized. The most recent strike was by security and buildings and grounds employees two years ago, however there were very tense negotiations recently with physical therapists. The Hospital administration is very sensitive to the non-union status of many of its employees and is very desirous of maintaining this situation. Most unionized employees working on nursing units do not feel that the union has much impact on their working life and they know little about it.

Policies and Procedures

Policies and procedures at the Hospital are highly formalized. The two main means of dissemination by written memoranda which are kept on file and by presentation during the orientation of new staff. For house staff, dissemination is by word of mouth.

Much of this formalization of policies and procedures exists in response to outside regulation. In some cases, formal policies are stretched by nursing staff in order make limited staffing more effective. For example, LPNs are not officially permitted to administer certain medications which must be administered by a registered nurse, however some LPNs administer these medications under some staffing situations when a registered nurse is not readily available.

Time Span and Rhythm

Hospital

Different areas of the Hospital respond to different temporal influences, however there are some Hospital-wide trends. Time tends to be in short supply everywhere in the Hospital. There is usually more work to do than time to do it. Many nurses and some other employees stay beyond their scheduled shifts or work over lunch break without additional compensation because of the press of work. Appointments are difficult to schedule with many patient-care staff, and it is often necessary for them to cancel established appointments at the last minute because of patient-care demands.

One nurse commented: "There aren't enough people to get everything done and get out on time. You try to get all that done and take a lunch break without driving yourself crazy."

While the work to be done on nursing units is generally defined by patient needs, nursing staff tend to have a fair amount of discretion in deciding how to organize the work, so long as orders are fulfilled and urgent tasks attended to. Physicians are

more constrained in their schedules by their need to move among different locations and keep patient appointments.

It should be noted that data for this study was gathered primarily in relation to daytime activity, although the Hospital functions on a twenty-four hour basis. This is a significant factor for staff who must provide coverage for evening and night. Different groups organize coverage differently. Most groups have regular shift assignments. Staff nurses and house staff physicians have rotations to each shift periodically.

For residents these rotations are particularly strenuous. Most residents actually spend very little time in activities away from the Hospital, since they work every third night in addition to long days. Most have only time to take care of urgent errands and catch up on sleep before returning to work.

One resident commented: "It's the hours that need to be coped with more than anything. You have to figure out how to have a life. Usually you don't have a life. You have a semi-life."

Obstetrics Unit

The rhythm of activity on the Obstetrics Unit tends to be erratic, especially in the Labor and Delivery section where it corresponds to the number of women in labor admitted. In the Nursery, feeding time tends to be busy with babies being transported over to mothers in Post-Partum.

In terms of annual work cycles, there is a "baby boom" from May through September and again from December through January. The summer period is especially heavy since it corresponds with the

period of peak staff shortages.

Medical Unit

On the Medical Unit rhythm tends to be more regular. Afternoons can be busy if there are a number of discharges and admissions to be handled. The activity level during the morning can be elevated, since physicians conduct rounds then, followed by writing of new orders.

At times, the rhythm of certain activities can be a source of stress here. This is particularly true in relation to laboratory tests. A great deal of time is spent awaiting the results of various tests which will influence treatment decisions. The long waiting periods are a source of particular frustration for patient care staff who complain that often after waiting for results they discover that blood samples have been lost. One of the specific aims of the new HIS is to improve reliability and timeliness of laboratory results.

According to one resident: "Every now and then you see people in the lab services who seem kind of crazy on the phone--who seem not to have any idea of why they are doing these labs."

Communication Processes

Hospital

As might be expected, the communication systems of the Hospital are quite complex and highly formalized. Such systems are required to link all of the component parts of the organization which are involved in its numerous tasks--including, most prominently, the primary task of patient care. The treatment of

acutely ill patients depends on effective communication between physicians, nursing staff, laboratory technicians, dietary services, x-ray technicians, consultants, and pharmacists, to name just a few. In addition, there are important communication processes related to training, billing and other administrative matters. The decision to implement HIS was in large part motivated by a desire to upgrade Hospital patient-care communications.

There are a number of different types of incoming information which get processed by different Hospital systems. Initial information concerning each patient is recorded by the Admitting Department when the patient enters the Hospital. Entry of this information into the HIS terminal creates an HIS file for the patient. This file will become the principal means of recording and transmitting information relative to the patient.

Additional information concerning the patient's treatment such as doctors' orders, nursing notes, test results, etc., are recorded and transmitted via the HIS system. The data is entered at any terminal, and the system automatically distributes the information to those who need to know by printing it out at their terminals. Some units at the Hospital use a manual paperwork system which parallels the functions of HIS because HIS has not yet been implemented on these units.

Professional journals and newsletters are an important source of information about the external environment in the hospital and general medical field. Most professionals, including patient-care and administrative employees, at the Hospital subscribe to a number of these journals. In addition, many Hospital employees attend

professional conferences as part of their job and report back on developments.

Many Hospital employees maintain contacts with colleagues at other hospitals. Some contacts with other hospitals are formalized. The Hospital belongs to a hospital association which attends to legislative activity and lobbies for hospital interests. In addition, the Hospital Administrator meets occasionally with his counterparts from the large metropolitan area teaching hospitals to discuss mutual concerns.

The Hospital receives regular communications from various external organizations with which it maintains relationships. These include insurance companies, the Joint Commission for the Accreditation of Hospitals, various agencies of the State and Federal governments, etc.

At times, the Hospital solicits studies and reports from outside experts. Recent examples include engineering and architectural proposals for construction of a new wing and a recently completed evaluation of the Cooperative Care facility. Task forces and committees within the Hospital sometimes produce reports on various issues as well. Examples include implementation plans and materials relative to the new HIS.

These communications are processed by various administrative departments and disseminated to appropriate personnel by memorandum. In addition, various administrative groups meet regularly, and these meetings provide a means for dissemination of information. The Hospital also maintains a monthly newsletter for distribution to all staff in which current policies and developments

are discussed.

The Hospital has specialized staff for handling patient complaints and concerns, and these are relayed to appropriate personnel. One of the Associate Administrators coordinates responses to lawsuits and the like.

There are formal reporting processes at the Hospital for budgetary and planning information. Budgetary information is provided by a computerized management information system which summarizes monthly expenditures by department and category. Planning at the Hospital follows a regular yearly cycle.

In addition to the formal means of information dissemination, most Hospital employees maintain an informal network of contacts in other related Hospital sectors. For most staff who have been at the Hospital for a period of years, this grapevine constitutes an important source of information, often alerting them to potential problems and issues during their development, before they become critical.

It should be noted that the Hospital has some communication deficits. For instance, as the researcher discovered while distributing letters concerning this study, there is no system for communicating directly with the Hospital's house staff residents as a group. Most have no mail boxes at the Hospital, nor is there a mailing list for them. Although their addresses are recorded on a list, envelopes would have to be typed for any mailing. The best available method for reaching them as a group is to distribute material with paychecks which are picked up every two weeks.

Outgoing information is of various types. Some kinds of

statistical data must be prepared for various government agencies, and there are regular administrative means for compiling and distributing this information to the appropriate agencies.

Likewise, patients must be billed for services and insurance claim forms must be handled. A special department exists for processing this information, and much of the billing information will be automatically recorded and printed out by HIS when it is fully implemented.

Public relations functions are managed by a special office of the Medical Center, and an associate administrator of the Hospital handles coordination with that office. Since the Hospital frequently admits patients in whom the news media take some interest, there is a need for regular systems to manage the flow of information appropriately.

Obstetrics Unit

There are a number of formal communication systems utilized on the Obstetrics Unit. Patient care related information is communicated in two ways. First, all information relative to patient care is entered into the patient's chart via the HIS terminal. Second, each nursing shift reports to the relief shift orally--that is, a nurse in the outgoing shift will speak with her counterpart who will be caring for the same patients on the incoming shift concerning important developments with the patient and any new orders. In general, the same nurses will follow a patient from day to day, although this is not always possible with shift changes and days off.

Administrative matters are communicated through posting on the bulletin board in the nursing staff lounge. Staff check this board regularly for schedule changes and other information. Notices of upcoming inservice training and other important information is posted here. A great deal of information is communicated through regular supervisory relationships.

Nursing staff meetings are something of a rarity on the Unit. During the three months this researcher spent interviewing on the Unit there were no staff meetings. Nursing leadership meetings are held on a monthly basis in general.

House and attending medical staff receive information about patients during morning rounds when the status of each patient is reviewed. The nursing staff contacts them by phone when their attention is required urgently or in emergency situations. There is an elaborate system of coverage for various contingencies.

Medical Unit

Communication systems on the Medical Unit are similar to those described above relative to the Obstetrics Unit. At the time of this study, HIS was not yet active on this Unit except for laboratory results reporting. Patient orders and records are transmitted and recorded by a manual system of written forms. End of shift nursing report is somewhat more formalized on the Unit. The outgoing shift records their report on cassette tapes which are listened to by incoming shift nursing staff.

INTERPRETATIVE DATA:

CURRENT ORGANIZATIONAL FUNCTIONING

Perceptions and Knowledge

Hospital Administration

Internally, Hospital management attention is divided between routine administrative matters, current projects, and any special situations. Routine matters vary depending on the sector, but typically include regular budget review and planning processes and relations between organizational sectors. The needs of physicians are a special concern of Hospital management. "The docs" are perceived as a particularly powerful interest group within the Hospital.

Current projects include the HIS implementation and the related Laboratory Information System, as well as plans for addition of a new wing and refurbishing of some units. Perception of these special projects is facilitated by a matrix approach to project management at the Hospital. Typically, these projects are managed by a team with representatives of management from the affected sectors.

Special situations include hitches in Hospital operations such as an unusually long "down" of the HIS. Labor relations can be another important focus of management attention as illustrated by the recent near-strike of physical therapists.

In addition to these issues, Hospital administrators are, by

and large, knowledgeable about the medical, patient-care issues in Hospital sectors under their jurisdiction. This knowledge extends across sectors in most cases, since administrators tend to have had changing responsibilities over the years.

Primary foci of external attention include the Medical Center at large and third-party payors, insurance companies and State and Federal government programs. Historically, most policy and major operational decisions are made at the Medical Center level.

Hospital administrators are primarily middle managers who implement and provide input in the decision-making process. Therefore, Hospital administration tends to be attuned to the policies and procedures of the Medical Center. Likewise, the policies and procedures of third-party payors are critical to the Hospital, since so much of its income depends on them. Hospital management is well informed concerning relevant issues in this arena.

Most administrators here agree that the Hospital is more receptive to new ideas than most similar institutions. Most also agree that the implementation of new ideas is a long, slow process because of the number of different groups who will generally be affected and that many new ideas never make it through this process.

The overall impression is of an informed and knowledgeable Hospital administration. In general, knowledge is accumulated and utilized in a rational and effective way. Plans are carefully thought out and articulated before implementation. If anything, noted one top administrator, there tends to be a fair amount of energy expended on plans that never come to fruition. This, however, would seem to be a normal part of effective management,

since it is necessary to proceed with some articulation of most new ideas before a reasonable determination can be made with respect to their workability.

Obstetrics Unit

On the Obstetrics Unit, nursing attention is dominated by the immediate care needs of patients. This is particularly true in the Labor and Delivery section. In Post-partum and Nursery, tasks tend to be more routine. Since many staff rotate between sections attention tends to be drawn to the level of activity in Labor as this controls the staffing distribution of the Unit to a significant degree.

Patients with complications tend to receive disproportionate attention because they are more interesting on a Unit accustomed to the normal birth processes. Even caesarian section deliveries become routine on a Unit which sees so many (about one in four).

According to the medical staff, the nursing staff is a good one. Many members of the nursing staff feel that, while it is basically competent, the level of knowledge and application relative to patient care on the Obstetrics Unit is not as high as in most other units at the Hospital. In particular, it was felt by many that the shortage of experienced nurses reached a crisis point over the summer when the provision of adequate patient care, especially in Labor, was jeopardized. The situation has improved somewhat since then according to most.

Among physicians, this factor of routine is even more important in determining the attention devoted to activities on the

Unit, since in general the same physicians must also provide coverage on the Gynecology Unit where patients tend to be more ill. One resident commented: "I find myself spending more time on GYN because most of the patients are sicker. OB is run as much as possible by the attendings because they'll come in and do the delivery." While obstetrics is the bread and butter for physicians in this specialty, for many the real interest is in gynecology. The feeling among nursing and medical staff is that physicians on the Unit are generally knowledgeable with a few well-known exceptions.

In terms of receptivity to new knowledge, there is a sense, particularly among the nursing staff, that Hospital is essentially a conservative institution which is not quick to adopt new ways of doing things in the obstetric field. This conservatism is felt to be located in the medical leadership of the service.

One nurse stated:

The doctors are conservative. One reason that obstetrics is such a conservative area is that for most OB is their paycheck. They prefer doing GYN, but they can't get GYN patients. Most of them can't afford to live on just GYN. They do OB on the side, and many of them don't really like OB.

Medical Unit

Attention on the Medical Unit is focused to an even higher degree on the patients than in the Obstetrics Unit. The reason for this is the oft-cited high acuity level of patients on this unit. Whereas, most obstetrics patients are undergoing the relatively normal process of giving birth, most on the Medical Unit are in the more complicated process of dying.

The body of knowledge related to the care of these patients is

much larger and more diverse than that required in obstetrics. The degree of certainty relative to what is known is much less because the physiological processes involved are generally much less predictable.

While the nursing staff here is considered among the most competent in the Hospital, there is some concern that many of the nurses are inexperienced recent graduates. On the other hand, since many of these nurses have come to the Hospital with personal training goals, they are highly motivated to learn and apply their knowledge. New medical syndromes and treatment techniques are a primary focus of attention among the nursing staff, particularly when they directly concern a patient on the Unit.

Where the medical staff is concerned, knowledge can at times be somewhat fragmented on this Unit with a number of different specialists being involved in the treatment of each patient. One resident described a specialist "who could only see the patient's arm", showing no sensitivity to the overall needs of the patient.

It is generally agreed, however, that the medical staff is knowledgeable and well-regarded on the Medical Unit. The Hospital is a center for research and training relative to numerous medical areas and, as such, attracts a high quality, knowledgeable medical staff who are highly motivated to keep up with the latest developments in their fields.

Expression, Action and Emotional Atmosphere

Hospital Administration

The emotional atmosphere of the Hospital administration is

generally upbeat and optimistic. Many of the younger staff have been attracted to work here by its reputation as a very well run hospital and a frontrunner in innovation.

This feeling of excitement is tempered by a philosophy of pragmatism. In conversation with Hospital administrators one often hears the word "do-ability". This denotes a concern for the practicality of new ideas.

This concern does not however smother new approaches as evidenced by the Hospital's willingness to invest in Cooperative Care and HIS. This willingness emanates from a commitment on the part of top management to innovation which has until now been located in the recently resigned Executive Vice President.

In addition, there is a quiet, underlieing tone of unmistakable professionalism here. Quality of patient care is the principal rationale which underlies most decisions with cost containment an important consideration.

There is a feeling of depth to this commitment at the Hospital which is reflected in the fact that nearly all Hospital staff at whatever level identify quality care as the primary goal of the organization. It is also reflected in the universal knowledge that this Hospital is one of a small minority that can afford to give quality of care so high a priority.

The Hospital projects this feeling to its staff and to outsiders through its modern, well-kept facilities. The emphasis on quality is explicitly projected in a lobby display which extolls the Hospital's role in recent micro-surgical advances while sollicitting contributions to a fund-raising drive. Posters proclaiming the

current implementation of HIS are prominently displayed near the main elevator bank.

Generally, the impression is of a top-notch hospital which provides the latest in medical care. This Hospital seems to take progressive, constructive change in stride while effectively ameliorating the more problematical trends in the health care field at large.

Obstetrics Unit

The emotional atmosphere on the Obstetrics Unit varies by section. Generally among the nursing staff, Labor is considered hectic and sometimes exciting, and the Nursery is pleasant although unexciting, while Post-Partum is considered "the pits," unpleasant and tedious.

On the Obstetrics Unit, Labor and Delivery is the preferred assignment for most of the nursing staff. Many of the nurses applied to work here specifically because of an interest in Labor and Delivery. The activity level in this section tends to be high with nurses shuttling between labor rooms to take intake histories, check on patients in labor, and assist in deliveries.

While most births are routine, there is an excitement in knowing that anything might happen at any moment--a complicated birth might require intervention or a baby in trouble might have to be rushed to the pediatric intensive care unit. In addition, seeing the happiness that new parents experience, while assisting them in a very direct way provides an immediate source of gratification for the staff in this section.

The experience here is, however, an ambivalent one. One nurse commented:

I found it difficult dealing with women in pain all the time. Granted that the outcome was very jubilant and very exhilarating, but nonetheless on a daily basis it was nice to come over to Post-Partum and see women walking around.

Although the staff here often feels overworked, frequently missing lunch on a busy day with lots of deliveries, they describe this as a "happy" Unit. Here as well as elsewhere on the Unit, there is also an underlieing tone of resentment about the lack of flexibility in relation to scheduling days off.

The prevailing mood on the Nursery is pleasant. Most of the paraprofessional Nursery staff prefer their assignment to this section and have worked there for a number of years, although they are often called upon to help set up for a caesarian section in Labor.

The Nursery has a small staff who are kept busy by a routine of changing and administering photo-therapy to babies, shuttling them back and forth from Post-Partum for feedings and visits, recording information on them, and so forth. The energy level here is high with considerable activity but lacking in the sort of excitement and urgency that one senses at times on Labor. There is a periodic flow of parents and other baby admirers in front of the Nursery windows.

Post-Partum is generally considered the least desirable placement for nurses on the Obstetrics Unit because of the nature of the work which is repetitive and uninteresting. The work that is considered the most interesting here--patient education and

counseling--is that for which there is the least time available.

The patients are not ill, but neither are they necessarily feeling up to par, especially if recovering from a caesarian delivery.

One nurse complained:

Even the patients over here--probably because they are well--they're not having that much of a problem: "My tea isn't hot enough. How come my try hasn't come? Aren't you getting me more jello?" Throwing laundry just on the floor and expecting us to pick it up. Well, I'm nobody's slave. This floor sometimes turns into a hotel.

At most, Post-Partum is considered a welcome break from the hectic activity on Labor for a few days, however the Post-Partum section is often understaffed, particularly since staff are pulled from here to cover Labor and sometimes Gynecology. By the time a rotation here is over, most nurses are eager to be back in Labor.

There are considerable feelings of resentment toward some sectors of the nursing staff who are not felt to carry their weight relative to patient care. One nurse said:

A lot of time, the nurses don't want to work together. Some of them are just lazy. The peer pressure for promotion gets you. You don't have to have team leaders. Lots of times I'm put in charge without the title. It's not fair. They take advantage. There's a lot of pressure, even if nobody admits it.

Unit leaders are not felt to be clinically proficient or willing to chip in to ease the work load. Neither are they perceived to be particularly busy with administrative concerns.

Nursing aides come in for a lot of resentment as well, since some of them are felt not to do "any more than they have to" as a result of being unionized. Frequent comments in this regard include: "You always have to tell them what to do even though they know perfectly well what has to be done." Making beds is a

particular sore spot.

Aides tend to view their role as more of a "job" which they do as best they can given the many and sometimes conflicting demands placed on them. Most take a philosophical attitude toward their position: "You just do whatever the nurses tell you to do. If one tells to do something different before you're finished, I just ask them--'Do you want me to finish this first?'"

Among house staff residents on the Obstetrics Unit the level of activity is extremely high. There are five house staff to cover this Unit and Gynecology. For most, the three month rotation at the Hospital is not considered desirable. Residents have some difficulty adjusting to their status as assistants to the attending physicians here after having been the principal physician in charge of their patients at other hospitals where the role of the attending is more supervisory. Here the patients are the private clients of the attendings. There is the sense of putting in your time and trying to make the most of the experience here. Most residents are happy to finish their rotation here.

For attendings the attachment to the Unit tends to be fairly neutral and limited, and for most it constitutes just one aspect with their overall relationship to the Medical Center. They come to the Unit when they have a patient in labor, and so their main contact is with the Labor section. Most are otherwise very busy maintaining private practices, teaching, etc.

There is concern on the part of some about recent talk of placing limits on the number of patients admitted by attendings due to the sometimes overcrowded conditions on the Unit. For most

attending this would be very disruptive, since their ability to maintain their private practice livelihood depends on their ability to admit patients to a hospital. Another concern of some attendings is the amount of attention patients receive in Post-Partum which is felt to be somewhat deficient.

Overall there is a sense of some detachment from patients which is reflected in the language used on the Unit. Patients are commonly referred to by medical terms, as in "getting ready for a section" or "taking care of episiotomies." Most patients stay only a few days on the Unit, only a matter of hours in Labor and the degree of attachment between staff and patients is limited.

Generally, the impression is of a Unit which functions adequately in most respects but which suffers from significant morale problems. While obstetrics is considered a desirable placement within the nursing field, the Unit is unable to hold nursing staff with any greater success than other nursing units here at the Hospital.

Medical Unit

The prevailing atmosphere on the Medical Unit is dominated by hectic activity. The emotional tone is one of strict affective control with an underlieing mood of moderate anxiety. For many of the nursing staff there is often a sense of being "dazed" or "drained". The term "reality shock" is used by most to convey the nature of the adjustment during their first months of work on the Unit.

For most nurses--especially new graduates who make up most of

the staff here--there are some feelings of frustration engendered by the conflict between the kind of idealized care they expect to provide based on their training in nursing school and the nature of the work as they find it on the Medical Unit. The nurses would like to spend more of their time providing needed counseling and educational services to patients and their families. Most of the time, their activities are controlled by the urgent immediate demands of the large number of acutely ill patients in their care.

Because the patients are so ill, they usually spend a number of weeks or even months on the Unit. Many of the patients have been admitted several times--first for diagnostic tests, then for treatments, and finally, in many cases, for care during the debilitating terminal phase of their illness. As a result, most nurses form relationships with patients and their families over the course of their stay on the Unit.

One nurse described the impact on her:

It affects me--it does. Not while I'm here. A lot of times I'll go home, and I'll think about what goes on. What they must be thinking. You handle so many things on a day to day--you just deal with it. And you forget exactly what the patient is feeling. And you go home and sit around and talk about what you did at work, and you don't think of them as an assignment that you had. You think of that person and their family, and you can think about it more personally--on that level, as opposed to just a patient of yours. I think about it, and it's very sad. And I try to be aware of that and try to do as much as I possibly can for that patient to make them a little more comfortable or their families a little more comfortable. You start to think and identify with your family. What if this was myself and my family? I wouldn't be handling it so well.

Thus, for the Medical Unit staff, work is periodically punctuated by the loss of a patient who has died. The feelings of sadness and grief which attend such losses can only be expressed in

a limited way within the professional role of nurse (or physician for that matter). These feelings tend often to spill over into life outside of work, although there is a sense that those outside of the field cannot really understand these feelings.

One nursing leader stated:

I talk about it to people outside of work, but there's not much understanding. And they sort of don't want to hear about the problems that we have here because it's rather depressing. We talk about it among ourselves. . . . You always take your work home with you. You don't ever forget about what's going on here. On a day off you're always thinking about so and so--did I do that? It's not like putting your desk away for the weekend.

A nurse commented:

I can't talk to my family. I mean I talk to my family all the time, but I feel guilty. Because if I'm upset, I start to tell them these things, and I say what am I doing, because it's just depressing. Nobody really wants to hear that. You feel a little guilty talking to anyone who doesn't work in some kind of health-related field.

Besides the need to contain these loss-related feelings, nursing staff must also control their anxiety relative to their own adequacy. Such anxiety is inevitably aroused in a pressurized situation where one must care for such a great number of acutely ill people for whom a neglected order or an error could prove fatal.

In addition, there are feelings of resentment relative to the demands that are placed upon the staff. Most staff feel overworked and continually fatigued by the rigorous work schedule. Everyone is on their feet continually during the work day. A great deal of energy is expended moving between patients and the nursing station where supplies are kept. Nursing staff frequently go without breaks, work overtime without pay, and work double shifts.

The inflexibility and irregularity of the work schedule is

very frustrating for the nursing staff who cover all shifts, seven days a week. Said one nurse: "It's very difficult having any social life with one weekend off in three or four." Management has recently made an attempt to address this problem by instituting an experimental four day work week which had been requested by some nurses.

House staff residents working on the Unit suffer from similar overwork. They work long hours, including every third night, providing coverage for patients on all of the medical units at the Hospital.

Their involvement in any one unit is somewhat diluted, in addition, by their rotation to new placements every three months. To a degree, they share the feelings of their counterparts on the Obstetrics Unit about being in an unusually subordinate position vis a vis the attending physicians who generally control the treatment approach quite closely here as well. Most are pleased to leave for other hospitals where they have more responsibility for treatment planning.

One quality of action noted on the Unit by some is the tendency of medical practice here to be very intervention-oriented. Because there are so many resources available, there is an inclination to utilize any that might be helpful. This tendency is reinforced by the training task of the house staff physicians who are eager to gain familiarity with medical technique through practice.

One nurse noted that few would think of simply allowing a patient to die when their heart stopped beating even though this

might be kindest for the patient and family. The standard procedure is to employ heroic methods to revive and prolong life, including the use of extensive life support equipment. The ethical dilemmas presented when a dying patient is not prevented from dying or is helped to die are also difficult for staff.

The overall impression is of a Unit which functions well under difficult circumstances. Despite a shortage of nursing staff, the care provided here is considered among the best available anywhere. It is clear that maintaining this level of functioning does take its toll on staff and contributes greatly to the turnover problem on the Unit. In a sense, the Unit copes with many of its more disruptive affects by exporting staff members when they become "filled up" with these feelings.

Attitudes and Relationships

Toward Others

Hospital Administration

Patients. Serving patients is regarded as the top priority task of the Hospital. Patients are generally viewed good-naturedly, occasionally with some degree of bemusement. A favorite story concerns a gypsy king who was admitted as a patient while his subjects camped out in the parking lot until his discharge.

Medical Center Administration. The relationship between the Hospital administration and that of the Medical Center is a complex one. On the one hand, the head of the Medical Center has until recently been an individual who is viewed as the father of the Hospital in its present form and perhaps the top hospital

administrator in the country.

Other elements of the Medical Center administration are viewed as rivalrous siblings with divergent priorities. Some are viewed as outright obstructionistic. "They are always telling you why something cannot be done, rather than trying to help you find a way to do it." Now that the Executive Vice President has departed, the relationship with the Medical Center is tinged with some anxiety and most take a wait and see attitude.

Employees. The employees of the Hospital are viewed as a good quality group of workers. Professional employees, particularly, are viewed as top-notch. Relations with employee groups are generally smooth. The last strike affecting the Hospital was a three month walk out by security and buildings and grounds employees two years ago. Prior to that there was a thirteen day strike in 1976 by Hospital support personnel.

Unions. Unions are regarded as something to be avoided. In the view of Hospital administrators they make life more complicated and troublesome by introducing an additional conflictual factor into the already complex equation of Hospital operations.

Nurses. Nurses are a special category of Hospital employees. The nationwide shortage makes nurses a critical resource which must be recruited and protected. The Hospital is careful to keep its benefits package for nurses in line with that offered elsewhere. Generally, the Hospital shuns using per-diem temporary nurses to fill in even when shorthanded because they are considered untrained

by Hospital standards.

Attending Physicians. "The docs" are also considered a special group. Strictly speaking, they are not Hospital employees, since they receive payment from their patients for services and/or the Medical School for teaching or research. They are something of a cross between valuable employees and preferred customers who are treated deferentially. When a physician calls, the call is returned promptly. While their knowledge is highly respected, it is viewed as limited when it comes to areas outside of medical expertise.

Medical School. In some respects, the Hospital is the junior partner in a symbiotic relationship with the Medical School. While the Hospital has patient care as its primary task, it exists within a University which has education as its primary task. The Medical School is more closely aligned with the overall task of the University.

The Hospital provides a source of income for Medical School faculty who are the attending physicians at the Hospital. The faculty, on the other hand, attracts a distinguished group of physicians who are viewed as a fundamental source of Hospital prestige. In addition, the Hospital supports the Medical School financially by contributing a surplus to its operating budget.

Third-Party Payors. Insurance companies and government agencies who reimburse for Hospital services are viewed as problematical. They are not felt to appreciate the special nature of the Hospital or to understand the structure of its costs. The

efforts of the State government to impose reimbursement rates are felt to be particularly restrictive. Rates promulgated in the seventies were recently overturned following a three year appeal process.

Outside Consultants. Generally, the Hospital prefers to do most work internally. HIS implementation provides a good example. From the beginning, planning has been carried out by a special task force from the Hospital with minimal involvement on the part of the vendor. The Hospital does use the services of outsiders for some projects, notably building and engineering, however it likes to minimize its reliance on outsiders.

Researchers. Researchers in general, and this researcher in particular, are viewed with some suspicion as potential sources of difficulties. One never knows what kind of latent problems will be stirred up by strangers wandering around the organization.

Again, the feeling that most things are better done by insiders is present. During negotiations for the current research, it was suggested at one point that if anyone were to study the HIS implementation it should be someone from the University itself, keeping things in the family.

Once the outside boundary of the organization has been crossed, one finds oneself readily accepted by staff of that organizational sector who generally respond with friendly interest. However, the process of guardedness reoccurs in each new sector.

Obstetrics Unit

Mothers. Mothers are regarded as pleasant, but for the most part uninteresting, passers-through. Their primary attachment is to their obstetricians, since the far greater proportion of their medical contact has been on an outpatient basis.

They tend to be preoccupied with their newborn babies, their husbands and visitors. Family-centeredness is encouraged by Unit policy. Children are limited to one visit though. Nurses tend to feel that some mothers are too distracted by visitors and phone calls from the business at hand.

There is a program of instruction for new mothers, including breast-feeding, bathing, etc. Otherwise, there is little time for attending to patients beyond their basic medical needs.

Fathers. Fathers are regarded as helping partners in the birth and attachment process. Their presence in the delivery room is encouraged, provided they have had appropriate previous instruction. Many fathers are seen around the labor area dressed in scrubs, some with cameras around their necks. They are not, however, allowed to be present during Caesarian section deliveries. No limits are placed on fathers with respect to visiting.

Babies. Babies are the point of it all--the source of much of the satisfaction that everyone gets from working on the Unit. Needless to say, they are viewed with universally positive regard. The welfare of the baby is the guiding principle of the Unit. To this end, breast-feeding and general contact and bonding between parents and their babies is strongly encouraged. The birth of a

dead or deformed child is one of the low points of life here, though most of the staff take a philosophical attitude toward these inevitable occurrences. Babies are stillborn less than once per month on average, although it is necessary to rush a baby to the Intensive Care Unit about twice as often.

Visitors. Visitors are regarded as a distraction from the primary task--the bonding of parents to babies. Visitors are not permitted in mothers' rooms and are restricted to the solarium visiting area.

Hospital and nursing administration. By and large, staff's attitudes about and relationship to Hospital administration are vague. Generally, the administration is felt to be competent and good intentioned. Most administrative problems are felt to reside in the nature of large hospital organizations and the constraints of the nursing shortage. The Hospital's good reputation is felt to be in part attributable to its good management.

Some of the nursing staff's frustration is attributed to the Hospital organization. One nurse stated: "The Hospital is a conservative hospital, very bureaucratic and into maintaining the status quo." Feelings about central nursing administration generally run parallel, although they are contaminated to a degree by feelings about Unit leadership. There is some sense that there must be something corrupt which allows these leaders to be tolerated by central leaders.

Researchers. Non-medical researchers are something of a

rarity here, and most staff did not have much idea of what to expect from this researcher. Some of the Unit leaders were evidently rather uneasy with talking about their experiences on the Unit as indicated by their reluctance to be tape recorded and by subsequent inquiries made to the nursing department concerning this research. In addition, despite frequent inquiries, this researcher was never able to arrange attendance at a nursing staff meeting. The staff for the most part seemed to experience some initial reticence in talking about their experiences but many seemed eager to share their perceptions and feelings once they became involved in a dialogue. One measure of staff's initial resistance to participation in the research is the great number of interview appointments cancelled. In addition, it was often difficult to secure space for conducting interviews. To some degree, the research was regarded initially as just one more demand from another transient person.

Ancillary services. Laboratories and some other ancillary services are generally seen as a source of irresponsibility and resultant extra work. Nearly everyone on staff complains that work sent out often goes astray and needs to be tracked down or, more often, resubmitted altogether. Often, it is suspected, samples are carelessly dropped or otherwise spoiled or appointments lost, and it is then claimed that they were never received. In fact, one of the big "selling points" of HIS is that it reduces the need for chasing down results by phone and helps afix responsibility for lost results. At present, the jury is still out on these capabilities.

Unions. Nursing unit staff have very little relationship with

the union. Those who belong to the union--aides, LPNs--tend not to be involved or much aware of union activities beyond being knowing of its existence and contract benefits. The union is not felt to make much if any difference in day-to-day work. There is little active unionization effort among professional staff--nurses and doctors.

Medical Unit

Patients. Patients are the central focus of activity on this Unit. Many are very sick and require continual intensive care. In general, it is difficult for nurses to avoid developing an attachment to many of the patients they care for because of the intimacy and duration of their contact and the neediness of the patients. As noted previously, this attachment results in an experience of loss when patients die, as many inevitably do. Many house staff develop similar attachments, though less intense due to shorter duration of contact and the rotation of house staff to other placements.

The nursing staff sometimes feels abused by some of the less ill patients. One nursing leader complained:

We should be treated as nurses, not as women. A lot of the patients: "Oh, get me my slippers. Get me my paper." They think you're here to clean up after them. They think they're at a hotel. That really annoys me.

Families and visitors. Patients' relatives and friends are regarded as somewhat peripheral to the activities of the Unit. While they are recognized as an important source of emotional support for patients, time and energy available for staff

involvement with them is minimal. At times they are felt to be a drain on resources or in the way--particularly during an emergency procedure. It is difficult for staff, knowing that these people could be helped by staff if there were resources available.

Hospital and nursing administration. Here again, perceptions of hospital and nursing department administration are rather diffuse, but overall positive in tone. There is a sense of some disappointment that more cannot be done to alleviate some of the existing understaffing and scheduling problems. One nursing leader stated that nursing department administrators "interview you every so often, but they never really listen."

On the other hand, there is an appreciation that many of these difficulties are beyond the control of managers. Most staff cite the institution of stress groups for nurses as a positive step, and recent approval of an experimental four day work week has boosted management's stock. Prior to approval there was some grumbling about perceived foot-dragging.

Researchers. Again, researchers are something of a rarity here outside of the medical realm. This researcher met with a similar initial reaction on this Unit: Inquiries were made to the Nursing Department by Unit leaders. In this case, the response was more open and overt with a copy of the research proposal being provided. Following the entry experience, staff were generally very open in talking about their experiences in working on the Unit. Fewer interview appointments were cancelled here, and space for interviews was generally available on the Unit.

Ancillary services. The relationship here is similar to that described on the Obstetrics Unit. Ancillary services are generally felt to be a constant source of delay and irritation by nurses and physicians alike. One nurse commented: "Sometimes it's difficult to get things done around here as fast as you'd like them to get done--things that patients are waiting for, tests and like that."

Some services such as those provided by nutritionists and social workers are regarded as very helpful. Like most helpful services, they are in short supply.

Toward Ideas and Things

Hospital Administration

Plant and equipment. Facilities and equipment are highly symbolic in the hospital field and tend to represent the effectiveness of the hospital. A hospital with the newest, most up-to-date equipment tends to be regarded as a leader in the field. The Hospital certainly tends to view itself in this way, and the cooperative care facility, new telephone system, and, of course, HIS, as well as the many specialized research and treatment units are cited in support of this self-image.

In addition, the physical plant plays another role in the organizational consciousness of the Hospital, namely that of temporal watershed. Modern time is marked by the move to the present location some twenty years ago, and the establishment of major new facilities mark eras.

Time. The Hospital administration has a fairly well balanced time orientation. While the past provides a supportive emotional

background for the organization, attention is primarily focused on the present and near-term future--on daily operations, implementation of current projects, and planning for the coming year. The Hospital has an annual planning and budgeting process which provides the focus for much of its near-term future orientation.

Space. As noted previously, space is a continual problem for the Hospital, and there is a continuous trend toward designing and building more. Working conditions are rather cramped and overcrowded in most sectors. There is also a continuing need for the renovation and upgrading of space as advances in medical technology dictate changes in the nature of the space required relative to different tasks.

There are current plans for building a new wing and for renovating various units. In fact, a sizable proportion of administrative activity can be characterized as the reorganization of old or the planning and building of new space.

Space is a problem externally as well. The ability of the Hospital to provide its nursing employees with reasonable housing in a very tight market is critical to its recruitment efforts. In addition, there is little adjacent land available for building, so expansion must use other locations or build on top of the present facility.

Work. The meaning of work at the Hospital is quite complex and varies from group to group. Many administrators enjoy the challenge of problem-solving presented by hospital management. The

end product of quality patient care is an important part of the satisfaction they experience in doing their jobs.

Being a part of a prestigious institution is also important in this respect. For many, their current position represents a stepping-stone in their career development. Because of the reputation of the Hospital as a leader in hospital administration, administrators who have worked here are in demand for positions at other hospitals. Because top Hospital management is relatively young, most administrators realize that there are constraints on how high they will probably be able to rise here.

Authority, power, and responsibility. The Hospital administration views both its authority and power as being rather constrained by the other groups involved in the operation of the Hospital. Externally, it is mainly its power that is felt to be constrained. The power of insurance companies and government agencies to set reimbursement rates and standards for care impinges quite directly on the Hospital. Often, these outside powers are felt to interfere with the legitimate authority of the Hospital.

Internally, administrative authority is limited by the vesting of legal authority for the treatment of each patient in physicians. In some respects, Hospital administration is regarded as subordinate to the power and authority of physicians who have delegated responsibility for certain administrative tasks to managers. In addition, nursing and other professional groups have a strong say in decisions that affect their roles.

These divisions of power and authority affect the way

administrative decisions are made at the Hospital. Most decisions are preceded by a period of careful consultation with those who will be affected. The formal decision-making philosophy is that of consensus where strong reservations on the part of an important interest group tend to place some options out of bounds.

On the other hand, the medical dependency culture permeates the nature of authority in the Hospital. Just as the physician is expected to make medical decisions in the best interest of the layman patient, so is all authority (including administrative authority) here to a degree presumed to be benignly paternal.

As one might expect, responsibility is taken very seriously at the Hospital. Especially where patients are concerned--and this is almost everywhere in the operation of the Hospital--everyone is very conscientious in the performance of their duties.

Socially, the Hospital does not have the same attitude toward responsibility. While the Hospital does accept some patients who cannot afford to pay for its services, it is far from eager to do so. Service to the poor is not felt to be within the scope of the Hospital's mission. To a degree, it is felt that the Hospital does its part in this regard by sharing some of its staff with a nearby City hospital which primarily serves the needs of the poor.

Obstetrics Unit

Plant and equipment. The principal impact of the plant on the Obstetrics Unit is the effect of crowding. While the space shortage is not severe, the facilities of the Unit are not adequate to handle peak demands. Peak labor demands require that patients double up in

delivery rooms. During peak periods post-partum patients are housed on other units, principally Gynecology.

The only private space available on the Unit is the Head Nurse's Office on Post-Partum. There is a conference room, but it is in continual use by nursing and medical staff and doubles as a lunch room and staff lounge.

The plant does not reflect the stated philosophy of the Unit in promoting maximum contact between parents and babies. Because of space constraints, babies are located in the Nursery section, separated from their mothers in Post-Partum by a public elevator lobby. Babies and mothers must traverse this area to be together. The Unit does maintain a few rooms for rooming-in where babies remain with their mothers most of the time. These rooms are only a small proportion of the total though.

The plant and equipment of the Obstetrics Unit deviates from that of the Hospital is general where the emphasis is on having the latest in technology. One attending obstetrician complained that he had to lobby for years to have adjustable labor beds installed, so his patients could sit up during deliveries. Even now, there is only one such bed available, and there is no sign of birthing chairs or other such recent innovations. In this respect, the plant and equipment of the Obstetrics Unit reflect its position as something of a medical backwater.

HIS. The nursing staff on the Unit has come to accept HIS as another piece of Hospital procedure with its good and bad aspects. There is considerable frustration over excessive system down time

and troublesome screens, especially where duplication of effort is required. Certain records are taken manually and later transcribed into HIS because no terminal is available in certain locations. Generally, everyone is pleased with the decreased need for phone calls. Few feel that it has changed their job much. Most have a wait-and-see attitude.

Physicians feel similarly about HIS on this Unit. Most feel relatively unaffected. The largest concern seems to be the delay in being able to write orders for patients who are admitted quickly in labor, since there is no file available for a patient before they are officially processed by the Admitting Department.

Time. The Obstetrics Unit is very much present oriented in its work. There is little sense of planning for the future here and nothing special about the past. The heavy work load consumes the present. Although one day varies from another in work load depending on patient census, there is no predictability in this respect. Particularly on labor, activities take place on a twenty-four hour basis with little distinction between night and day, since babies are born at all hours.

Space. The Unit's relation to crowded space is discussed above under Plant. Another aspect of the relationship to space is the sense that space boundaries are not adequately controlled in the Labor area. The difficulty in getting physicians and medical students to dress properly for sterile areas was the subject of frustrated discussion during a nursing leadership meeting observed by the researcher. A proposal was made to have locked doors with

buzzers installed on sterile rooms in order to gain some control.

Work. There is a marked split in the meaning of work for nursing staff on the Obstetrics Unit. On the one hand, placement on this Unit is considered a plum because of the action and excitement of being involved in delivering babies. On the other, much of the real work that goes on here is far from exciting. In fact, on Post-Partum the work is mainly dull routine.

One nurse commented:

We have well babies. We don't have sick babies, really. Occasionally we'll have a little problem, but very seldom. And then, everything here on Post-Partum is fairly routine. Even if we have what they call a sick patient--to me it's just another post-partum mother with a few complications, but it's nothing like working on heavier floors like surgery. We have it fairly easy here, but at the same time fatiguing. When I go home, I want to sleep. I can't be bothered with cooking and cleaning.

Another nurse stated:

Part of the frustration is that people who are interested in obstetrics are interested in teaching patients--supporting mothers with their infants. The things that attract people to obstetrics on our floor get frustrated, and one reason is that when staffing is low you don't have time. You do petty little physical things, and you never get to do things that you consider a real priority in terms of their emotional and psychological care.

In a sense there is a hierarchy here which determines how much of the fun work one gets to do. Physicians get to do the really enjoyable work, delivering babies. Nurses assist closely and interact with patients but also do many of the duller tasks like sitting with the patient through a long labor. The real drudgery is delegated to the nursing aides who change beds, deliver meals, set up delivery rooms, etc.

Authority, power, and responsibility. The authority and power

of the nursing staff on this Unit is viewed as rather constrained by a number of powerful external forces, including the central nursing department and attending physicians. While many members of the staff are interested in a more progressive practice of obstetrics nursing, their ability to proceed in new directions is felt to be obstructed by the conservativeness of these groups. Power to induce change is felt in some cases to reside more in consumer demand than in nursing views.

In a more immediate sense, the legal authority to direct the treatment of patients resides with the patients' physicians. There is some degree of resentment that physicians "get the glory" for delivering the baby while so many others contribute in less glorious ways.

On this Unit, power has become associated with a sense of corruption, since power is often used to assign unpleasant duties and schedules to others. For those in the lower levels of the hierarchy, nursing aides, power seems to be greatest in their ability to resist some aspects of working by sticking to scheduled breaks and shift times.

Attitudes toward responsibility are rather negative here, since being responsible is to some degree associated with being exploited. As one team leader put it:

Permanent day team leader--its a nebulous position with no power. You don't do staffing, but you are in charge of the floor. You are an assistant head nurse without any reimbursement in terms of money, without any true authority. But you have to be in charge of the chaos that goes on. It's a very frustrating thing.

In addition, since patients here are not ill, there is little

fear that laxity will cause harm to anyone. The main consequence of minor irresponsibility is likely to be displeasure on the part of co-workers. While the Unit performs adequately in relation to its tasks, there is wide-spread agreement that it could do better.

Medical Unit

Plant and equipment. Due to the acute illness of many of its patients, there is a great deal of medical equipment located on this Unit, including heart monitors, respirators, medication and isolation carts, and so forth. This equipment supports the primary task of the Unit which is quality patient care. At times, however it tends to interfere a bit with the work and life on the Unit. For instance, some of the equipment is rather noisy. Storage is also a problem.

HIS. Although everyone on the Medical Unit nursing staff is aware of the impending full implementation of HIS here, few have any strong feelings about it. For laboratory results where it is already in use, most nursing staff cite the decreased need for telephone calls as the major benefit. HIS is viewed as one more piece of new technology.

Among physicians who have had experience with HIS on other units, most have strong reservations concerning its impact. Difficulty in reading charts and problems generated by system downtime are frequently cited. Some feel that elimination of the need to physically sign orders will lead to a reduced clarity of responsibilities.

Time. Time is an even scarcer commodity on the Medical Unit than elsewhere in the Hospital because of the increased intensity of care required by the more acutely ill patients here. The orientation of most staff is very much to the present, working day by day. One nurse commented: "Nursing is a twenty-four hour thing. So if you don't get it done in your eight hours, then somebody else has to do it."

The future is viewed as a time of continuing rapid evolutionary change. One nurse commented: "There are always changes--new therapies, new doctors, more complex people, new systems. It's always changing."

Space. Space on the Unit is extremely valuable with equipment and supplies stored in every nook and cranny. The orientation of the nursing staff to space centers on the nursing station and fluctuates between there and the patients' rooms. The staff is in constant motion, attending to the needs of different patients.

Work. For most of the staff here the work is interesting but very demanding. For many younger staff the work is a valued training experience. It is the needs of the patients that form the overarching framework of the work experience here, and many of these needs are intensely urgent.

For the new graduate nurses, the work continues to be infused with an idealized perspective developed during nursing school. During training, nurses are indoctrinated with progressive ideas about the professional role of nursing in health care delivery.

When they arrive on the Unit, they learn rapidly that many of

these ideas are not actualizable. There simply is not time to perform many of the functions that they have been taught form a central aspect of the nursing role--e.g., patient education and counseling--or even to do most work in a careful, thoughtful way.

The feelings induced by this disparity between the ideal work and the actual work range from guilt and depression to resentment and anger. Whatever the response, most feel that they take the job home with them most days and that they have little energy left over for other aspects of their lives.

For the house staff, the work is equally involving. Since they work every third night, their life revolves around their work. Emotionally, they are very involved in learning to make important and even critical medical decisions on a routine basis. One important aspect of house staff's relation to the work here is that they are very much more in a subordinate role to the attending physicians here than in other placements and most chafe under the implicit restrictions involved.

For nursing aides, PUCs, and LPNs, the work is a way of earning a living. On average they have worked here for ten years or more, and they have developed more distance from the work than younger staff.

Authority, power, and responsibility. As elsewhere in the Hospital, much of the legal power and authority in relation to patient care is vested in physicians. Also as elsewhere, much of this power is shared with the nursing staff relative to routine care.

Some of the nurses do chafe at times under their restricted

authority, especially when it comes to issues of patient comfort.

The reluctance of some physicians to prescribe some pain medications for terminally ill patients and their willingness to intervene to prolong life are two areas of occasional disagreement.

For the most part however, there is a good working division of authority between the medical and nursing staff here.

Administratively, both physicians and nurses here are constrained in their power relative to other Hospital sectors, and both are at times frustrated by snafu that affect patients' welfare. On the unit itself, power and authority are felt to be benevolently exercised by those who have it, and this sense extends to perceptions of the Hospital at large.

It is widely felt among nursing staff that they are held responsible for more than their fair share of the work. Nurses contend that because other groups have more circumscribed role descriptions, whenever a new task arises it tends to be allocated to nursing unless vigorously resisted.

In general, job performance on the Medical Unit tends to be highly responsible. The desire of younger staff to perform well in new roles, their idealism, and the knowledge that errors or neglect could be critical for very ill patients serve to ensure this high level of responsible performance.

Toward Self

Hospital Administration

The Hospital administration is very positive in its view of itself. At the same time there is a sense of humbleness. While

everyone is aware of being a participant in the management of a prestigious institution, much of this accomplishment is attributed to the recently departed Executive Vice President. With one exception, the entire top management team was brought in under his tenure.

In many respects the team is in the position of the sons of the founder of a prosperous family business. Now that the father is gone, will the sons be as successful in guiding the enterprise? Will the new family head be as benevolent and wise, and how will he regard the sons?

While the administration has a great deal of confidence in its abilities, there is a moderate amount of anxiety related to the future. While the outlook for the immediate future is regarded as a continuation of past success and prosperity, the principal focus of concern is on the appointments of successors to the Executive Vice President and the Provost of the Medical Center. Obviously, much of the future direction of the Medical Center and thus the Hospital hinges upon these appointments. There is also a recognition that medical institutions will continue to exist in a turbulent environment over at least the next decade.

Obstetrics Unit

The Obstetrics Unit views itself as a bit second-rate. Being part of a Hospital where being on the cutting edge of medical progress is an important part of the self-image, a unit which is not the focus of exciting research and breakthroughs would perhaps inevitably seem an institutional stepchild of sorts.

The stepchild position also reflects the traditional status of obstetrics within the medical profession. In a male dominated profession, this specialty which deals principally with exclusively female processes has historically found itself in a rather peculiar position.

With the relatively recent impact of the women's movement and the entry of female obstetricians into the field, there has been a some change in this historical status. The winds of change have not, however, made an entirely clean sweep. Few see any major changes in the near future here.

One nursing leader stated:

It's not a very progressive unit. There are a lot of things going on in OB/GYN today, and we are one of the last hospitals to put any of those things into effect. We don't have a birthing room. We don't allow fathers in the C-section room.

The Unit's self-perceptions reflect a dichotomy. On the one hand, this traditional status and the unpleasant aspects of work on the Unit tend to produce a negative view. On the other, the staff's satisfaction at helping to bring new life into the world and the continual presence of this "happy event" has a definite impact. The result is an ambivalent self-image which cannot fully integrate these opposing experiences of life here.

When asked explicitly about the personality of the unit, one nursing leader replied:

A very happy person[ality] because of what comes with childbearing. I don't think the personality is organized enough. It could get depressing very easily if you think about the heavy days you work.

Medical Unit

The self-image of the Medical Unit is generally quite positive. The young staff takes a great deal of pride in doing a difficult job well. This positive self-regard is reinforced by the knowledge that outsiders view this Unit as among the most effective in the Hospital.

Under this facade--which is by no means shallow--there is some amount of soul-searching. Occasional feelings of guilt or self-doubt and depression among young staff members reflect the realistic self-perception that they are inexperienced. The underlieing feelings are those of one who is told that they are doing well, but are not really sure of this in their own heart and are even more unsure of whether they can continue to do well.

When asked explicitly about the personality of the unit, comments reflected the overwhelming amount of activity experienced on the unit. One nurse described the unit as "hectic, disorganized, effective." Another offered a similar description:

Psychotic--generally, just zoo-ey. It's too diffuse for me to imagine it as one person. There's too much going on because there's so many people in it. But I do think it would be basically a friendly type person, but other than that I can't really put all this activity into one person.

Despite submerged self-doubts, the positive view of an effective, professional Unit prevails in the work life here. It is mainly during the off hours at home when the professional controls are relaxed that the underlieing aspects of the self-image sometimes emerge.

Intraorganizational Relations--
Key People and Groups

Hospital Administration

Medical Center Vice President and Hospital Administrator. A likeable, cautious man in his late thirties, he seems surprisingly young for the top manager of a major institution. This impression reflects the fact that, until now, his authority has been closely controlled by the Executive Vice President. He entered the administration of the Hospital directly from a graduate hospital administration program and advanced as the protege of the former Executive Vice President who was then the Hospital Administrator. He gives the impression of an effective manager but not a strong leader.

Associate Hospital Administrator for Nursing and Medical Center Executive Director of Nursing. A strong, forceful woman in her late thirties, she gives the impression of a politically astute and ambitious leader. A doctorate holder, she was brought in a year and a half ago by the Executive Vice President as a defacto (though not dejure) Vice President with a direct reporting relationship to him. She was brought here to help integrate nursing services across the institutions which make up the Medical Center including implementation of HIS.

Obstetrics Unit

Administrative Supervisor, Obstetrics/Gynecology. A rather controlled, assertive middle-aged woman who has held this position for five years. She was brought in from outside the Hospital to

help organize the Unit and is very planning and training oriented. She is not seen as a positive sentient leader. One nursing leader stated:

Nursing supervisors have an awful lot of power and tend to run things the way they want them. . . . It's not a [staff] meeting --it's a dictatorship. . . . None of the leadership are happy, but they put up with the situation.

Head Nurse, Post-Partum. A somewhat depressed, passive older woman who has worked on this Unit for sixteen years. One tends to wonder whether time has passed her by--perhaps she is waiting for retirement. She is seen by other leadership and staff as a "leadership problem." Some staff complain that she "hides out." One nursing leader commented: "The Head Nurse in Post-Partum is a disaster. She just doesn't set a good example. People have little respect for her so that she is certainly not a leader."

Head Nurse, Labor and Delivery. A rather guarded, harried woman in her thirties who has worked her way up through the ranks on the Unit since graduating from nursing school. She seems to see herself as a peer of the other experienced nurses more than a leader.

Head Nurse, Nursery. A real live wire who everyone agrees is vastly overqualified for this position, she is frequently viewed as a rival for the throne. She was the night Administrative Supervisor for the entire Hospital until last year when she requested a demotion to this position in order to work days. Trained in England, she has worked at the Hospital since coming to this country a number of years ago.

Nursing leadership. With few exceptions, the nursing leaders on this Unit are regarded with some degree of contempt and resentment. As noted previously, nurses particularly feel that their leaders do not work hard, pitch in to help when the going gets rough, or have much to share with the staff. At least some part of this resentment comes from the identification of these leaders with responsibility for the inconvenient and restrictive schedules which the staff is required to work.

One nurse commented:

We don't have the best quality leadership. . . . They don't want you to take sick time. When you're sitting down for evaluation, they point it out. . . . Leadership doesn't want you to socialize too much with other groups. They want you to stay within your own group. . . . They are watching you all the time. You have to watch how you act.

Another stated: "It's as if the overtime is coming out of leadership's pocket--that they have to break into their piggy bank to pay overtime." A nursing leader said:

Leadership is really bad here. . . . They don't give that much guidance. If you make a mistake, you're in trouble. You get very little feedback like you're doing a good job. Letting people float on their own and do the best they can. And if they do make a mistake, they hear about it. . . . Their attitude is: If you work here, that's fine. If you have a problem--you're not happy with certain things, then we'll just let you go before we'll ever make an attempt to change anything. And if you quit here--no matter how much you may have dedicated yourself to the job--the attitude is goodbye. Never a thank you or you've done a great job, can't we work things out. They sort of treat you just like you're a body.

Nurses. Nurses are both the largest and most central work group in the life of the Unit. They are responsible for the coordination of patient care activity and, thus, tend to mediate between other groups.

One nursing leader observed that they are

a good group, very bright. [Their] morale on the floor is low. . . . The staff works hard. They're smart. They won't stay long. Everybody is so miserable. [This] is one of the only hospitals where you can get a job in obstetrics. People are very frustrated.

They are regarded as being relatively young and inexperienced, especially by the other nursing employees (aides and LPNs) who remember a time when the nurses were a more stable group with status more equal to that of other nursing employees. There is some resentment on the part of other nursing employees that nurses have achieved a higher status, professional role and have some privileges that are not extended to other nursing employees (higher salaries, more training opportunities).

Nursing aides. There is a marked split in the perception of aides as a group. There are good aides and bad aides, and most individuals are seen as belonging to one or the other group. In general, aides are resented by the nursing staff because they are felt to take little responsibility or initiative in making work easier on the Unit.

Lurking in the background here is the knowledge that aides have a certain amount of protection as a result of unionization for refusing to overwork in some of the ways that nurses feel they must. Aides take their breaks and leave at end of shift regardless of task demands. Some of the hostility expressed by nurses relative to these behaviors is surely due to feelings of envy.

One nurse observed:

The aides are like aides everywhere--they don't do very much. The aides on obstetrics are worse than anyplace else in the

house. They've been demoted. We get the worst. They've been tried on other floors, and they end up on obstetrics. We have some really good aides. There is a big deal going on now between the aides and the nurses about making beds. This has been going on for five years. The aides will not make a bed unless a nurse is there to help. The Head Nurse is intimidated by the aides, and she lets them have their own way.

Most of the aides are much older than the nurses and have family responsibilities and correspondingly higher priorities on life outside of work. Nurses perceive some resistance on the part of aides to taking orders from younger, less experienced people.... One nurse said:

[There is] a lot of lack of respect here, especially from the aides. Maybe it's because I'm a young girl. Some of these people are old enough to be my mother or grandmother. That's the most discouraging thing--the lack of respect here.

Physicians. Obstetricians are regarded as mostly competent, except for a few who are known incompetents or who have unpleasant personalities. Except for Labor where physicians perform the deliveries, physicians generally play little part in the operations of the Unit. Even on labor, they are likely to be continuously present only for the end of labor and the delivery. Residents are similarly regarded, except that as individuals they rotate every three months and are viewed as temporary members of the Unit staff.

One nursing leader commented:

OB/GYN specialists are supposed to be the lowest status of all physicians. The theory is that it attracts physicians that don't do so well in school. Working with women is low status. The obstetricians we see are very chauvanistic, very patronizing to their patients, have little respect for women. There are exceptions. Clinically, technically the care is not bad. . . . Doctors don't give the nurses any kind of credit whatsoever. . . . It took me three years to find a doctor that I would choose as my obstetrician.

Another nursing leader stated:

Some of them I wouldn't send a dog to. Being a woman I identify more with these women in labor. Some of these attendings yelling at their patients, calling them idiots, demeaning them. When these doctors have never been in labor, they don't know what it's like. Doctors who have to reprimand or even demean the nurses, and their practice is awful. I find it very difficult when I'm working in Labor to be part of their practice. To be part of what's going on with the woman in labor where you have a woman who is completely dilated, and all she has to do is push the baby out--and yet the doctor is giving her some sort of anesthesia.

Medical Unit

Administrative Supervisor. A pleasant middle-aged woman who has worked in this position for a number of years. She is viewed by staff as a cooperator who is willing to allow a fair amount of autonomy so long as she sees good results.

Head Nurse. A likeable young woman in her thirties, she is viewed as a strong, competent leader by both staff and leadership. She has held her current position for four years, moving from surgery where she worked five years after graduating from school.

Nursing leadership. Unit managers are regarded as being very competent in their roles. The experienced Unit Head Nurse, in particular, is cited by many from diverse groups as being a critical element in the excellence of patient care here. Most nursing staff feel that the quality of supervision they receive is good, and that they are able to look to Unit leaders as positive role models. This is particularly important for the young new graduate nurses.

There is a feeling that these leaders may have unrealistically high standards at times. One nurse commented: "Sometimes they

really wring your energy, then they wonder why you call in sick. There are only so many days you can get up and come in."

Nurses. As on other nursing units, nurses play a central role in the operations of the Unit. Generally, they are viewed as a good, competent group, although many are young and inexperienced. The high rate of turnover is felt to be a major characteristic of this group. One nurse commented: "That's a pretty major change--so many people have left--so many new people."

Within the group there is a significant amount of tension focused on issues of task and role adequacy. One nurse stated:

I feel in nursing a lot of times people don't come out with what they think. They'll complain about it and talk about it, but they won't directly come up to you. Feedback is not given to you because they're afraid you're going to say, "Well, you didn't do this"--or something--the whole controntation. So they'll tell somebody else.

Another nurse spoke about the way the group responded to one nurse:

Everyone stopped talking to her. Her general personality was very loud and rambunctious. It was almost embarrassing in front of patients and doctors and people who didn't know her. Behind her back everyone would talk about her.

Again, there is a degree of resentment on the part of some other nursing workers that nurses have gradually taken on a more separate, professionalized role over a number of years and that turnover of nurses is now so high. One LPN recalled that the entire nursing staff used to be included regularly in staff meetings but that now LPNs and aides attend infrequently. Inevitably, these long-tenured workers view individual nurses as somewhat temporary elements in the life of the Unit.

Physicians regard them as being of excellent quality,

considering their general level of experience. There is some resentment on the part of some house staff that nurses do not exercise more sensitivity in calling on them late at night for what the physicians regard as minor matters. An often cited example is that of nurses who, having received an order to call the resident if there is any change in a higher fever, call while the resident is sleeping to report that the fever has subsided somewhat.

Nursing aides. As on obstetrics, this group is felt to be problematical in some respects. Again, there is a marked split in perceptions of aides: Generally, day-shift aides are felt to be helpful and "good", while night-shift aides are regarded as "do-nothings" who just put in their time and draw their pay. These aides are resented by nurses who must work with them when they rotate to night duty.

One nurse complained:

Dealing with some of the nurses aides is difficult. They're unionized: What they will do. What they won't do. Talk to them in a certain way, and they will do that. They will take their break at this time no matter what's going on on the floor--whereas an RN will think three times before doing that.

Another nurse described the problem this way:

A lot of people have problems with them. A lot of these people have been here for years and years. I've been here a year and a half, and I have to tell them what to do.

Physicians. Physicians as a group are regarded positively. They are felt to be available and helpful when needed and easy to work with by and large. Nurses do at times resent being called upon to perform mundane tasks for physicians, like taking orders over the phone and entering them in charts.

Nurses feel that most of the physicians are willing to discuss treatment options when a nurse has questions about a particular approach. Some however, particularly the younger, less experienced house staff, will not allow themselves to be influenced by nursing opinion on treatment issues. Generally, the attendings are regarded as more of a known quantity, since residents come and go regularly as they finish rotations.

ANALYSIS

Organization-Environment Boundary

Hospital

The relationship of the Hospital to its environment is complex with numerous effects, both positive and negative. Significant sectors of the environment impacting upon the Hospital include the Medical Center as a whole, government agencies and other third-party payors, the public from which patients are drawn, and professional groups to which employees belong.

One of the most significant environmental relationships is that with the Medical Center of which the Hospital is one component. The boundary between the Hospital and the Medical Center is a rather permeable one. At the staff level, many services are shared between different units of the Medical Center, including the Hospital. At the management level, no major decisions are taken without careful consultation with and the approval of Medical Center administrators. In general, this management control is relatively benign and mainly serves to coordinate the functioning of the various Medical Center components.

A major aspect of the Medical Center interaction is the intimate relationship with the Medical School. In a formal sense, the Hospital has historically contributed a sizeable chunk of cash to the operation of the Medical School and provided a training site for medical students and residents. What it receives in return is

an outstanding group of attending physicians who bring a large pool of potential patients to the Hospital and resident physicians who staff it. The relationship appears to be mutually advantageous.

Relations with third-party payors are considerably more conflictual. Over the past decade, the amount of money expended to provide health care services has skyrocketed--both as an absolute quantity and as a proportion of the overall economy. Inflation in the health care industry has outstripped the high rate experienced in other economic sectors. As a result, third-party payors for these services, including government, have been desperately seeking ways to curb the growth of these outlays.

Efforts to restrict the level of reimbursement for services have a very direct impact on hospitals. In general, when costs for a service exceed the rate of reimbursement for that service, a hospital seeks to limit or eliminate provision of the service and covers the differential with overhead funds and surpluses from other charges. Many hospitals have run out of maneuvering room though, and there have been a number of bankruptcies and closings in recent years.

The principal impact of these efforts relative to the Hospital has been to cause cash-flow problems. While this pressure is inconvenient, it is not highly disruptive, since the Hospital's financial situation is relatively more secure than that of most hospitals.

In part, this relative financial well-being is due to the beneficial effects of the Hospital's relations with the public from which patients are admitted. Because the Hospital maintains a high

standing in the public eye, the Hospital is able to maintain a very high occupancy rate which contributes to efficient operation and reduced costs.

The relationship with professional groups from which staff are drawn is also significant relative to the Hospital's well-being. By and large, these relations contribute positively to Hospital functioning. Again, the excellent reputation which derives from a prestigious faculty allows the Medical School, and thus the Hospital, to attract top notch attending and resident physicians.

The nation-wide nursing shortage definitely limits the Hospital, preventing it from achieving desirable nursing staffing levels. The impact of this trend in the environment is somewhat attenuated by the Hospital's standing among graduate nurses. The fact that these nurses seek employment at the Hospital because of its reputation for providing sound professional training experience, helps the Hospital to replenish its nursing staff each fall.

On the other hand, the Hospital is thus forced to rely upon relatively inexperienced nursing staff and often to operate with marginal staffing levels. To a great extent the Hospital is subject to seasonal variations in the availability of these graduates. These effects hinder the primary task of patient care.

They also feed back into the problem situation by subjecting the nursing staff to levels of stress which eventually lead staff to leave the Hospital, seeking less stressful employment. On the whole, though, one has the sense that the Hospital is coping as well as might be expected with a difficult environmental situation.

The Hospital's relative success in coping with this

problematical situation reflects its general effectiveness in managing relations with its environment. In general, it is a highly regarded institution in relation to both patient care and training tasks.

Its effectiveness in maintaining itself as a vital and growing enterprise in a turbulent environment characterized by resource and other constraints is particularly impressive given the overall declining trend in the hospital field. According to the Hospital Association of New York State, the Hospital was one of less than twenty percent of its members without an operating loss in 1979 (the most recent year for which figures are readily available).

Obstetrics Unit

Relations with the environment have a significant impact on the functioning of the Obstetrics Unit. Key elements of this relationship include the process of admitting patients to the Unit, the availability of staff, and the cultural context of obstetrics as a medical specialty.

The Unit is able to control the admission of patients in labor only very indirectly. It can limit the number of attending physicians with admitting privileges or it can limit the number of patients that attendings with privileges are allowed to admit. Either of these actions allows the Unit to control the average rate of admissions to some extent, although both involve complications relative to the attending staff.

The larger problem is the uncontrollable variability in admissions to the Unit. While some of the seasonal variability is

predictable with peaks in summer and winter, the day to day variability is entirely unpredictable.

The major impact of this unpredictability is the disruption of work schedules with attendant increase in stress. By encouraging staff to leave the Unit to seek less stressful employment elsewhere, this effect contributes to a second environmentally-related problem, nursing staff shortages.

The nursing shortage has similar effects on this Unit as elsewhere in the Hospital. The Unit must at times operate with marginally adequate nursing staffing levels and with nurses who are inexperienced.

The effect of these marginally adequate staffing levels on the Obstetrics Unit is to dramatically change the nature of the nursing work on the Unit. This impact is most obvious on Post-Partum where staff must often attend only to the most urgent medical needs of patients.

These task requirements remove opportunities for nurses to perform many of the more interesting kinds of tasks which attract them to obstetrics in the first place--especially patient counseling and education. It is in this type of work that the gratifying relationships which constitute an important payoff for the nurse are formed.

Nurses end up feeling deprived of this gratification and resentful. Some of this resentment becomes attached to patients who are seen as "too busy" with family and friends to relate meaningfully with nursing staff. The real source of this deprivation is probably located more in the task demands of current

work organization on the Unit than in preoccupations of patients.

Much of this resentment is directed toward Unit leaders who cannot protect the staff from these deprivations. Another aspect of this dynamic is a marked split between feelings about duty on Post-Partum ("the pits") and Labor and Delivery.

Labor is at least able to retain some sense of immediacy of involvement and resultant excitement despite the high work load. It is clear though that the level of gratification suffers here as well at times with nurses shuttling to cover a number of patients.

The overall effect of this environmentally-related dynamic is to produce a pervasive atmosphere of resentful alienation on the Unit. Given the demands of the work and the available resources, there is little that Unit leaders can do to ameliorate the conditions which produce these feelings.

The cultural context of obstetrics as a medical specialty has some impact on the functioning of the Obstetrics Unit. There appear to be two related dynamics operating in this regard.

The historical development of the field of medicine with its emphasis on intervention and action relative to disease and illness has made obstetrics (where the involvement is with predominantly normal physiological processes) something of a medical backwater. This contributes to the position of the Unit as a bit of a stepchild within the Hospital and has some input to the emotional atmosphere of deprivation extant on the Unit.

An interacting environmental dynamic is the changing role and status of women in the culture at large. As women have increased their power and made more demands relative to their needs, this has

impacted on the functioning of the Obstetrics Unit in at least two ways.

First, patients are viewed increasingly as consumers. The desire of these consumers for different types of services has changed the organization of the work on the Unit in a number of ways, ranging from the presence of husbands in delivery rooms to the rooming-in practice. Prospects are for continued changes motivated by "consumer demand".

In fact, this source of change is viewed as a primary progressive force relative to Unit work by nursing staff. Nurses see an alliance between their views about how the Unit ought to change and the desires of women patients for more responsive treatment.

Second, the changing roles and status of women has contributed to the changing role of nurses. In recent years, the predominantly female nursing role has become increasingly professionalized with higher status. Nurses have sought a more active role in patient care decision-making and greater recognition for their contributions to medical care.

In addition, a substantial number of women have entered the obstetrics field as physicians in recent years, and this has helped to dilute some of the problematical gender-related dynamics of physician-nurse relations. The contrast between powerful male physicians and powerless female nurses has lessened but remains an important intergroup issue.

Medical Unit

The Medical Unit also has a number of significant environmental influences relative to its functioning. These influences include the general nursing staff shortage, the training needs of the Medical School, dependence on various ancillary service departments, and the cultural context of the medical and nursing professions.

The impact of the general nursing staff shortage is similar here to that elsewhere in the Hospital. Disruptive and overly demanding schedules are commonplace for the professional nursing staff, many of who are relatively inexperienced recent graduates. As a result the level of stress is high.

As seen on the Obstetrics Unit, there is a diversion of scarce professional nursing resources away from more gratifying counseling and education activities to more pressing work associated with urgent medical needs. Here the emotional impact is somewhat different. Aggressive impulses are directed more inward, resulting at times in some feelings of guilt, self-doubt, and depression.

The training activities of the Medical School tend to contribute to a sense of fragmentation on the Unit. The Unit is covered by a relatively large number of residents who rotate every three months. Medical students rotate every month. These rotations (in addition to patient turnover) tend to make Unit staff feel that there are a great number of people coming and going all the time.

There is little gratification in making more than superficial relationships with these transitory participants in Unit life. Yet the housestaff play a key role in the work of the Unit. The

rotations reinforce the dynamic of loss on a Unit where many patients die, there is some sense that energy is constantly hemorrhaging away. The high turnover of nursing staff is both a result of and contributing factor in this dynamic.

Another environmental source of frustration for the Unit is the dependence on various ancillary departments of the Hospital for critical services. The isolation of these departments from the impact on patient care of their unresponsiveness is a constant irritation for the Unit staff who must live with patient pain and suffering daily.

When a key treatment decision awaits the results of a laboratory test which gets "lost", feelings of impotent rage result. These feelings contribute to the high level of stress prevalent on the Unit.

The cultural context of the nursing and medical professions is also a contributor to Unit stress. One aspect of this context is the relative powerlessness of nurses in relation to physicians as professional groups. The experience of relative professional powerlessness (in addition to their powerlessness in the face of death) contributes at times to the stress among Unit nursing staff.

Another aspect of this context is the high degree of specialization which has developed in the practice of medicine. This specialization of functions tends to contribute to the sense of fragmentation discussed above, since it often results in increased numbers of participants in a patient's treatment, each of whom has less and less investment in, and at times perception of, the patient's overall well-being.

Assets and ImpairmentsHospital

The Hospital currently has a number of quite tangible assets, internally. Foremost among these are the quality of its personnel and patient care program. Most Hospital personnel throughout the organization seem to be mainly competent, dedicated individuals-- people who are sincerely interested in helping patients. Patient care programs appear to be well-conceived and resourceful, meeting the needs of most patients. In addition, Hospital facilities are reasonably adequate and attractive.

The Hospital has as well a number of less tangible, but equally important, functional assets. Hospital leaders seem effective in their perception of and response to the environment, both internal and external. Their willingness to experiment with new approaches to health care tasks like Cooperative Care and HIS are evidence of their flexibility and farsightedness in keeping the Hospital on the crest of beneficial developments in the field.

These functional strengths may to some degree be jeopardized by the current transition in the leadership of the Medical Center. For the immediate future the Hospital seems likely to concentrate on carrying out developmental plans which have been in progress for a number of years, including the implementation and refinement of HIS and the building of a new wing.

As for longer term trends, these are less predictable, but Hospital management seems at least to have internalized an aggressive stance relative to the future and to have the capability to develop and implement long range plans. One does have the sense

in talking with key Hospital leaders that future directions will depend a great deal on the vision of new Medical Center leaders.

The functioning of the Hospital is somewhat impaired by the current nursing shortage. The quality of patient care tends to be degraded to a degree by the lack of sufficient experienced professional nursing staff. In addition, stress related to over-demanding nursing work schedules and frustrating organization of nursing work contributes to a high turnover among nursing staff. A great deal of energy is expended by the Hospital on recruiting and training new professional nurses to replace those who resign.

Obstetrics Unit

Tangible assets of the Obstetrics Unit include a highly professional and, for the most part, skilled medical and nursing staff. The program of patient care for both mothers and babies seems adequate. The physical facilities of the Unit are reasonably adequate and attractive, although their capacity is barely adequate during periods of peak demand.

Functional assets of the Unit include its flexibility in maintaining a generally adequate, and often good, level of patient care while accommodating a great deal of variability in the amount of work. Most Unit nursing managers seem capable, although their sentient leadership is rather impaired by the emotional dynamics of the Unit.

Unit impairments are mainly functional in nature owing to the shortages of experienced professional nurses. While these impairments seem to have a major impact on the quality of patient

care here only during certain periods of peak demand, there are other serious impacts.

These include impacts on the organization of work which profoundly affect the emotional atmosphere of the unit. The major consequence of this atmosphere seems to be the level of stress experienced by the nursing staff on the Unit. One effect of this stress is difficulty in retaining experienced nursing staff.

While patient care remains adequate for the most part, there are times, especially over the summer, when it is felt to suffer markedly. In addition, it seems likely that the quality of Post-Partum care provided could be generally improved by an increase in nursing staffing which would allow a reorganization of the work.

Unit nursing managers are aware of these problems and seem to be interested in experimenting with new management approaches, however increasing the nursing staff resources or reducing the number of patients admitted is to a great degree beyond their control. It is difficult to imagine more than marginal changes relative to these impairments in the near-term future.

Medical Unit

Like other sectors of the Hospital, tangible assets of the Medical Unit include a highly professional nursing and medical staff. What some lack in experience is partially compensated by intelligence and dedication. The program of patient care is reputedly among the best of its kind anywhere. Physical facilities and equipment are adequate and well-kept although very cramped.

Functional assets include capability to continually attend to

and internalize new medical and nursing knowledge and techniques. In addition, Unit managers seem exceptionally capable, especially in managing the emotional needs of nursing staff. There is a willingness to experiment with new approaches like four day work weeks and stress groups for the nursing staff.

As on other Units, there is some degree of functional impairment resulting from the shortage of professional nursing and house staff. This impairment is reflected in both the quality of patient care and the quality of working life.

Quality of patient care is affected by an informal triage system where activities like patient education and counseling are heavily reduced in favor of more immediately urgent treatments like distribution of medications, maintaining IV set-ups, etc. For instance, there are few resources available to help the families of dying patients understand and adjust to patients' conditions.

This triage system affects the quality of working life for professional staff who feel overworked and overstressed by diverting them from more gratifying activities involving human contact to more technical and mechanical activities. The end result is a loss of experienced nursing staff to less stressful settings.

Again, it is difficult to imagine any drastic change in Unit staffing which would greatly impact on these impairments to improve the already relatively high level of functioning in the foreseeable future.

Level of Integration: Work and Emotional Life

Every organization has two levels of needs which govern its

behavior: Task (or work) needs--because an organization has purpose--and sentient (or emotional) needs--because an organization is a group of people with personalities. The level of organizational integration concerns the nature of the "fit" between these two systems of motivation: That is, in what ways and to what extent does the organization's emotional life facilitate and impede its work life--its goals and purposes--and vice versa.

Hospital

Many areas of the Hospital's functioning, particularly in relation to its patient care task, seem well integrated. The professional competence and idealistic dedication of most Hospital personnel has provided strong support for the commitment to quality patient care.

It is clear, however, that this commitment is at times somewhat undermined by impairments associated with professional staffing shortages. These shortages result from a number of factors, including externally imposed budgetary constraints, changes in the cultural environment, and changes in the roles involved.

In recent years, nurses have come to resemble medical housestaff in some of the sacrifices associated with their role. For residents, these deprivations are somewhat easier to tolerate, since they are clearly in a training role and will, within a few years, advance to a more remunerative and higher status role. Training rotations and assignment to multiple units further reinforce the temporary nature of the current role and insulate house staff from some of the emotional life of nursing units.

For nurses, professional advancement is far from assured, and the associated increase in status much more limited. While the Hospital has developed a hierarchical nursing management structure to allow for promotion, it is clear that most will have to leave the Hospital to achieve a more comfortable role. Many regard their work here as a temporary training experience.

At the root of these problems is the reality of patient-care work. This work, which is extremely psychologically demanding, requires workers to cope with a variety of anxiety-laden stimuli. Patient caretakers deal physically with disease, repugnant anatomical care tasks, and death. Emotionally, they deal with fear, disgust, depression, and exhaustion among other feelings. They must cope with both their own reactions to these stimuli, as well as the reactions of others, most prominently patients and their families.

The psychological meaning of nursing work must also be considered in this context. The very name of this profession, "nursing," provides an indication of the range of conscious and unconscious associations related to this work. The dependency relations between patient and nurse elicit for both fantasies of the earliest dependency relations between nursing infant and mother. Whatever unresolved conflicts exist for nurses and their patients in this realm contribute to the stress experienced chronically in nursing work.

Restriction of direct access to Hospital patients during this research limits data concerning their psychodynamic role on nursing units. However, Menzies (1967) provides an analysis of the nature of the roles of patients and their families in hospitals which seems

applicable in this setting:

. . .both patients and relatives make psychological demands on nurses which increase their experience of stress. The hospital is expected to do more than accept the ill patient, care for his physical needs, and help realistically with his psychological stress. The hospital is implicitly expected to accept and, by doing so, free patients and relatives from certain aspects of the emotional problems aroused by the patient and his illness. The hospital, particularly the nurses, must allow the projection into them of such feelings as depression and anxiety, fear of the patient and his illness, disgust at the illness and necessary nursing tasks. Patients and relatives treat the staff in such a way as to ensure that the nurses experience these feelings instead of. . .they themselves. . . . (p. 286)

At the macro-organizational level of the Hospital, there are a variety of means for defending against the anxiety associated with these stimuli. These defensive structures include extremely high professional role standards, an emphasis on innovation and technology, and a high degree of role specialization.

Extremely high professional standards for Hospital personnel function to repress impulsive, emotionally-based behaviors. The professional staff member is expected to behave with rational detachment at all times in his work. Those who deviate from this requirement can expect to be severely reprimanded, expelled from the Hospital, and even expelled from their profession, depending on the circumstances of their transgression.

The utility of these standards relative to the work of the Hospital is obvious. If hospital staff became emotionally involved in the work to the point of making critical decisions impulsively, rather than rationally, the results could be disastrous. On the other hand, the need to control expression of feelings to an extreme degree places a great burden on individuals in professional roles.

A strong emphasis on innovation and technology serves to

direct attention away from the painful reality of today's work toward a brighter, more hopeful tomorrow. In addition, it offers at least some relief from burdensome human contact and responsibilities.

There is little doubt that technological advances have offered some improvement in health care and eased the work of Hospital personnel. They have also been extraordinarily expensive. Health care has become a capital intensive enterprise, as well as remaining labor intensive.

In addition, technological innovations have dehumanized an increasing proportion of health care work. That is, they have tended to increase the distance between patients and health care providers, both physically and psychologically. Emphasis on progress has also raised public expectations of health care institutions, perhaps beyond realistic levels.

Finally, the expense of the new health care technologies has prompted external attempts to prevent the hospital industry from further increasing its demand on the resources of the economy. Frequently, the means used to externally regulate these resource demands are inappropriate and ineffective.

The high degree of role specialization in the Hospital is related in part to the increasing use of high technology and increasingly sophisticated treatment techniques. Emotionally, this specialization of function serves to insulate personnel from the reality of patient care as something which involves a whole person and their feelings.

Role specialization is very useful in that it allows staff a high degree of familiarity with the body of knowledge which bears

directly on their work, and it allows many tasks to be performed more efficiently. On the other hand, it limits the effectiveness of some patient care work by isolating the worker from peripheral information and direct feedback which might have a bearing on key decisions.

In addition, specialization of many staff members places an increasing emotional burden on those who remain relatively unspecialized in their functions. For the most part, this burden is carried increasingly in the Hospital by nursing staff who have a more generalized role.

In effect, their role is generally limited, not by specialization, but by a personal choice to leave the Hospital after a period of time. Obviously, the costs of their departure to the Hospital in loss of expertise and the expense of training an inexperienced replacement is great.

Hospital management is aware of many of these dynamics and has attempted to intervene to improve Hospital functioning. The current implementation of a computerized Hospital Information System is aimed in part at reducing nursing staff workloads and frustrating communication problems.

On the other hand, some management actions in the recent past have tended to exacerbate these dynamics. A prominent example is the development of the Cooperative Care facility. This is correctly viewed as a progressive innovation in health care, since it allows the patients and their families to take a more active role in their own care as soon as possible. The Hospital was also able to grow without proportionally increasing utilization of scarce nursing

resources.

However, by removing these patients to a separate facility, it has tended to raise the average acuity level of patients in other Hospital sectors. The result is increased stress on Hospital medical and nursing staff. So, management attempts to improve functioning, while generally positive in effect, must be viewed as something of a mixed bag.

Obstetrics Unit

The level of integration of Obstetrics Unit functioning seems to vary by sector. Functioning in Labor and Nursery sectors seems well integrated relative to the patient care task, while problematical dynamics seem more apparent on Post-Partum.

Some of the factors promoting this split have been discussed earlier, including the differential value and priority assigned to the work of Labor. Another potential factor in this dynamic may be a tendency on the part of some patients on Post-Partum to experience a degree of depressive let-down after giving birth.

After being the center of attention with attendant rewards during pregnancy, some mothers experience a sense of loss when their babies assume this position while they are exhausted from the birth process. In addition, mothers are making a difficult, abrupt adjustment from being taken care of to doing care-taking.

These feelings are bound to impact upon the nursing staff of Post-Partum. It seems quite likely that staff here "catch" a bit of post-partum depression themselves. The role most vulnerable to this depression is that of Post-Partum Head Nurse, since she does not

rotate to other sectors.

The presence of mothers and infants on the Unit may contribute to the arousal of very primitive fantasy material concerning the earliest experiences of nursing staff. The primitive defense processes associated with this stage of life, the paranoid-schizoid position, seem consistent with the group psychodynamic functioning on the Unit. In the paranoid-schizoid position, aggressive aspects of the self are split-off and projected into others who become bad, persecutory objects. This splitting process also requires good, ideal objects who are available for introjection.

The Post-Partum head nurse role is available for projection of unacceptable feelings experienced by the nursing staff at large. The Administrative Supervisor role also seems contaminated by these projections. By attacking this Head Nurse, the staff is able to externalize some of the hostility that they would otherwise experience as guilt when their performance is affected by the emotional atmosphere of this sector. The withholding, scrutinizing qualities attributed to Unit leadership are consistent with paranoid-schizoid processes.

Because the nursing staff rotates among the three sectors, it is easier for one leader to be split-off as the bad mother. Nursing aides (who do not generally rotate among sectors) are also available as objects of similar negative projections and hostility. It is interesting to note that the Nursery Head Nurse, with whom the professional staff has least contact, is regarded most positively by many as the most competent among Unit leaders. She is also the "mother" who cares for the real infants on the floor.

These regressive defensive structures are costly to the Unit in a number of ways. They are only partially effective in controlling the problematical feelings aroused by work on the Unit. The dynamic operating on Post-Partum definitely interferes with the work there by severely limiting leadership effectiveness and general morale. In the end, many of the professional nursing staff become disillusioned and leave the Unit.

Other less regressive defenses operate here as well, including the professionalization of work and work roles described under the Hospital section. These are less debilitating, but are inadequate to deal with the feelings aroused on the Unit. They do function, however, to maintain an adequate level of task performance on the Unit most of the time.

Management seems to be relatively unaware of many of the defensive dynamics operating here. There is an awareness of a "leadership problem" on Post-Partum and an understanding that the work there is unpleasant, but no real effort to deal with these issues.

An attempt is being made to require longer commitments from nurses requesting duty on the Unit. While this move may alleviate some of the staffing problems, it seems likely to intensify the above described dynamics by tightening the safety valve of staff export.

Medical Unit

Most aspects of the Medical Unit's functioning relative to its patient care work seem well integrated. Most of the defensive

structures described above for the Hospital at large operate fairly effectively here, including professionalization of the work and work roles, emphasis on innovation and technology, and specialization of roles. Two additional defensive mechanisms seem relevant here, idealization of the work and export of staff members and feelings.

The level of stress aroused by work on this Unit is higher than that experienced in most other Hospital sectors. This is mainly attributable to the high average acuity level of the patient population and to the frequent deaths of patients here.

The dependency relationship between these patients and their nurse caretakers may contribute to the arousal of fantasy material concerning the early dependent experiences of the nursing staff. The defensive processes seen here seem more consistent with those of the depressive position--including strong ambivalence, guilt, and reparation. In the depressive position, both positive and negative feelings are experienced relative to the parental object. Aggressive impulses toward the object lead to feelings of guilt and despair over potential loss and the desire to make reparation for these impulses to protect against it.

Idealization of the work on this Unit is promoted by the professional indoctrination received during training by new graduate nurses who make up a high proportion of the professional staff here. This defense is closely linked with the professionalization of roles on the Unit, and it functions to inhibit the expression of any hostility aroused by difficult work or troublesome patients.

Because of the control required by their work role, many of the professional nursing staff find that they "take their job home

with them", cannot get it off their minds, and continue to experience the feelings of the working day while off duty. Many are unable to adequately express their feelings outside of work either because their outside associates do not have similar enough work situations or are not interested in listening.

Although feelings about nursing leadership are highly ambivalent, there is a reluctance to blame leadership directly for the deprivations of working on the Unit. Many of the hostile feelings which are inevitably aroused by this demanding work are ultimately controlled by being directed inward to the self and within the nursing staff as criticism of other nurses. Resultant feelings of guilt, inadequacy, and depression are often experienced by nursing staff. Reparative resolutions to devote renewed energy to doing more for patients are frequently made.

Some hostile feelings are projected onto some of the nursing aides who do what is unacceptable for the nurses--goof off or otherwise limit the demands they accept upon themselves. To the degree that these "bad" aides receive these aggressive impulses, nurses are able to escape the above described internal retributions.

In the long run, none of these defensive maneuvers is adequate to control the emotional reaction to work on the Unit. The "burnout" rate is high--sixty percent of the nursing staff leaves during each year. The cost of their departure is high, adding to the experience of loss and absorbing resources in the training of replacements. However, the defensive structure of the Unit is quite adequate to maintain a high level of task performance here.

Unit leaders are aware of most of these dynamics and are

experimenting with several new approaches to stress on the Unit, including a four day work week to allow more time away from work and staff stress groups to provide a special place for staff to work through some of their feelings about work and get support from their peers.

These approaches will likely reduce the level of stress on the Unit to a small degree. However, increased staffing on the Unit to allow more time for individuals to respond to their experiences and work more collaboratively seems unlikely to be forthcoming given the current nursing shortage and budgetary constraints.

PART THREE

DISCUSSION AND CONCLUSIONS

DISCUSSION

The organizational dynamics described in the foregoing case studies display a number of common trends, as well as the dissimilarities that one might anticipate in different organizational sectors. These dynamic similarities and differences can be understood in relation to the organizational environments of the two nursing units studied, particularly relative to the nature of their work.

In addition to being sub-units of the same Hospital, the nursing units studied share similar elements in their work environment. On both units, the primary task involves providing health care for patients. Both units are also required to perform this work with significant staffing resource constraints.

Health care is a particularly difficult kind of work because of the anxiety-arousing nature of associated activities, especially for those who work directly with patients. Physicians, nurses, and other staff are continually in intimate contact with the pain, suffering, and sometimes death of patients in a very physical way. This contact can elicit a variety of powerful, uncomfortable personal responses ranging from disgust to sexual arousal. Working in this environment places a special kind of stress on the staff of these units.

In addition, the nature of dependency relationships with patients involved in nursing work is likely to arouse primitive

fantasies concerning conflictual early dependent experiences of staff members. These fantasies mobilize primitive psychological defensive processes associated with the paranoid-schizoid and depressive positions of early life.

The staffing constraints under which this work is performed on both units constitutes another source of stress. As a result of personnel shortages, staff members work long, irregular hours. These pressures are most acute for residents and staff nurses who rotate shifts to provide night coverage. Residents are routinely required to work every third night in addition to daytime duties, and nurses often work two consecutive shifts. Days off can be unpredictable.

The work environments of these two units also differ in some rather significant respects. The specific health care activities performed are quite different. There are also differences in the size of the units and in the degree of control over patient inflow.

Activities on the Medical Unit relate to the needs of very ill and dying patients. Many patients are admitted multiple times for lengthy stays during the course of their degenerative illnesses and become known to the Unit staff as individuals. Attachments develop between patients and staff members. Many patients eventually die on the Unit.

In contrast, patients on the Obstetrics Unit are, for the most part, healthy women and their healthy babies. While patients require assistance during the delivery and some post-natal care, they are not generally in a medical crisis. Except during the actual delivery, patient needs are routine and not urgent. Patient

stays on the Unit are generally brief. The usual stay is not long enough for deep attachments to form.

The units are also different in size. The fifty member Medical Unit nursing staff serves thirty-six patients and occupies half a floor. The Obstetrics Unit has a nursing staff of seventy-five, often serves more than thirty-six mothers and thirty-six babies, and occupies an entire floor. The sheer volume of patients is even higher than this indicates, since the average length of stay is less than a quarter of that on the Medical Unit. It is formally divided into three functional sub-units.

The sense on the Obstetrics Unit is of a larger enterprise with many different parts. People in one area are not always aware of activity elsewhere on the floor. The Medical Unit is more of a small group situation with activities occurring within one arena.

The defensive organization and dynamic functioning of these two units reflect their similarities and differences of task and environment described above. In examining these ways of functioning it is important to keep in mind that they represent both organizational strength and limitation. No organization can function well without the means to psychologically master anxieties.

A number of defensive structures are found on both units, as well as elsewhere in the Hospital, although degrees of emphasis do differ from one sector to another. These elements of defensive functioning include high professional role standards, idealization of the work, emphasis on technology and related role specialization, emphasis on more discrete and distant work tasks, projection of unacceptable feelings and attitudes onto others, and export of

feelings and "burnt-out" staff members. Each of these elements has both positive and negative aspects.

As noted previously, high professional role standards on these units tend to assist in the repression of impulsive, emotional behaviors. Rational detachment is the role ideal. These role standards for personnel help to ensure that critical medical decisions are made appropriately, but the requirement to control the expression of powerful feelings can be quite stressful for staff members.

Idealization of the work is somewhat related to these high role standards. Emphasis on the altruistic motivations and rewards of health care providers tends to reinforce the dedication of staff members, make them feel special, and justify their sacrifices. On the other hand, this idealized view of the work tends to induce guilt over dissonant feelings of frustration, resentment, and anger.

While the advantages of medical innovation are obvious, emphasis on technology and innovation has numerous defensive effects. On the one hand, it can deflect attention from the inadequacies and burdens of present work toward hope for the future. Technology also offers an impersonal repository for displacement of unwanted responsibilities by making it possible to blame "the machine" for various problems. Technology helps to alleviate certain anxieties related to uncertainty by making it possible to perform a multitude of mechanized tests in order to rule out unlikely possibilities.

Another defensive aspect of technology is the distance it tends to create between patients and health care providers, both

physically and psychologically. Blood tests are sent away to laboratories at remote building locations. In other instances, technological devices intervene between patient and health care provider. Sophisticated data gathering devices like CAT-scanners, heart monitors, and the like, tend to make physicians and other staff members more and more into data analysts rather than interpersonnal and physical examiners and interacters.

The role of technology and innovation is clearer on the Medical Unit where the depth and pace of change has been greater (and the salience of hopeless medical conditions much more pronounced). With the advent of new technologies like the fetal heart monitor and innovations like in utero surgery, many of these effects are seen on the Obstetrics Unit as well. Prospects for increasing impact of these effects seem great on both units.

The specialized roles required by the new medical technologies and the increasing breadth of the medical knowledge base also tend to increase the psychological distance between staff members and patients. Laboratory technicians who deal only with the patients blood are an extreme example. Numerous other medical specialists deal only with specific parts of the body or particular aspects of problems, rather than with the patient as a whole person. It would seem easier to deal with a diseased liver than with a seriously ill patient who may die.

A prominent effect of this increasing specialization of function is the special emotional burden that it creates for those staff members who remain relatively unspecialized. They must increasingly carry brunt of the emotional relationship to the

patient. By and large, it is the nursing staff who have this more burdensome generalized role. Even on the nursing staff, one sees an increasing tendency to seek a more circumscribed role--to develop highly specific job descriptions and so forth.

On both units, staffing resource constraints have led to an increased focus on the most dull and mechanical aspects of the work. To a great degree, this organization of the work has occurred because these tasks tend to be the most urgent. It is certainly urgent to administer medications, do blood work, change dressings, and so forth in a timely fashion.

On the other hand, these facets of the work also become emphasized because they are the most easily quantifiable, and thus the most easily "orderable" and accountable. It is relatively easy to discern the damage that may be done to a patient when medications are not given properly, while it is relatively difficult to specify the exact kind of human contact which might promote a greater degree of well-being for the patient.

In an organizational task environment with the pressure of staffing constraints (and sometimes a high degree of uncertainty relative to task outcome), there is a tendency to focus on those tasks which are relatively discrete, certain, and measurable. Highly structured tasks are less anxiety arousing.

These tasks are also less likely to promote anxiety because they require less experience of the patient as a whole person and less use of the worker as a whole person. Blood can be drawn from an arm mechanically. Counseling and educational tasks require a greater degree of engagement between the worker and patient. This

deeper engagement can be uncomfortable for one or both.

One way of dealing with unacceptable feelings and impulses on both units is by attributing them to certain split-off parts of the staff. Common objects for these attributions are the nursing aides. On both units, certain nursing aides--often those on the night shift--are perceived as being rebellious, irresponsible, unhelpful, and so forth. On the Obstetrics Unit, some Unit leaders are repositories for this type of projection as well--being seen as depressed, cold, aloof, withholding "bad mothers". Many of the attitudes and behaviors which would be quite unacceptable for staff members become located in these subgroups.

The availability of leadership for these kinds of negative projections on the Obstetrics Unit seems, in part, related to its larger size. Since there are a number of sub-unit leaders, some of them can be sacrificed to these negative roles without losing all parental objects. With fewer leaders, the Medical Unit seems to need to preserve them for positive roles. While there are some negative perceptions of intermediate level leadership on the Medical Unit, these feelings are more ambivalent than on Obstetrics.

The need for bad objects among the Obstetrics nursing leadership may also be related to the regressive pull toward a paranoid-schizoid position exerted by the presence of infants on the Unit. A more fragmented quality of attachments related to the much greater rate of patient turnover on Obstetrics may produce a tendency toward paranoid-schizoid processes. Personality valencies of Unit leaders are probably also a factor in their degree of availability for these bad object roles. One can only speculate

about how and why such personalities were chosen by the Hospital organization for particular positions.

Export of unacceptable feelings to the external environment is another defensive process seen on both units. Because of the emotional control required by work roles, many staff members find that they "take their work home with them." Thoughts and feelings about work remain prominent during time off. This is especially true on the Medical Unit where depressive processes seem more prevalent.

Another means by which problematical feelings are exported is through departure of staff members. This may occur when unexpressed hostile impulses are controlled by being directed inward to the self, resulting in feelings of guilt, inadequacy, and depression. These depressive position processes are related to the arousal of primitive conflictual fantasies in staff members by dependency work relationships.

"Burn-out" may take place when aggression toward introjected good objects can no longer be controlled. This would product overwhelming feelings of despair. Eventually, staff members who experience these feelings leave the Hospital, taking these encapsulated feelings with them. Approximately sixty percent of nursing staff leaves each year and are replaced by new graduates. Rotations of resident physicians are implicit in their training structure.

While turnover rates are similar on both units, hostile feelings seem more rigidly controlled on the Medical Unit with a greater tendency toward self and within-peer-group critical

expressions. It seems possible that the frequent death of patients here--the proximity of death--makes externally expressed aggression less acceptable. The more prolonged nature of relationships to patients here probably are also a factor in promoting more ambivalent attachments here. The Obstetrics Unit where no one dies or is around for very long seems a correspondingly safer environment for aggressive expression, and hostile remarks toward others are much more frequently heard here.

In addition, the patients on the Medical Unit are in reality much sicker and much more dependent on the staff of the Unit, both physically and emotionally. Patients on the Obstetrics Unit, on the other hand, are not generally ill at all. They are not dependent on the staff of the Unit in anything approaching the way that the medical patients are dependent on their staff.

This dependent neediness of patients probably contributes to the inhibition of aggression on the part of Medical Unit staff members. After all, what right have they to complain--what is their suffering next to that of these patients?

The defensive structures and styles of the two units are somewhat similar. All of the elements described above are seen in the functioning of each unit, with different emphases as noted. The main trend of this difference seems to be the relative tendencies toward inward vs. outward (depressive vs. paranoid-schizoid) expressions of aggressive impulses on the Medical and Obstetrics units, respectively.

A number of factors, in addition to the differing nature of the work on these units as described above, contribute to this

difference in the balance between modes of aggressive expression. These factors include differences in the permeability of external boundaries and in the size of the work groups on these units.

The quality of transactions across the external boundaries of the two units is markedly different, in terms of both admission and discharge of patients. Patient admission on the Medical Unit is a relatively controlled process. The rate of admission is much lower than that on the Obstetrics Unit where the admission process can have a much more invasive, uncontrollable quality at times. There are much stronger feelings of frustration on the Obstetrics Unit relative to the lack of effective control over admissions.

Discharge has a markedly different meaning on these units. Discharge of patients from the Obstetrics Unit is a positive event: happy new mothers returning home with healthy babies. Staff often feel relieved that the Unit patient population has declined when discharges occur. Discharges are a relatively routine procedure with little or no sense of accompanying loss. Stays are not long enough for deep attachments to form.

On the Medical Unit discharge often means the loss of a cathected object. Patients are intensively cared for during stays of significant duration. Often the loss of a patient here is the permanent result of their death. Grief, sadness, and depressive feelings are associated with this loss.

The Medical Unit seems to function at a somewhat higher level of integration than the Obstetrics Unit. The Medical Unit is widely regarded, both internally and externally, as among the best of its type anywhere. The Obstetrics Unit is regarded, again both

internally and externally, as adequate but not particularly excellent in its task performance.

The Medical Unit serves difficult patients excellently, while the Obstetrics Unit serves less problematical patients adequately. On the other hand, the Obstetrics Unit serves a much greater number of patients. Both units suffer from the export of valuable staff resources.

The personalities of unit leaders do not seem to be the critical variables in determining the level of integration of the functioning of these nursing units. While personality trends may play some part in their selection for certain roles within the staff group, all of the unit managers seemed adequate in their work roles, without extreme character disturbance.

This is not to say that these individuals have not made a contribution to the functioning of their units, but rather that the defensive dynamics and overall level of functioning might remain much quite similar with different individuals occupying the leadership roles (assuming that these individuals also would be competent and free of marked character pathology).

The functioning and defensive style of these two nursing units is, in substantial part, the product of a number of task-related factors. These factors include the specific health care activities performed, the nature of the patient populations, staffing resource constraints, the size of the units, and the nature of admission and discharge processes.

A striking quality of this system of stress tributaries to the defensive functioning of these organizational sectors is its

synergistic effect--the way in which each contributing factor impacts upon each other factor so that the effect of each is greater than what it would probably be without the others. These factors exert a more or less constant, stressful, regressive pull on the functioning of these units.

Similar elements can be seen in the defensive functioning of each unit. These elements include high professional role standards, idealization of the work, emphasis on technology and related role . specialization, emphasis on more discrete and distant work tasks, projection of unacceptable feelings and attitudes onto others, and export of feelings and "burnt-out" staff members.

The defensive systems which have developed on these nursing units are generally effective in controlling organizational anxiety and promoting their effective functioning. The major cost in the operation of these defensive processes is the continual loss of valuable staff resources.

Many differences in the functioning of these two units can be understood by examining the relationship between task-related stressors and defensive processes on each unit within its environment. The systemic interaction of this matrix seems to help explain many aspects of life on these units.

CONCLUSIONS

The findings of this research are clearly congruent with those of previous psychodynamic studies of health care organizations. The nursing units studied confirm the task-related valency toward regressive functioning in health care organizations described by both Menzies (1967) and Kernberg (1975). The primitive defensive processes cited by Jacques (1955) operate here. The role of technology in contributing to the defensive structure of the organization as specified by Emery and Trist (1960) is seen. The critical impact of the handling of aggression within the work group discussed by Gustafson and Hausman (1975) is seen as well.

The work of Menzies (1967) is directly applicable to the nursing units studied here. While Menzies studied a nursing service at large, many of the task-related stressors and defensive processes and social structures identified in her study operate in the nursing units examined. Techniques for increasing distance from patients in treatment, idealization of work and work roles, and the splitting off and projection of irresponsible impulses are important aspects of the work culture.

The role of secondary anxiety resulting from the employment of these defensive structures is equally important. Feelings of loss caused by excessive departure of staff members and deprivation of individual work and social satisfactions are key elements in the dynamic functioning of the units.

Kernberg's (1975) notion of induced regression in leadership is also seen to be operating to a degree, particularly in one sector of the larger Obstetrics Unit. Here the depressive dynamics of the Unit seem to have overwhelmed a key sector manager.

The role of primitive psychological processes of splitting, projection, and introjection in defending against primitive, paranoid and depressive anxieties of system members as described by Jacques (1955) is seen on both units. The investing of low status nursing aides with irresponsible qualities serves to partially protect nursing staff members from internal attack in the form of guilt.

Technological determinants of the work and defensive culture on these units validate the work of Emery and Trist (1960). These determinants include technological requirements for increasing specialization and distancing of staff functions from direct patient contact and the resulting concentration of emotional stress on the nursing role.

Gustafson and Hausman's (1975) examination of the handling of aggression in the caring work group illuminates the importance of this phenomena in the functioning of the organizations studied. It is clear that in the units studied a critical impairment--the excessive exportation of veteran staff members--results from the inability of the system to effectively integrate the aggression of staff members.

The selection for this research of an organization with some insulation from the commonly experienced stresses of fiscal crisis or severe constraint gives a clearer view of many of the more

explicitly task-related dynamics. A central conclusion of this research must be, not only that these phenomena are commonly observed in the organizational life of health care (and other) enterprises, but also that by effectively understanding them within a psychodynamic systems framework a great deal of light can be shed upon the organizational functioning of these enterprises.

APPENDICES

A. GENERAL QUESTIONNAIRE

A. Environment and history

1. Geographic location, size of physical plant units
2. Catchment area, demographics of client population
3. History of establishment and development

B. Board of trustees

1. Procedures for selection
2. Members, backgrounds, occupations, terms
3. Budget and policy process

C. Formal organization

1. Nature and size of principal work units
2. Nature and distribution of positions (chart)
3. Any recent changes

D. Management systems

1. Formal management systems (MBO, PPBS, etc.), strategies, and philosophies
2. Communications procedures: regular meetings, reports, manuals, evaluations, bulletins, newsletters, etc.

E. Personnel

1. Distribution according to age, sex, ethnicity, education, tenure, source of recruitment, etc.
2. Relevant personnel policies, salaries
3. Existing unions and associations, contracts

B. INTERVIEW STRUCTURE

Statement of Interviewer in Relation to Consent of Subjects

Interviewers will make the following statement to each subject before beginning the interview. The statement and the subject's consent will be witnessed by a third party:

Do you understand that the purpose of this study is to assess the effects of the new Hospital Information System on the quality of working life here and on the general functioning of the Hospital?

Do you understand that this interview will consist of a variety of questions concerning your experiences here at the Hospital, the functioning of the Hospital, and the new H.I.S.?

Do you understand that anything you tell me will be confidential, in the sense that it will not be attributed to you or used in any way which would tend to identify you? That any reports growing out of this research will present only general conclusions?

Do you understand that you have the right not to participate in this interview or to decline to answer any question to which you might object and that there is no penalty for exercising these options? You will not be singled out in any way. You may withdraw your participation at any time without penalty.

Do you have any questions about any of these things?

Do you consent to be interviewed at this time?

A. Entry experience

1. What were the circumstances in your coming to this Hospital?
2. What were your first impressions when you came here? How have they changed?
3. What is done to help a person cope and develop here? What is done to orient new employees to the system?

B. Role experience

1. What do you do here? Is your job easy or difficult to do here? Why?
2. Tell me about the people here. How are they to work with? Why?

3. If you were going to hire someone for a job like yours, what kind of person would you hire?
4. How do you find out how you are doing at your job? What happens when problems develop? Examples? What kinds of help can you look for and from whom?
5. What are the main rules around here that everyone has to follow?
6. What are the busy times around here? What is your workload like? Why?

C. Information systems

1. How do you find out what is going on in this Hospital? In your unit(s) (ward, office, department, etc.)? In other units?
2. How does this Hospital keep up with what is going on elsewhere in the field? What kind of things is it most interested in keeping up with?
3. How does this Hospital make use of a person's ideas and experience? Examples?
4. What does this Hospital say that it stands for? How does it get its message across? What do outsiders think of this Hospital? Which groups have which attitudes? How do you know?

D. H.I.S. experience

1. Tell me what you know about H.I.S.
2. Were you involved in the decision to install H.I.S.? In planning? In implementation? How?
3. What has been done to help you learn about H.I.S.?
4. What has been your experience with H.I.S.? How has it affected your job?

E. Organization dynamics

1. If this Hospital were a person, what kind of person would it be? Is s/he always like this?

2. How much energy does this Hospital have? All the time? Is it useful or just spinning wheels? Examples? How strong is this organization?
3. How much do people here really know about what they are doing?
4. If this Hospital were a person, what would that person be doing?

F. Future orientation

1. Suppose you were head of this Hospital and had to make long range plans for it. What do you think would be the most important thing about it that you would have to keep in mind in making those plans?
2. Suppose this Hospital had to stop doing some of the things it now does. Assuming your job would not be affected, what should not be changed? Why?
3. What future do you see for this Hospital?

G. Conclusion

1. If you were me, what questions would you have asked that I did not? Is there anything else that I need to know in order to understand how things work around here?
2. Thinking back over the things we have discussed, do you think that most people here would look at these things the same way you do? Why?
3. Do you have any questions for me?

C. INTERVIEW SAMPLE TABLE

Table 1

Interview Sample by Work Group and Work Role

Work Role	Work Group			Total
	Hospital at Large	Medical Unit	Obstet. Unit	
Hospital Admin.	8	0	0	8
Dept Head/Supervisor	3	1	1	5
Head Nurse	1	1	3	5
Asst. Head Nurse	0	1	0	1
Team Leader	0	1	2	3
Senior Staff Nurse	2	3	1	6
Staff Nurse	0	1	1	2
Lic. Practical Nurse	0	1	2	3
Nursing Aide	0	2	2	4
Unit Clerk	0	1	1	2
Logistics Manager	0	1	1	2
Clinical Instructor	0	1	1	2
Attending Physician	1	1	2	4
Resident Physician	1	2	2	5
Others:	0	3	0	3
Social Worker				
Nutritionist				
Consultant				
Total	16	20	19	<u>55</u>

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