Complex Health Care Relationships

McCreary Lecture at the University of British Columbia

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I will begin with a distinction between, complicated and complex projects (as illustrated in Table 1).

Simple projects like following a recipe to bake a cake, may assume some knowledge of technique and terminology. Once these are mastered, following the recipe carries with it a very high expectation of success.

Complicated problems contain subsets of simple problems but are not merely reducible to them. Their complicated nature is often related not only to the scale of a problem such as that of sending a rocket to the moon, but also to issues of coordination or specialized expertise beyond the understanding of the formulae. Complicated problems, can often be seen as a large assembly of simple components with the added requirement of expert knowledge, and once resolved, are generalizable.

Complex problems can include complicated and simple components, but are not reducible to either (Goodwin, 1994) since they too have special requirements, including an understanding of unique local conditions (Stacey, 1992), interdependency (Holland, 1995) with the added attribute of non-linearity (Lorenz, 1993), and a capacity to adapt as conditions change (Kauffman, 1995; Kelly, 1994). Unavoidably, complex systems carry with them large elements of ambiguity and uncertainty (Wheatley, 1992) that are in many ways similar to the problems associated with, for example, raising a child. Despite the uncertainty associated with complexity, all three kinds of problems can be approached with some degree of optimism: we do look forward to raising a child despite the complexity of the project.
I will try to argue that health, health care organizations and healthcare systems are best understood as complex systems. I will then attempt to show how many health care experts implicitly describe complex problems as complicated ones and hence employ planning approaches applicable to complicated projects rather than using better-suited complex interventions (Glouberman & Zimmerman, 2002). Finally, I will suggest two
ways to help health professionals overcome some of the obstacles to more collaborative work.

Health is Best Viewed as Complex

I've been working with research partners at Health and Everything trying to develop a framework that appreciates the multifaceted nature of health (Glouberman, 2001). Our analysis showed that most concepts of health fall into one of three categories: (1) biomedical concepts that focus on the body as an organism (McKeown, 1971; Singer & Underwood, 1962); (2) epidemiological concepts that stress the environment (Goerke & Stebbins, 1968; Wilkinson, 1996); or (3) sociological concepts that recognize the importance of complex interactions between the two (Antonovsky, 1979; Parsons, 1951).

The third category has been underemphasized so far, but in fact leads to a more dynamic picture of health in which the quality of the interaction between an individual and his or her social context is a major contributor to health (Kisilevsky, Groff, & Nicholson, 2000). Positive interactions, such as those in good marital relationships, improve health (Argyle, 1996), while negative interactions such as those between certain workers and excessively controlling workplaces, harm health (Marmot, Bosma, Heminway, Brunner, & Stansfeld, 1997). We hypothesized that health is a function of the non-linear interaction of many influences.

Our changing understanding of health affects the entire health field. Much of medical science is struggling to transform itself from a deterministic, mechanistic, organic focus on the state of the individual body to a more interactive, less deterministic practice that recognizes the importance of a broad range of influences on health. Hospitals and other health care organizations are trying to define their role beyond repairing the organism. But this is a difficult struggle: a recent Canadian history of medicine by Jacalyn Duffin (Duffin, 1999) describes some of the problems. Duffin chronicles the current uncertainty about extending medical understanding beyond the body and points out the difficulties associated with criteria of evidence that assume a deterministic and mechanistic view of
human beings. The book recognizes the importance of population-based research in addition to organic studies and argues that medical schools must adopt a broader account of human health, but Duffin is uncertain how they will ever get there.

It is possible to trace the evolution of ideas about health by looking at how more and more influences on health have been identified and how health care researchers have come to appreciate complex interactions among these influences and with health status. The Lalonde Report (Lalonde, 1974) urged Canadians to recognize that influences on health went beyond biological constitution and medical interventions. It added two others: lifestyle and environment. Since then, the term "determinant" has been used to speak of these influences as if each of these influences is a causal factor. Various studies have added to the number of determinants. A review by Anderson and Armstead (Anderson & Armstead, 1995) found 28 different factors that had been identified as influences determinants of health status (see Table 2).
Table 2: Determinants of Health Status

<table>
<thead>
<tr>
<th>Physiological factors</th>
<th>Psychological and behavioral factors</th>
<th>Socio-demographic factors</th>
<th>Socio-economic status (SES)</th>
<th>Social, environmental, medical factors</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>Psychological distress</td>
<td>Age</td>
<td>Education</td>
<td>Residential characteristics</td>
<td>Health and illness</td>
</tr>
<tr>
<td>Immune</td>
<td>Personality factors</td>
<td>Ethnicity</td>
<td>Income</td>
<td>Occupational environment</td>
<td></td>
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<tr>
<td>Muscular</td>
<td>Health-promoting behaviours</td>
<td>Gender</td>
<td>Occupation</td>
<td>Social support</td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td>Health-damaging behaviours</td>
<td>Location</td>
<td>Family wealth</td>
<td>Social/ professional hierarchy</td>
<td></td>
</tr>
<tr>
<td>Genetic</td>
<td></td>
<td></td>
<td>Perceived SES</td>
<td>Access to health care</td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td></td>
<td></td>
<td>Economic mobility</td>
<td></td>
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<tr>
<td>Weight</td>
<td></td>
<td></td>
<td>Childhood SES</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Material possessions</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>National income distribution</td>
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It was quickly recognized that the determinants are not mutually exclusive. “Lifestyle,” for example, is not independent of socio-economic environment, which is why the impact of health education about tobacco varies in different social settings. An individual who is surrounded by family members, friends, and coworkers who smoke may continue to smoke even though he or she knows that it is unhealthy. These and other interactions between the determinants make it more difficult to accurately predict the outcomes of interventions. Unforeseeable events can affect the health not only of individuals but of
entire populations. These observations suggest the value of approaching health through the lens of complexity.

Hospitals and Health Care Systems Are Complex

Henry Mintzberg and I spent quite a lot of time studying health care organizations and systems. We made a series of short visits to hospitals and other health care organizations where we observed doctors, nurses and managers in their daily activities, interviewed these health care professionals and later had long discussions about our findings. We prepared many drafts of the articles that were eventually published (Glouberman & Mintzberg, 2001a, 2001b).

Our results provided a simple framework for thinking about the complexity of hospitals and health care systems. The framework differentiates at least four different groups involved in their management: Doctors, nurses, managers and board members. We categorized these groups into the somewhat generic quadrants of our framework: Those most concerned with cure, care, control and community. Furthermore, we found that those categories could still be useful when considered at the system level. Figure 1 illustrates the framework. We argue that much of the complexity surrounding health care does not come from the work itself but from the nature and quality of the interactions among the different cultures that participate in it.

Most health care organizations contain the groups in Figure 1. Doctors' main role is to direct the cure of patients while nurses and other health care professionals are primarily dedicated to their care. Both groups work and manage clinically - close to patients. They are at the clinical edge of the organization. The horizontal line in the figure separates this clinical area, from the non-clinical above it. Managers who control the allocation of resources and board members who represent the community are above the dividing line. These two groups manage and work away from direct patient contact. The vertical line separates nurses and managers) who work and manage in the hospital, from doctors and
board members who are usually not hospital employees, and who, though loyal to the hospital, have other and more fundamental attachments outside it.

In dysfunctional health care organizations there are powerful divisions among the four groups. Each forms a fiercely independent enclave that does not understand, cooperate or even talk to the others. This results in a complex web of miscommunication, misunderstanding and rivalry that makes the operation of the hospitals an intractable problem, and contributes to crises in health care delivery. Much of the difficulty in working relationships hinges on how these four interact. I will begin with a brief characterization of the four faces in hospitals.

We will use a series of thumbnail sketches as an overview of the four to identify some of the differences between these groups and to organize information about the issues at hand. These groups work in different organizational structures, have very different views of what constitutes power and maintain distinct ideas about how to receive and give respect. This initial organization will thus attempt to clarify some of these differences.

Figure 1: A Framework for Hospitals

[Diagram of the framework showing different sections: Community, Cure, Care, and Control with Inside/Outside Divide and Clinical Divide.]
CURE Represents Hospital Doctors

Doctors are in the clinical and outside quadrant of the framework. Hospital doctors tend to have a highly specific interest in a specialized (or even sub-specialized) area of Cure, usually defined by body parts, organs or diseases. They try to know as much as they can about this area, and to find patients for whom they can apply this knowledge with increasing proficiency and from whom they can learn even more. National and international colleagues in their area form a kind of "chimney" of specialization that they climb to gain clinical, academic and research recognition (Freddi & Bjorkman, 1989). If they do relate to a career type, it is that of independent professional practice. They tend to remain in the same job for their entire work lives. Their efforts are directed toward expanding their practice, which usually includes clinical work. Their status is thus dependent on their place in their area of specialization.

Hospital doctors measure their status and power in a variety of ways. One is by the nature of their specialty. Within medicine, there is a hierarchy of specialties, which places surgery above dermatology for instance, and hospital specialists above family practitioners. Their status is also a function of how high up they are in their own international chimney. How do colleagues around the world rate their expertise? How are their papers received? Where are they asked to present their results? The international reputation of a hospital doctor is what garners the most respect from board members and often from other doctors. Teaching roles and university rank are more local indicators of their status. The amount of resources dedicated to their particular area of expertise is also a sign of their power. These resources can include specialized equipment, research laboratories, clinical facilities and staff in training with them.

Perhaps because of their professional autonomy and the demands of their life style, they tend to see the hospital as a location in which they do their work, not as an organization that they work for. They often behave like independent entrepreneurs and have been compared to shopkeepers who work in a town, not for it. Though loyal citizens of the town, their interests are not always identical with those of other residents in it.
(Shopkeepers might prefer a larger shopper's parking lot to a swimming pool, for example.)

Although they are below the horizontal divide in our table and on the outside of our vertical divide, doctors are hardly down-and-out. According to OECD studies, doctors tend to earn within a narrow band of net income (Sandier, 1990). In most western countries, their average income is a multiple of the national average wage, and their income rises with the per capita GDP of the country they work in. The net earnings of hospital specialists in Canada in 1998 averaged $92,000 per year. This is almost three times that of registered nurses, whose average was $35,000. The method of remuneration does not seem to have much impact on their net income. This may be because doctors expect to live an upper middle class life style in almost all western countries, and as such, have similar income targets regardless of the means by which they are paid (i.e. public or private, insurance companies etc…).

**CONTROL and Hospital Managers**

Control is very difficult for non-clinical health care managers. Because they are far from patients and do not have clinical expertise, they tend to manage away from the clinical activities. Managers are above the clinical divide and away from patients in several ways. They manage operational activities that do not directly involve patient care. Middle managers often spend 85% of their time on such services as food preparation, housekeeping and parking, though these items consume only 15% of hospital budgets.

Very senior managers manage relationships with external agencies to assure the funding of their hospital and to improve its ties to academic and research institutions. They feel their role is to manage strategically, not operationally, and they stay far from patients and the actual wards.

Health care managers often prefer to see their institutions as corporations and themselves as corporate employees. Their view of the ideal hospital is one where corporate lines of authority are respected. Most have come to their present posts after a series of jobs,
usually in different hospitals. Their career paths are spirals in which they move laterally and upward between five and seven jobs, each with a more prestigious title, a bigger budget, or a larger work force, until they become CEOs.

When they join an institution as an employee, they feel an obligation to their organization, and at times do not understand why doctors do not behave more corporately. A major objective of hospital managers is to have a well-managed, forward-looking corporation. This is hard to do because they have little authority over clinical activities. They open or close beds and allocate or withdraw resources often in crude and ineffective ways.

The status and power of hospital managers is often expressed in terms of their place in the corporation – as director, vice president or at the highest level, president and CEO. Their power is a function of the size of their domain, expressed in terms of budget and staffing size. Thus hospital CEOs will often introduce themselves to each other by declaring their title, and mentioning (often with a slight exaggeration) the size of their budget and the number of people who work for them. Respected managers are those who have successfully fulfilled their roles of controlling the allocation of resources.

**COMMUNITY and Governance**

The community is represented by boards and their members. Boards are the final authority of hospitals and their members have special responsibility to oversee its activities. In health care organizations, boards are farthest from the day to day activity of the hospital. As non-professionals, they do not understand much about the clinical activities, and because of their distance they cannot appreciate many operational problems.

Traditionally, boards contained prominent members of the community who donated their time and money to hospitals as social institutions. The social importance of the institution reflected on them. They considered "their" hospitals to be the "best" because of an area of
excellence, a historical bit of pioneering medicine, and the presence of doctors with international reputations.

Board members continue to have a strong obligation to maintain the reputation of their institution as "the best" and if there were a universal motto for board members it very well might be "Access to the Best." In the past, board members went to great lengths to follow this motto and put their money where their mottoes were. Today, the costs of health care and the introduction of government and insurance funding leave them able to contribute only at the margins. They might build a building or buy a piece of expensive equipment, but they cannot support the operational costs of hospitals.

Financial constraint has led boards to focus on a second goal: keeping to the budget. The demands of fiscal responsibility put boards in a dilemma: they are caught between excellence of doctors and control of expenditure. In many health care organizations the new motto (with dismay) is "Access to the Best that is Affordable."

The meeting is the venue of board members. Their organizational structure is the committee, of which there are many in most hospitals. Their career path (or perhaps, fate) is to move from committee to committee and some serve on many councils, boards, trusts, and task forces during their careers.

Status of board members has several dimensions. For the most part, they derive their status and power from their job in the “real world” outside the hospital. Individual wealth and corporate role are critical criteria. The social position of their particular hospital and their role in it contributes a philanthropic aspect to their status.

**CARE and Nursing**

Although the caring face of health care includes nurses and other allied health workers, I will concentrate on nursing at this stage. Nurses' main responsibility is direct and
continuous patient care. They are closest to the patients and organize and manage the workflow around them.

Historically, nurses were the first to run hospitals. When nurses were in charge, they had responsibility for all patient care and summoned doctors only when medical interventions were necessary. Managers are comparative parvenus to health care organizations although they now carry considerable authority.

From the time of Florence Nightingale, nursing had a military organization - it was a pyramidal hierarchy with a split between the non-commissioned troops and the commissioned officers. Nurses above a certain level were officers. Student nurses, staff nurses, and most ward head nurses were the non-commissioned troops. In the early days, senior nurses, like military officers, had upper class backgrounds. Later, academic credentials became the path to senior rank. The distinction continues and has begun to take different forms. Some nurses argue that only the senior nurses are professionals because they are the only ones with appropriate academic credentials and enough professional authority (White, 1985). Nonetheless, most nurses express a strong loyalty to their profession.

This division was recommended almost 100 years ago:

> There can be two classes of nurses, one made up of young women of education, culture, and refinement, whose mental equipment and preliminary education will make it possible for them to learn the needful things of their calling; and the other class, made up of well-disposed young women of excellent intention and limited education, whose curriculum can be limited within their mental possibilities, and that will enable them to give a certain amount of very primitive care to the sick. (Hornsby & Schmidt, 1913, p.305)

In hierarchical organizations, the career path is up or out. Thus, nurses' career moves tend to be up the hierarchy or out of nursing. For younger nurses, the tendency has been to
move out of nursing, and then in and out as economic and family demands change (Audit Commission, 1991).

The nursing literature describes the struggle between doctors and nurses, sometimes calling it “the Doctor-Nurse Game.” In the early 1990s the diary of a medical resident in the 1880s prompted a study in which a current medical resident kept a journal for a year. The journals of the two medical residents "written more than 100 years apart…revealed more similarities than differences in nurse-doctor relationships" (Pillitteri & Ackerman, 1993).

A summary of the situation quoted below uses a military metaphor which describes the combative nature of nursing politics:

For the last Hundred years the general hospital has been the key battleground for the various forces arrayed in the division of labour in health care. There seems no reason this should change now. (Dingwall, Rafferty, & Webster, 1988)

This military language describes the doctor-nurse struggle as a war of the sexes about careers, organizations, professional status and income, authority over patients, and even models of patient care (Clifford, 1989). There are many attempts in nursing to justify the special nature of caring and to clarify philosophically the distinct role of the nurse.

For nurses, there are a series of status and power identifiers. In the early 20th Century status was directly connected to one’s place in the nursing hierarchy. The most senior nurse, in the role of Matron, was the partner of the most senior doctor, the medical superintendent of the hospital. They assumed strongly paternalistic (and maternalistic) roles in a rigid hierarchical structure. Today, nursing status is connected to a variety of factors. Some markers or indicators of status mimic medical status. Degree of independence of practice is a second typical mark. Other marks have to do with rank in what is left of the nursing hierarchy. Still others relate to educational attainment. Nurse managers more and more often gain postgraduate PhDs and declare themselves to be doctors, perhaps in competition for the status and respect bestowed upon physicians.
Table 3 summarizes the characteristics of the four faces of health care. Each works with a different organizational type, has different interests and a different career path. There are even differences in the language they use. Managers adopt the most recent terms from the Harvard Business Review, while nurses speak of care plans, tasks and standards of practice. Doctors use Latin words for common organs and diseases, and board members insist on plain talk but seem never to get it.

Table 3: Characteristics of Four Cultures in Hospitals

<table>
<thead>
<tr>
<th></th>
<th>Doctors</th>
<th>Nurses</th>
<th>Managers</th>
<th>Boards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Career Path</strong></td>
<td>Steady state</td>
<td>Linear</td>
<td>Spiral</td>
<td>Transitory</td>
</tr>
<tr>
<td><strong>Career Movement</strong></td>
<td>None (Growth)</td>
<td>Up and/or out</td>
<td>Lateral &amp; Upward</td>
<td>Lateral/up</td>
</tr>
<tr>
<td><strong>Jobs in Career</strong></td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>Many</td>
</tr>
<tr>
<td><strong>Status Symbols</strong></td>
<td>Labs, academic rank Beds</td>
<td>Place in hierarchy, span of control</td>
<td>Title, budget span of control</td>
<td>Role in real world</td>
</tr>
<tr>
<td><strong>Organizing Structure</strong></td>
<td>Prof. practice</td>
<td>Peace time army</td>
<td>Corporation</td>
<td>Committee</td>
</tr>
<tr>
<td><strong>Value Base</strong></td>
<td>Proficiency</td>
<td>Professional</td>
<td>Efficiency</td>
<td>Access to the Best</td>
</tr>
<tr>
<td><strong>Currency</strong></td>
<td>Time</td>
<td>Staff and Hours</td>
<td>Money</td>
<td>Money Quality</td>
</tr>
<tr>
<td><strong>Job Security</strong></td>
<td>Tenure</td>
<td>Job Market</td>
<td>Contractual</td>
<td>Time Limited</td>
</tr>
</tbody>
</table>
Fragmentation

The divisions among the four groups are exacerbated by further fragmentation within each of them. Although this simplified framework contains four quadrants, there are, in fact, many more divisions. For the sake of convenience, all the allied health professionals and technologists are included with nurses. As nursing functions have become more specialized, physiotherapists, occupational therapists, social workers, and a range of specialized technicians like phlebotomists and respiratory technicians have distinguished themselves from nurses. They have their own practice standards and some have established their own professional bodies. Similarly, non-clinical support staff are included with managers although there are differences between them.

More medical knowledge in narrower areas has spawned four times as many certified specialties and sub-specialties as forty years ago (Swanson, 1993). The Toronto General Hospital lists more than 100 outpatient clinics each devoted to a particular area of specialization. There have been great benefits from the knowledge base of medical science as new and more effective interventions appear, but there has also been a widely acknowledged cost of fragmentation. Specialists tend to work in their own chimneys and crossover between them can be very difficult. Rivalry among the specialties can become intense and even dangerous. There are many examples of this. One good example is the case of the death of a professional basketball player several years ago. Reggie Lewis was a star player for the Boston Celtics. After he collapsed during a playoff game, he was examined by two sets of doctors in two different Harvard teaching hospitals. One group diagnosed his problem as a serious heart condition and another said he had a slight neurological problem but an athlete's heart ("Celtic Star Hid Heart Murmur," 1993). These conflicting diagnoses led him to continue his athletic activity. He collapsed again and died several months later in a flurry of controversy that made the rivalry between medical specialties far more explicit.

The British Audit Commission revealed dramatic consequences of management fragmentation. They found that it takes six people and seventeen different operations to
change a light bulb in a National Health Service (NHS) hospital. This bureaucratization of procedures has led to a fragmentation of functional roles and tasks. There are many forms to fill out, a lot of delay, and poor communications between departments even though everyone may be trying very hard. The manager of the electricians in a hospital worked hard to improve the light bulb changing and reduced it to a week in non-urgent cases (Hamilton, 1993).

Fragmentation extends into governance. Boards have numerous committees with separate and often redundant mandates. They create even more sub-committees and task forces to deal with specific issues or undertake new projects. One hospital had a committee of committees simply to keep track of other committees.

In nursing, many specialties follow medical disciplines. Operating room nurses distinguish themselves from those in intensive care areas; emergency room nurses consider themselves superior to staff nurses in the medical wards. The head nurse of dialysis in one hospital distinguished between haemodialysis nurses and peritoneal dialysis nurses by saying that each job required a different personality, background and training. The reduction of nursing work into fragmented tasks had serious consequences to continuity of care and to improved relationships with patients. Workload measurement connected to information systems inadvertently redefined patient care as the sum of services provided (Hart, 1991). This created a serious dilemma for nursing. As nursing work became re-described as tasks, technicians or other professionals such as blood drawers and psychological counsellors undertook much of the technical care. Aides and other non-professionals dressed or fed patients and did the more hands-on tasks. There was little direct patient care exclusive to professional nurses, and for some it was hard to see what remained essential to the nursing profession (Hugman, 1991; Jolley & Brykeczynska, 1993; White, 1985).

The fragmentation of care was connected to a harsh separation between academic training and the reality of the work they faced in the wards. This made for a difficult transition for new nurses. Most were not ready for what faced them and many left nursing because they
couldn’t reconcile the academic nursing theory with practice. The demands of academic nursing for careful assessment and planning of care were distant from the painful and difficult work of caring for patients (Hingley, Cooper, & Harris, 1986).

The farther away a program gets from an apprenticeship system, and the more an educational program attempts to prepare nurses who can deal effectively with the knowledge and technological explosions now and in the future, the greater will be the likelihood of producing school-work conflict and reality shock (Kramer, 1974).

The fragmentation of health care makes it harder to manage workflow. It also results in redundant or contradictory diagnoses by medical specialists, nurses, physiotherapists and social workers. They all have their models of care, their standards of practice and their own professions to defend.

The multiplicity of fragmented roles results in a grid with hundreds of job categories, each with many levels. Many cells contain only one incumbent. The division of tasks means that in a three-day stay, a patient will have face to face contact with between 50 and 80 people. Handovers from shift to shift, from professional to professional, and from professional to support worker are invariably difficult. They require large amounts of paper work, carry with them well understood inefficiencies of handover and increase the risk of error. For a chronic patient with multiple episodes of care or a person dealing with different agencies and organisations, this navigation and information problem is enormous.

Nurses especially suffer in this environment. It is difficult to coordinate extremely complex processes with so many authorities, ideas and demands. Nurses are caught between the mountains of recording and the needs of patients. When I observed a ward, I found many examples of this kind of difficulty, which taxed nurses. On a daily basis, the early morning rounds were followed by a period of clarification of the orders by the nurses. They had to be sure that they understood the orders correctly. This invariably
required several telephone calls to ordering physicians to clarify, correct or append the order. Once the clarification occurred, the orders were carried out. After this, they were noted in the patient chart. This process was repeated with waves of clarification, action and charting. In the midst of this activity, particular patient needs had to be met. Providing pain medication, assuring that food was delivered, preparing patients for onward procedures or to go home all occurred throughout this period.

This fragmentation quickly identifies two major issues that manifest themselves inside hospitals. The first and more general one is how to increase collaboration among the various groups in the hospital. As long as the four groups identified (as well as the other interests in the hospital) find it difficult to understand each other it will be difficult to set a shared agenda and allocate resources. The second and even more critical problem that results from excessive fragmentation is the difficulty in the co-ordination of patient care across the various boundaries of specialization, professional interest and idiosyncrasy. These two problems occur not only at the hospital level but also in the health care systems as a whole. The coordination of care across the system, especially between the acute hospital and other agencies and providers mirrors the problems of coordination inside the hospital. There are finally problems associated with collaboration among all the components of the broader health care system. These issues are portrayed graphically in Figure 2.
Some Attempts To Change the Structures and Power Relationships in Health Care

There seems to be something radically wrong with the trained nurse of to-day – the medical profession says there is something wrong; the thinking women at the head of training-schools say there is something wrong; and the lay public finds something radically wrong. Not all of these elements agree as to just what the trouble is, in fact, they all seem to differ.

The doctors say the nurses who are being graduated from the training-schools are not efficient, and a great many thinking members of the medical profession say that the nurses are being trained to too fine a point, but not in the right direction. The heads of training-schools think the nurses are not being sufficiently trained. The public does not seem to care to analyze situation, but merely finds fault with the nurse as an individual. (Hornsby & Schmidt, 1913, p.304)

This passage is almost ninety years old, and there have since been many attempts to resolve the issues raised. Most dealt with these problems as if they occurred in a complicated rather than a complex context. As a result, they largely involved identifying and implementing structural and procedural changes to health care organizations and systems. Most recognized the splits between care, cure, control and community. Some tried to force the four quadrants to conform to external standards, others seem to demand that they merge their perspectives. I will not review these attempts in detail. They have had mixed results at best, as the examples below suggest. I hope that these examples are good enough to show that new structures by themselves will not solve the relationship and power problems associated with complex health care environments. I have chosen three examples, care planning, clinical directorates and program management as typical examples of restructuring that attempt to integrate the work of health care and allocate a more equitable balance of power in the health care organization.
Care Planning

The introduction of care planning in various forms has largely been driven by nurses. In some hospitals it has helped them coordinate workflow while in others it has increased paperwork at the expense of direct care for patients. One of the successes of care planning includes the development of more transparent care processes. Very often, the process of developing a care plan builds relationships across the boundaries of discipline and profession. Everyone involved has a better idea of their role, and patients can know what the process will be for many procedures in advance. The problems associated with care planning include the large amount of time needed for development, the difficulty in getting doctors engaged in the planning process, the problems associated with keeping formal care plans up to date, and the large number of exceptions to the plans that often render them irrelevant. Doctors’ reluctance to engage in the process has exacerbated bad feelings between them and nurses. I will discuss below the idea that this approach seeks to standardize the work pattern without considering the fact that in health care, a great deal of adjustment among various providers is also needed.

During my observation of a ward, an irate patient was released from hospital two days earlier than the care plan asserted. He had prepared himself on the basis of the handout description of his procedure and because he was in his mid-eighties and somewhat physically frail, he had arranged for his niece to bring him to the hospital from some distance and to pick him up in three days. His early release caused great difficulties in logistics for his niece, who had brought her car in for servicing while he remained in hospital.

Clinical Directorates

Clinical directorates were meant to bring clinicians into management roles. In theory, it was meant to integrate clinical responsibility with management and the allocation of resources. Clinical directors were to create a work team made up of the professionals who worked in a particular area. They would learn to collaborate for the benefit of patients
within the resource envelope allocated to them. Because any member of the team could, in theory, assume the mantle of clinical director this structure viewed all professionals as equals.

In practice, this management experiment was an attempt to lure physicians into assuming more management responsibility. There was often a reluctance among doctors and other clinical professionals to assume management responsibility, and a lack of preparedness for doing so. Many clinical directors were poor managers and were induced to assume the role by promises of special privileges or extra help. They were rarely given a free hand at managing their areas, but were placed into a corporate hierarchy as middle managers. (I often tested their capacity to allocate resources by asking them if they could get one of their wards repainted. Most could not.) For many it was a painful experience that merely proved their incompetence at management and the unwillingness of managers to give up control. For others, there was the dilemma of identifying themselves with management or with clinicians. There was a fine line that divided those who became traitors to their profession, having defected into the management camp, from those who remained true to their fellow doctors and merely represented the medical point of view to their increasingly disenchanted management colleagues.

The few nurses who became clinical directors often had little success in managing the medical staff. Most often they were not clinical directors, but served as nurse auxiliary to the medical director in a relationship that mimicked the older tradition of medical superintendent and matron. The role did not by itself increase respect for those nurses who assumed it.

When clinical directorates succeeded, they did so because the collaboration was already there. There was a large measure of mutual respect, and some history of reasonably good relations among the different professions.
Program Management

Program management was meant to create structures that followed patient needs rather than medical disciplines or institutional demands. Programs cut across traditional silos and attempted to create integrated programs of care. In some versions, they engaged nurses to follow patients throughout their hospital experience. In others, it trained multi-skilled workers and professionals to perform a variety of care related tasks. Multi-skilling would decrease the fragmentation of the patient experience by allowing more continuous contact with the people who cared for them. Nurses were often given primary responsibility for particular patients and could follow those patients throughout their hospital experience.

At its best, program management improved the patient experience in hospitals and resulted in increasing stability of patient care teams. Many of the multi-skilled workers assumed new and more interesting responsibilities and were given more possibility for career advancement. Nurses had more contact with individual patients and could develop more complete relationships with them. Reporting relationships were inside the program teams rather than in a discipline. Just as clinical directorates gave lead responsibility to doctors for their area, program management gave special responsibility to nurses as program leaders. The physiotherapists and other allied health professionals would report to the nurse who most often became the program leader.

The greatest difficulties with program management have to do with the creation of new boundaries to replace the old ones. If the metaphor for the old boundaries between disciplines was that they functioned like vertical silos, the new boundaries began to work horizontally, much like sewer pipes. Cross-program co-ordination became more difficult as the programs consolidated their structures. Older patients with multiple conditions created difficulties for programs dedicated only to one condition. Structures, by their very nature, create new barriers by reducing older ones.
This also created new difficulties for professionals. The horizontal orientation of program groups disrupted the vertical structures inside the various disciplines. It made for more difficult professional ties and collegiality and reduced the voice of many professionals in the management of the institution. The head nurse of a program-managed hospital had only professional responsibility, but no line authority. This meant that nursing as a profession had less power overall but more power locally. The consequence was that there was a reduced capacity of disciplines to protect their job security. In one hospital the psychologists were fired en masse once program management was instituted because their lead no longer could sit at the management table to defend his area.

Although these attempts are not comprehensive, I would suggest that they are sufficient to suggest a more general difficulty attributable to structural change in complex contexts. These changes do not consider local circumstances. Often they disregard existing relationships and can in fact disrupt them and substitute new anxieties and difficulties for the previous ones. A good account of some of the perils of restructuring without considering other factors appears in *Beyond Restructuring* (Glouberman, 1996).

The fantasy of a seamless health care system often is thought of as one with a single governance structure. Michael Gordon, the chief of medicine at Baycrest argued that seamlessness might not be such a good thing - seamless garments tend to be shapeless. The mention of seamlessness always brought to mind grandfather who was a tailor and appreciated the value of a good seam. Seams in health care acknowledge such important boundaries as those between institutional and community services, or between different levels of care and they help to provide a shape for a health care system. The issue is how to manage the boundaries between the different components of the system.

Boundaries, whether of discipline or of structure can have benefits. The differentiation of disciplines has resulted in a division of labour in the acquisition of knowledge. But now it is no longer possible or even desirable for any one person or organization to be the repository of all knowledge. The person, who regardless of background can easily traverse the boundaries, is increasingly valuable. "Boundroids" have already appeared in
many health care organizations. They have developed the capacity to form trusting relationships with people outside their discipline and at other levels of the organization. They come from all four cultures.

There are many successful boundroids, who in a wide variety of structural obstacles manage to create and foster good working relationships that allow for improved coordination of patient care. The need for developing such relationships is clear in any environment.

In health care, the initiation of such relationships most often develops from the common purpose inherent in the work.

Most people who enter the health field do so from a desire to help others. Doctors, nurses and managers in health organizations choose their occupation because they want to contribute to others as well as to have a career. Board members see themselves as giving their time to the public good. This shared altruism provides a common purpose for everyone who is in the health field. When the relationships among them are well developed this shared sense strengthens their capacity to collaborate. It is widely recognized that shared values of this kind contribute not only to collaboration in work but also to the development of good relationships.

In health care, however, it is often the case that this shared value is lost behind the widespread attribution of selfish ulterior motives to the other groups. Nurses often speak of assuming the greatest part of the burden of truly caring for patients and fear that doctors are interested only in maintaining their power and authority. Doctors worry that managers are interested only in balancing their budget and are not really concerned with patients. Managers feel that the clinical parts of the organization do not adequately respond to patients' wishes and assert heavy professional control over them.

These mutual suspicions tend to be alleviated when working relationships are good and become worse when they deteriorate. One characteristic of complex systems is the
tendency for feedback loops to amplify either positive or negative inputs. Mutual suspicion tends to feed on itself this way and results in stereotyping the behaviour of other groups. We have found that it is possible to reverse the cycle and begin the process of re-establishing a more virtuous cycle of shared altruism by recalling the contributions that others usually continue to make to the health of patients even under difficult circumstances and declaring afresh the initial motivations of everyone in the field.

Another dimension of relationships is the importance of continuous interaction on a face to face basis and in a variety of ways. During one observation of a ward, I found that the doctors and nurses rarely spoke to each other in face-to-face contact. On a typical morning the residents would enter the ward and retrieve the charts of their patients, and do the rounds without a nurse present. They would write their orders in the chart and leave. The nurses would then read the orders and if there was a question about them they would call the residents and speak to them on the phone. Senior doctors did not appear on the ward during the week that I was there. Apparently they would see their surgical patients in their offices and in the operating room area and would only rarely come to the ward. In general, the sense I had on one particular ward was that there relationships were very much like those in a bad marriage: the business got done with as little contact as possible.

It may very well be that much of this behaviour is due to rather mechanistic conceptions of efficiency that minimize the importance of work relationships. Building relationships takes time and familiarity. Talking to people on a regular basis allows people to get to know each other better. Seeing them over a long period of time and in many different circumstances gives a sense of what they are like as people. It allows people to recognize and appreciate varieties of altruism, different perspectives and how others contribute to the broader enterprise. The allocation of time and space to allow such relationships to be established and grow is an investment that will be repaid in a variety of ways,

I am optimistic because in most health care environments there is an acknowledged common purpose and a large number of well-established relationships that have survived
despite many changes in the system. My recommendation is to become more cognizant of their importance as ways across the various health care boundaries.


