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The Group for the Advancement of Psychiatry

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July, 1960

report no. **46**

ADMINISTRATION OF THE PUBLIC PSYCHIATRIC HOSPITAL

formulated by
the committee on hospitals

Group for the Advancement of Psychiatry

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ADMINISTRATION OF THE PUBLIC PSYCHIATRIC HOSPITAL

Formulated by
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CONTENTS

ADMINISTRATION OF THE PUBLIC PSYCHIATRIC HOSPITAL

I. INTRODUCTION

The contemporary literature of psychiatry, the deliberations of our professional societies, and the work of committees active in the general psychiatric field deal with a wide range of issues concerning mental health and illness. Although problems are analyzed with discrimination, and promising solutions are commonly proposed, an evident reticence has been running through much of this work. With few exceptions, the *formal* structure of the interpersonal relationships between staff participants is not examined; the actual *administrative* setting is not commented upon; and the essential contributions made by effective administration to the conduct of whatever project is under discussion are not analyzed.

There are probably many reasons for this. There is the modesty of the administrator, more impressed by the work his staff is doing than by his own contribution to creating the setting required for it. There is the natural, although unscientific, tendency, from which professional people are by no means immune, to take the environment in which they work for granted. There is also the indifference, if not overt distaste with which these same professional people may at times regard administration—in their view, an unrewarding, arithmetical kind of activity, dealing exclusively with ledgers and double-entry bookkeeping. A less frequently verbalized reason may at times be the danger of reprisals by a sensitive director against those who call attention to administrative failure and ineptitude. There may also be occasions in which the etiquette of the drawing room becomes so intrusive that it altogether precludes a candid analysis of the influences of administration upon a sober clinical study.

Medical workers have had frequent opportunity to observe the miscarriage of important and apparently well-conceived programs

—therapeutic, organizational, collaborative, social and educational. Upon careful analysis, a sizable percentage of these unhappy results may be directly traced to faulty administration—stultifying purpose, clouding issues, and creating frustration in groups originally made up of qualified, well-intentioned and able people.

It is our purpose to come to grips with these remarkable silences, and to examine in detail the psychiatric anatomy of administration, Our belief is that a hard core of principles may be abstracted and formulated in terms that, we hope, will be applicable to most situations in which groups work together under leadership toward a common aim. Although we doubt that these principles will obtain in the psychiatric hospital only, it is the influence of administration in this setting alone that we propose to explore.

We have not undertaken the task of elaborating definitions which are definitive in scope, and will be content if ours serve to clarify the present discussion. For our purpose, then, we think of successful administration as the creation of an environment which enables a group of qualified people to contribute toward a socially valued purpose to the fullest extent of their individual capacities—with resulting personal satisfaction, growth and fulfillment.

Singling out the matter of success, it appears reasonable to expect the eventual collapse of administration that is *consistently* ineffective in its technical aspects, regardless of the excellence of its aims. The rapid dissolution of many Utopian movements has been readily predictable on organizational grounds, even when the purpose of the group has reflected idealistic strivings of unchallenged worth.

On the other hand, examples are not lacking of the efficient administration of organizations devoted to the most questionable ends. Clouded as such matters are by folklore and popular feeling, there is evidence that syndicated crime, venal political machines, and such secret organizations as the Mafia have, for long periods, successfully challenged the regulatory authority of the larger societies in which they have operated. Although the very nature of such groups prevents an objective inquiry into their administrative methods, the simple fact of their long survival, as well as the disclosures made when they have been broken up, indicates that administrative competence among their leaders is a more effective cohesive force than moral involvement in organizational ends among

their members. Successful administration implies the competent employment of effective techniques; and although technical proficiency is not, in our view, sufficient for success in its fullest moral sense, we conceive of it as necessary.

Successful administration is the creation of an environment—of an appropriate physical setting, of a favorable psychological climate, and of an established pattern for the interpersonal relationships required for the efficient discharge of an organization's function. Pioneers became administrators when they thoughtfully asked one another, "How are we to settle this new land?" The hospital superintendent who convinces the legislature of the need for a new research building, who advises the architects on required facilities, who makes the final decision regarding the number and qualifications of personnel necessary in its staffing, who determines that the physician in charge shall report to the clinical director rather than to the business manager, who refuses to discharge a capable technician at the request of a spoils politician—a superintendent who deals purposefully with such issues—is involved in the most literal sense in the creation of an environment, and so, in administration.

Administrative activities do not occur as isolated systems, but are dependent upon ever larger aggregates of reasonably predictable purpose and decision. The pioneers purchased their wagons, selected their oxen, forced their way across rivers, staked their land, built their houses and elected their spokesmen within a larger administrative framework, and with personal conviction that "the government" had made certain prior determinations: Free land would be offered in undeveloped sections of the country; just claims would be legalized after proper filing; slaughtered game would belong to the successful hunter; the criminal code would not apply to the killing of hostile Indians.

"The government" in turn had reached these and similar decisions within the yet larger framework of national purpose—with domestic political forces, economic pressures, war, international agreement, and diplomatic maneuver as the sources, instruments and expression of policy.

Even in those instances in which organizational aims are totally at odds with the avowed purposes of the larger aggregate—as in the example already given of syndicated crime—the fact of dependence remains, as well as the necessity for reasonable predicta-

bility in purposes and decision. The embezzler looks for no change in the tendency of the larger administrative unit to accumulate quantities of money in banks; he only hopes to make the safety of those institutions illusory. He engineers his peculation with complete reliance on the inevitable visit from the bank examiner, and is confident that the false entries he makes in his books will not be altered by his fellow-workers from whom he expects strict adherence to administratively endorsed patterns of conduct.

So, the public hospital administrator must look for some predictability in the legislature, for the definition of certain broad purposes by whatever department administers the state institutions, and for decisions by his administrative superior on issues beyond his authority. This dependence may be codified with the greatest precision, or left murky, uncertain and contradictory. Whether tacit or explicit, it exists.

The dependence of each administrative system upon a larger and more inclusive complex is even more obvious when the activities falling *under* the administrative authority of the hospital superintendent are particularized. Here the needs for crisp decision and for a high level of predictability often approach those required in military combat. The soldier's prompt execution of commands when an enemy machine gun is being silenced is strikingly similar to the responsiveness of the operating room nurse during a major surgical procedure. In both instances, the immediacy of the objective, and the seriousness of the undertaking transcend all other considerations. Quite simply, the issue *is* life and death. Freed of all extraneous trappings, administrative interaction becomes visible in its stark essentials.

Similarity to Military Organization

The administrative similarity between hospitals and military establishments is not, however, confined to the dramatic moments of surgical intervention and hand-to-hand combat. The logistic preparation for battle involves more of patience and sweat than of physical bravery, yet an unmet crisis in the Quartermaster's Department can immobilize a regiment more effectively than enemy fire. It is equally apparent that the operating room is not the only theater in which medicine pursues its sober undertakings. The same obligatory interdependence, the same need for decision, the same need for predictability of purpose, exists between the several departments of a hospital as exists between those of a military organization. The dietitian must be certain that she will be provided with foodstuffs. Only then, can she undertake to prepare a diet for the patients. The engineer must be certain that his staff of journeymen will be paid. Only then, can he agree to maintain the physical plant in some state of operability. The chief nurse must be given the authority to employ personnel on the afternoon and evening shifts if she is to take responsibility for nursing care during these hours. In each instance, an administrative decision has had to be made.

All things being equal, the more sharply the superintendent's administrative relationships with his staff are illuminated by workable understandings, the better job he will be able to do; and the more productive will be the efforts of each department within the hospital.

Concept of Authority

Authority is a concept currently overlaid with a singularly disparate group of notions. The affective overdetermination of those reactions which center around authority has been admirably clarified by the explorations of dynamic psychiatry. Identification phenomena, as widely-diversified experiences involving parental, sibling and child surrogates, appear not only to complicate operational relationships in hospitals, but also to exert a significant effect upon cultural patterns, social viewpoints and abstract attitudes. In contemporary usage, the word "authority" is apt to evoke an emotional response within us. We easily mistake leadership for bossiness, instruction for carping, responsibility for officiousness, and dedication for self-interest. Not that authority is innocent of such abuse nor that abuse is less culpable when occurring in high places! Our respect for human dignity and our rejection of the philosophy of exploitation give full warrant to our condemnation of misused authority. There is danger, however, in joining the euphemistic chorus which would make all direction a polite solicitation, all decision the vague consensus of numerical majorities, and authority itself an epithet; there is danger that the valid meaning of authority, being too long unspoken, will weaken and disappear. Our tenderness for the misplaced sensitivity of the misinformed, the ignorant and the lazy is perhaps less admirable than adherence to a principle badly in need of clear enunciation.

Let it be said at once that in our view all proper administrative

action involves the element of authority, and that authority inheres in those aspects of a communication which stimulate to co-operative action. Authority rests upon the need for order in any organization of effort. It becomes meaningless when the capacity to comply is lacking. Its willing acknowledgment may result from identification with the aims of the enterprise or may stem from personal identification with, or love for, the leader. We conceive it essential, however, to recognize that—basic to these truths, and behind all considerations of expediency, phraseology, tact, and the human equation—authority is expressed through the imposition of the will of one individual upon another. It rests in the last analysis upon the invocation of sanctions and, in the event of disobedience, upon an immediately operational system of punishment (as well as of rewards).

Is this statement unnecessarily harsh, calculated to arouse the very negativism which psychiatry has been at such pains to understand and to allay in interpersonal relationships? Or are we guilty of giving undue emphasis to the obvious? We think not. Reality seems harsh to those who seek its magical reconstitution. Interpersonal relationships are emotionally rewarding and materially productive to the exact degree that the participants are able to fulfill each other's legitimate expectations—*freed* of sham and pretense. As for the obvious, the sorry record of hurt feelings, malice, suspicion, feather-bedding and downright sabotage—which dogs the efforts of far too high a proportion of medically worthy enterprises—does not forcibly support the notion that everyone has fully grasped the nature of administrative action and authority.

We do not believe that all hospital administrators are Simon Legrees, or that all staffs are composed of anarchists. And we do not believe that the absence of unconscious conflicts centering around leadership—or the universal resolution of neurotically-determined resistance to authority—will, in and by itself, bring about an administrative millennium. We do suggest that too little conscious effect has been directed to the thoughtful examination of administrative interaction; and we deplore the lack of candor in defining the true nature of administrative authority.

How is it, then, that individuals and groups, containing their full complement of atypical personalities, purposefully subject themselves to the will of another, marshal all their ingenuity to

comply with the force of his direction, and support, as just, the sanctions he imposes? Is this a new helotry, a presage of 1984? The indignity of serfdom, however, does not lie in the issuance of a command by one individual and its execution by another, but in the absence of a shared motive. The baseness of slavery does not lie in the division of labor, but in the lack of mutual consent. The meanness of servility does not consist in the abnegation of self-interest, but in the collapse of an ideal. The words "superior" and "subordinate" have no moral correlates in an ordinal system, nor is self-respect synonymous with role. Authority takes on a kindlier appearance, and one regrettably unfamiliar to many, when it points only to our own desire, when it focuses our energy for its pursuit, when it smooths the path toward its attainment, when it lifts us to new heights of self-realization, and allots stern justice to those who transgress our common intent. The degree to which an organization defines its goals as elements within the purposes to which society accords its greatest respect, and the degree to which the individual within the organization identifies himself with suprapersonal aims of this character, measure the degree of the individual's approach to completeness.

Exercise of Legitimate Authority

Legitimate administrative authority is exercised only in the interest of organizational ends, and so demands a sincere devotion to those ends from all who would administer. Such authority extends into untried areas, becomes more rigorous, and takes on a deeper *earnestness*, as greater understanding and broader vision give wider moral significance to its purposes. Perversion of power does not lie in its capricious exercise, or even in the attempted exploitation of power for selfish ends, but rather in a cynical corruption of organizational purpose, a calculated degradation of group aims, and expedient debasement of established standards.

The administrative ideal is that each member of the organization shall fully understand its goals and fully share its purposes, for only in this way does identification become inevitable; and only with *identification* is pursuit of the superior purpose made possible. No organization escapes the lengthened shadow of its leader, and no leader safety neglects the *privileges* of his station. He can, for a time, direct by threat or by fear. It then becomes doubtful that his organization will achieve real stability or that its accomplishments

will attain significance. He can, for a time, direct by cajolery and seduce by bribery. The shallow resources of personal obligation, venality and artificial prestige are, however, soon exhausted; and again the organization will tend to disintegrate, and its achievements will suffer. The thoughtful administrator, aware of the nature and importance of identification, will find daily opportunity to promote its healthy growth. The greater his own dedication, and the wiser his counsel in pursuit of the common end, the more readily will he magnetize the energies of others, for in an *atavistic* sense, he is at once prophet and sacrifice, totem and chief, scapegoat and father. He is both impotent and all-powerful.

Successful administration is the creation of an environment which enables a group of qualified people to contribute toward socially valued purposes to the fullest extent of their individual capacities, with resultant personal satisfaction, growth and fulfillment. The qualifications of those who participate in such an organized effort must, in our view, include not only technical competence, but also the capacity for a measure of dedication. This may be conceptualized as sufficient freedom from neurotic conflict to make possible an emotional investment of some stability in extrapersonal aims. Alternatively, it may be regarded as a capacity for self-respect, for pride in one's work, and for the insight which sees the whole as greater than the sum of its parts. Again, it may be considered to be a capacity for the professional life and a sensitivity to its values. However the quality is defined, we find little evidence to support a pessimistic view as to its prevalence. We hold the contrary opinion that it is in reality one of man's basic psychologic *wants*. It is commonly unformulated; it is repeatedly deceived, often rebuffed, but infrequently destroyed. Its transformation from a potential capacity into an active force is one of the signal achievements of successful administration. A screening technique capable of even a rough assessment of the capacity for dedication would be of exceptional value to the administrator, allowing him to measure his own skill in leadership against another's capacity for response.

The kind of emotional investment which we seek is based firmly in reality. It implies none of the excesses of fanaticism. It is practical, enlightened, persistent and eminently patient. It shrewdly distinguishes the greater issue from the lesser, and gracefully accepts

defeat in the skirmish so long as a chance remains for success in the campaign. It always seeks for co-operation, but does not shrink from combat when this is necessary. It searches for the better, not for the harder, way; the group ideal, not personal advantage; extension of the self, not ascetic mortification.

Organizational aims may subvert, complement or extend those of the larger society. In the first instance, open identification by the participants with organizational ends becomes difficult if not impossible; and the organization's survival hangs upon tightly coercive administrative control, upon the use of threat, and upon the uncertainties of specially structured in-group loyalties.

Where organizational aims do no more than complement materialistic social purpose, a kind of counterfeit identification is commonly seen, and a type of pseudo-loyalty is developed. Participation becomes a job, not a career. Rewards are limited to employment security, shortened working hours, more generous retirement benefits, higher salaries. Administration tends to become a purely technical procedure of maneuver and compromise. It cannot provide leadership, because the group has no suprapersonal goal. It cannot inspire devotion because it is not dedicated. It cannot ask for self-denial, because it has its roots in self-indulgence.

Group aims which are defined within those purposes to which society accords its greatest respect extend man's *conscious domain*, and form the instruments of his cultural advance. They may, and often must, lead into untried fields, yet always with a measure of restraint, for if efforts too far outstrip the understanding of the larger society, they cannot be esteemed—they quickly lose momentum and decline into the sterile emptiness of a metaphysical exercise.

Dedication in our sense is not a search for abstract virtue, but a zestful, rationally-approved involvement in a common task, consciously preferred to any other. Endeavor of this caliber calls not alone for technical proficiency from its administrators, but also for leadership which effectively interprets the group mission, invites participation in its pursuit, and inspires an eager denial of all subverting personal indulgence in all who work for its realization. The really competent leader is constantly alert to forward the abilities of those whose skill, competence or general ability exceeds his own or may come to do so under the leader's guidance.

II. PROVIDING THE ENVIRONMENT FOR PSYCHIATRIC CARE AND TREATMENT

The Goals of Psychiatric Administration

Without goals, clearly set out and understood, only vague generalizations or inchoate regulations can be formulated, never policies. Unless goal-setting and policy-making are done openly and clearly, either a covert, implied and usually restrictive policy evolves, or chaos develops. In practice, mental hospitals sometimes have goals that were set and policies that were framed by people long since dead.

Within the larger social administrative framework of which the hospital is a part, the superintendent's function must be to set goals, to formulate policy, to insure that means are available for carrying out policy—and, then, to reach the goals.

Few hospitals are equally suited to every sort of patient, although a psychiatric hospital must be equipped to deal with a variety of illnesses. Unless proper accommodation has been provided for the various types and suitable staffing-arrangements made, experience suggests that an environment well suited for the care of psychotics is not equally appropriate for psychoneurotics, for psychopathic personalities and patients with character disorders, for alcoholics, for the mentally retarded, for failing old folks, for epileptics without associated psychosis and for psychotic children. It should hardly be necessary to mention here the mentally ill criminal. Each of these groups needs its appropriate program and the staff to carry it out.

Attempts to bring together, under one administration, an indiscriminate variety of sick people who require different sorts of care and treatment—with little regard for the patients' interests and without needed and often highly specialized facilities—have been responsible, at least in part, for the present unsatisfactory state of many mental hospitals. The sort of interpersonal relationships which most benefit psychopathic personalities, for instance, may be harmful to schizophrenics and vice versa. It is oversanguine to

expect psychiatric nurses and aides to acquire a versatility in interpersonal relationships that is achieved by few psychiatrists.

In setting goals for the hospital, a balance must be maintained, so that one goal is not developed at the expense of another. In social terms, the goal of the mental hospital is *to restore the capability of the patient (to "re-able" him is the expressive British term)*, that is to reintegrate him in his own or another community. Whatever the etiology of the great psychotic illnesses, those afflicted by them tend to come to the hospital because their interpersonal relationships have collapsed, resulting in alienation from the social group. This is followed by extrusion of the individual when alienation becomes irksome to the community, either because social pressure forces the deviant to seek psychiatric aid voluntarily or insures that he is committed by process of law and confined for safe custody and treatment. Many patients seek help voluntarily.

In medical terms the goal is to correct the process of psychopathology by the most effective and speedy means available. This aim can be compactly expressed thus: To accept people alienated by mental illness and to restore them to the highest degree of social functioning within the limits set by cultural tolerance and their residual infirmities, whether mental or physical.

Unless social and medical goals are achieved together, full success cannot be claimed.

About every other function of a mental hospital is that which Florence Nightingale described as "the first requirement": *To do the sick no harm.* Four main functions remain; and the neglect of any one of these, or the parasitic growth of one so that it assumes disproportionate importance, must result in loss of efficiency.

First, is the need to provide for the essential biological requirements common to all human beings; these are shelter, food, clothing and sanitary arrangements. There is nothing specifically psychiatric or indeed even medical, about these requirements, which only the negligent fail to provide for those in their power.

Second, is the necessity to provide for the basic psychosocial needs, such as the need to be loved and appreciated, the need to assert one's self and to be able to compete successfully with others; the need to have one's own private living space—with its deep biological reverberations in animal behavior—the wish to have both a soul and a place of one's own. To provide these successfully

in an institution requires a very intimate understanding of the nature of the illnesses from which mentally ill people suffer. Failure in this understanding has frequently made treatment unnecessarily difficult or even impossible. A hospital which does not meet these essential psychosocial requirements cannot treat and *"reable"* patients successfully, because it will desocialize them as quickly as it improves them.

Third, is the need to insure the safety of both patients and public, insofar as mental or physical illnesses constitute a threat to the well-being of either. Provision should, therefore, be made for voluntary admission to encourage prompt treatment during the early phases of the patient's illness and to capitalize whenever possible on his co-operation. By eliminating generally-repressive regulations, the hospital can be more certain that humane, though strict, supervision is given to those few patients who need it, either for their own safety or for the safety of others. In a well-run mental hospital which does not care for the so-called criminally insane, those requiring such supervision at any given moment are rarely more than a tiny fraction of the patient community.

Fourth, is the necessity to provide an up-to-date, hospital-based treatment program, not confined by sectarianism, using every means available to benefit the patient, and to urge the extension of every appropriate community resource that will promote the welfare of the patient.

Fifth, there is an obligation to undertake staff development and, when possible, the training of students for work in psychiatric facilities. Clinical research favorably influences patient care and is usually possible even where staff is limited. Research and teaching activities enrich the hospital environment.

The Constancy of Administrative Goals

Goals are determined by a variety of factors. They must accord with psychiatric principles. The medical superintendent is obligated to insist that goals be set that are in keeping with modern knowledge, not only in the immediate interest of patient-care, but also because recruitment problems are in part at least, the consequence of low professional standards. The goals must be attainable within the limitations of the resources available, because unrealistic goals

result in depression of morale. This does not mean that the available resources should be looked upon as being static. The superintendent must be alert to possibilities of increasing them so that present goals can be reached more quickly and new ones set.

Goals cannot exceed social and cultural expectations too greatly, without risking the loss of public understanding and support. But again, these expectations need not be accepted as unchangeable and must not be allowed to remain static. Ways of informing the community of the patients' requirements must be developed so as to encourage support and interest in more effective programs.

The Hospital Environment Cannot Be Changed by Fiat Alone

The staff and the patients are more impressed by action that implies a change than by words, however inspiring, that announce such a change. The superintendent and his advisers must be alert for opportunity to show by deed rather than by word that proper care is to be afforded to all patients. A hospital cannot be changed without analysis, strategy and tactics. In analyzing the hospital, the superintendent must know how it is functioning, in what way it is deficient, and—of especial importance, where it is effective. Unless he obtains detailed information, no change can be undertaken, because he cannot tell what he is trying to change.

Analysis

It is wise to investigate the nature of the hospital subculture so that the expectations and habit patterns of patients, staff, relatives and the public can be understood. To do this, the professional guidance of a social scientist is often helpful. Once the norms of the existing subculture are known, the objective is to support those which are in keeping with therapy and good care, and to change those leading to exploitation or degradation of patients. A full and detailed survey of patient-care allows one to discover where care is most deficient, the length of time which patients have spent in hospital and the possibilities for their *"re-ablement"*.

In surveying the staffing deficiencies of the hospital, it is not only necessary to cover the clinical side carefully but also the non-clinical side, paying particular attention to instances of failure to meet the clinical needs. For instance, hospital industries may ex-

ploit the labor of patients, not only without therapeutic returns, but even with actual harm to those involved.

Other surveys, which are on the whole easier to plan, deal with physical facilities, both clinical and supportive, furniture, equipment, supplies, grounds, etc. While these are all important, they are not anything like so difficult to plan as those mentioned earlier.

Strategy

After analysis comes strategy, which means asking what should be done, not in a general way, but to meet the particular needs of a particular hospital which has a unique history and setting of its own. Strategy must unite in a single plan the areas which have been outlined under *Analysis*.

There are persons to whom the informal social groupings turn for expression of group opinion. In planning changes, these "norm-bearers" must be identified and assisted to understand and accept new norms. With their help, change in the hospital culture becomes easier. This process is not simple and requires the best efforts of the administrator.

The long-term changes can be divided into a number of separate but overlapping categories. These include organizational changes to prepare for major staff additions, changes in human relationships, and changes in staff to bring the hospital up to acceptable standards. On the material side comes refurnishing and re-equipping and major building changes. Governments are often more willing to provide money for capital improvements than for the necessary staff, but new buildings may be largely useless unless advance consideration has been given to the requirements for staff and the program which these buildings are to serve. It is wise to resist the temptation of acquiring a new building unless there is an accompanying commitment to staff it properly.

Tactics

While a strategy is necessary and indeed essential, tactics cannot be neglected. At the same time that a communication system is being built and preparation for major changes is being made, rapid and dramatic steps should be taken to raise morale.

Experience suggests that attempts to stimulate one or two wards, into unfamiliar activity by re-assigning staff members from other

wards, easily result in hostility and resentment on the depleted wards, while those who work on the favored wards feel isolated from the staff group as a whole. "Special" wards, like special cases, of whom Stanton and Schwartz[1] speak, should generally be avoided. What is likely to gain approval from patients and staff alike and with it their trust, their support and involvement in the changes to come, is a rapid alleviation of many of the discouraging shortcomings of equipment, clothing, furniture, etc., which are so common in mental hospitals. The superintendent should, therefore, insist, when accepting his appointment, that funds be immediately available to do this. He will never have a better opportunity.

Improvements in clothing and furniture are especially valuable, because they imply that the well-being of patients has become of greater concern to the hospital management. Apart from the real need, they are of great symbolic importance, and increasing the amount or improving the quality is a nonverbal communication which is more readily and more certainly understood than dozens of memos and lectures.

There are also certain minor internal structural changes which produce benefits at small expenditure. Some of these are discussed later. In particular these can alleviate *overconcentration* although it may be possible to do nothing immediately about *overcrowding*.

Certain minor staff additions will give benefits inside the existing organization and will help in developing a new organization. A good example would be a rapid expansion of the social work department, since there would be a new expectation in the hospital that more patients would leave.

Compromise and the Redefinition of Goals

In any organization goals will, from time to time, be redefined. Sometimes, as a result of redefinition, an objective must be accepted which, while less than the best, is better than the worst. Compromise, when it is an advance toward a goal, though achieving something less than that goal, is often necessary and usually wise. Provided, always, that it is recognized for what it is, a second best may be accepted as an interim measure.

[1]Stanton, A. H., and Schwartz, M. S.: THE MENTAL HOSPITAL. Basic Books, New York. 1954.

But compromise must not be confused with capitulation or with maneuvers aimed at avoiding problems. Compromise involves a conscious weighing of alternatives, selecting those that offer promise and avoiding those likely to be harmful. While the social problems of mental hospitals should be dealt with etiologically and resolved; compromise is necessary when this is not possible, and must be accepted for what it is, not rationalized as being a solution to the difficulties.

Co-ordinates for Measuring the Hospital Environment

The hospital environment can be measured by different co-ordinates which include its formal structure, its communication system, its size, its spatial arrangements, the number and nature of its staff, the flexibility of its program and the relationship of that program to its needs.

The Leadership Patterns of the Hospital

The organizational structure used for administration will determine the sort of leadership patterns which emerge. Stanton and Schwartz[1] have shown that even a small mental hospital embraces a variety of disciplines and occupations whose relationships will not necessarily be harmonious. On the superintendent, falls the responsibility for deciding what formal structure to use. Indeed, planning and introducing this must be one of his main functions. Brown[2] identifies three main types of organization as Kurt Lewin did earlier: autocratic, laissez-faire and democratic. The superintendent's task is first to decide upon the patterns of organization most suitable for a psychiatric hospital and then to administer the hospital so it is able to reach its goals.

Brown describes autocratic structures in the following terms: They have "A leader who is in effect a one man orchestra and who is what we shall describe as an autocrat. The autocratic ruler shows the following characteristics: he gives orders which he insists shall be obeyed, he determines policies for the group without consulting them, he gives no detailed information about future plans, but simply tells the group what immediate steps they must take, he

[1]Stanton and Schwartz: Op. cit.

[2]Brown, J.A.C.: THE SOCIAL PSYCHOLOGY OF INDUSTRY. Penguin Books, Harmonsworth. 1954.

gives personal praise or criticism to each member on his own initiative, and remains aloof from the group for the greater part of the time."

Several types of autocratic organization suggest themselves; such as, the strict autocracy and the benevolent autocracy, either of these may in turn be competent or incompetent.

In contrast to this, there are laissez-faire organizations which are not led. In such a group, the leader has abdicated, and the group is obliged to flounder along on its own in an atmosphere of mounting tension and increasing frustration. The results are unsatisfactory in business or military affairs, and are intolerable in psychiatric hospitals.

Democratic organizations depend on leadership which believes in consulting the group, which works out policy in group discussions, which sees to it that there is at least tentative acceptance of policy by the group. In this sort of organization, people are rarely asked to do things without some knowledge of the long-term plans. Employees know what they are doing and why. Authority is delegated down the line, but decision-making and responsibility for determination of action are retained by the leader.*

There are also pseudo-democratic organizations which attempt to effect these principles but fail because of the insecurity of the leaders, the immaturity of the led, or because no suitable organizational structure is devised. These then resemble incompetent autocracies or laissez-faire organizations.

As a psychiatrist the superintendent must decide what sort of organization is likely to foster the most beneficial interaction between those who have immediate care of the patients on the wards and the patients themselves. The virtue of a democratic organization is that it allows "all levels of management to feel secure enough to consider the well-being of their subordinates instead of constantly looking up to their superiors to make sure that their own conduct is being approved." It must surely be clear that ward staff members must have this sort of security if they are to interact satisfactorily with their patients.

However, it may not be possible to set up the ideal organization immediately. In the interim another form of organization may have to be used.

*See: "What the Administrator Does." Chapter III.

The least harmful is probably a benevolent autocracy. It must, however, be understood that in terms of the interaction likely to be most beneficial to certain patients, a "kind parent" relationship, percolating through every member of the organization, gravely hinders the patient's integration. If such an organization has to be used, even temporarily, its dangers must be faced. A benevolent and well-structured autocracy is far less disturbing than the muddled uncertainty of the laissez-faire organization or the power-struggle and frustration of a pseudo-democratic one. Both of these can be confidently labelled "most harmful" for a psychiatric hospital.

In a large organization such as a mental hospital, a homogeneous form of administration is probably neither necessary nor desirable. Different departments may have different leadership patterns. It is, however, both desirable *and* necessary to see that every department has a type of organization appropriate for its purpose, and the more such a department impinges upon the patients the more carefully this organization must be considered.

Communications

If the hospital's goal is to give acceptable psychiatric care, this must take precedence over illusory ease or convenience of running. While in industry, good up-and-down communication is required for efficient working, free communication in the mental hospital not only insures efficiency from the mechanical point of view, but is essential for the well-being of patients. Misunderstandings and failures in communication produce tension among ward staff members and others caring for patients. Unless this tension is dealt with by frequent open discussion, it reverberates and is transmitted to the patients, causing exacerbations of their illnesses.

Communication must be established and maintained between the hospital and the outside world and within the hospital itself. A most important line of communication that must be quickly established starts with the relationship between the superintendent and his superiors. Can he inform them of unpalatable facts? Will they listen to evil tidings?

The failure to make and maintain this essential communication line has done much harm to the mentally ill. Because of this failure, those who provide the money for running mental hospitals have

remained largely ignorant of the distressing conditions in which many patients exist.

Community relations represent another important aspect of communication. When the needs of patients are not met, it may sometimes be necessary to seek the help of the public in the effort to reach a solution. While this must be done with circumspection, it has frequently proved, in the history of mental hospitals, to be the only way in which the patients' needs could be recognized by the public. It is also desirable to build good relationships with other hospitals in the vicinity and with the professional people staffing them.

Once upward and external communications are established, the superintendent must develop the hospital's internal communication system, starting with himself and his chief executives. In discussions with them, the hospital's goals are clearly identified and policies established for achieving them. Once such policies have been determined, superintendent and advisers decide what means will be needed for carrying them out and how these means can be obtained. The superintendent and his executive aides must maintain reciprocal communication. He must give them information at appropriate times so that they can make the decisions they have to make. They, in turn, feed back information to him so that he can make his decisions with knowledge of what is happening in their departments.

In this connection, an advisory committee for the superintendent often proves to be a useful administrative device. Such a committee consists of the superintendent, as chairman, and such heads of departments as report directly to him, as members. Too often committees are not distinguished from conferences. Paterson[3] has shown that it is useful to recognize two widely differing functions which can be served by organizational gatherings, and which must be kept separate, though they are frequently confused. Conferences meet to confer or discuss. No decisions need be reached. A conference may be entirely successful if there has been a free exchange of information and opinions. A committee, however, meets to commit its members to decisions. If these differences in purpose are recognized, much unnecessary frustration and anxiety can be avoided. The function of the superintendent's advisory committee

[3]Paterson, T. T.: Personal communication. 1958.

is to give him advice about the hospital policy. The decisions which must be reached concern what policies are best for the hospital. The decisions, once made, are given to the chairman of the committee (the superintendent) who then may accept the advice in his role as administrator of the hospital. He may, in this role, also have to disregard the advice; but, in practice, this very rarely happens. The members of the superintendent's committee develop a sense of participation in, and identification with, the goals of the hospital by their continuous and active part in policy making. The experience encourages them to form similar committees for their own advice throughout the hospital.

Not only do these principal executives give and take information; but, by free discussion on appropriate occasions, they allow the superintendent to gauge their feelings and opinions. Such free exchange can only occur where there is mutual trust and respect. It cannot be forced. It grows. It is a function of the superintendent to husband it. He must insure that communication at this level, as at any other, never breaks down. One way to do this is by regular meetings and discussions at which these executives are present. Since the psychiatric hospital in particular requires excellent communication if it is to carry out its therapeutic function, it seems desirable to encourage the optimum span of control and not to extend any individual's tolerance unnecessarily.

There is evidence from experience in both administration and psychiatry that group relationships flourish best in groups around the size range of four to 10. Consequently, a superintendent would be well advised to have no more than eight persons reporting directly to him; and he should encourage his subordinates to restrict their span to this number or less, so that the organization will allow the freest possible communication and thus allow flexibility.

To insure efficient communication in decision-making these formal channels must *always* be used. In an organization unused to this, there is often some discomfort at first. It is neither possible nor desirable to close all informal channels. They serve a useful and complementary purpose. It is only when people know that decisions will be reached and implemented by formal procedures alone that the main streams of communication will be carried by them.

While it is theoretically possible in small organizations for informal channels to carry communications and to compensate for

deficiencies in the formal organization, mental hospitals are commonly too large for this, so that failure in the formal organization means that total failure will result.

Once a decision is made, certain steps must be taken if it is to be a useful instrument of communication and control. It must first be formulated—expressed in words which will be understood by those who are to put it into effect. Then it must be communicated to them. When circumstances allow, the decision must be discussed and the decision-maker told of any objections and reservations which those who are to carry it out have, so that he can correct his plan or explain it more clearly. There are, of course, circumstances when this would be neither possible nor appropriate.

Once a decision is understood, a way of carrying it out must be devised. Action on the decision must then be taken. The results of the action must be reported to the decision-maker. It is his responsibility to discuss them with those most concerned and evaluate the results of the decision. Finally, when necessary, corrective action must be taken and once more communicated to those concerned.

It is only by developing an elaborate communications instrument of this sort that a delicate, responsive and flexible feedback system, which will allow a hospital to benefit mentally ill people, can evolve. A less sensitive arrangement will harm as much as it helps.

However, communication is not only a matter of decision-making. It involves the growth of interpersonal relationships, and the expression of disagreement by free discussion, which leads to reduction of tension and allows problem-solving to take place. In consequence of this, the confidence of group members in each other grows. Opportunity for experience of this sort is especially necessary in a psychiatric hospital. If it does not exist, rising tensions and anxiety among staff members will be discharged through the patients, harming them.*

While recognizing the need for formal and informal verbal communications, nonverbal communication must never be neglected. A psychiatric administrator must be constantly alert to the meaning of actions and activities, among staff members and patients, which carry information if properly understood. These nonverbal communications may consist of such disparate phenomena as sudden

*See discussion of informal communication, Chapter V.

increases in the use of laundry on a ward or increases in resignations from a particular department. The superintendent and his advisers must give careful attention and thought to every communication of this sort. Their aim, as far as possible, is to have nonverbal communications put into words, and so result in more appropriate actions.

A communication system carrying information, advice, orders and decisions, enhancing interaction among staff and patients, and attuned to informal and nonverbal methods of communication, *though not governed by them,* will, if properly devised, assist in providing surroundings suitable for psychiatric care and therapy. Like anything else of value, it must be maintained in good repair.

Size of Hospital

The superintendent usually has little or no choice about the size of his hospital, which is usually far larger than that advocated by competent psychiatric authorities the world over.[4] The great Dr. Thomas Kirkbride[5] of Philadelphia, suggested 250 beds, with 500 as an undesirable top limit for a psychiatric hospital. Modern industrial practice[2] aims at limiting factory unit size to 600 persons or less, because this results in the best sort of staff relationships, and so in most efficient production. The psychiatric hospital with its very subtle problems of human interaction should surely stay well below the much simpler factory. The larger an organization becomes, the more rigid and formalized its hierarchal system must be if it is to avoid chaos. This rigidity and formality necessary to keep a large organization functioning is particularly harmful to psychotic people who are suffering from grave disturbances in interpersonal relationships.

This discussion, however, brings cold comfort for the great majority of medical superintendents whose hospitals already exceed this desirable limit by five to 50 times. What, if anything, can be done to remedy the disastrous errors caused by neglect of the advice of Kirkbride? If the size of the hospital clinical-administrative unit,

[4]World Health Organization Technical Report No. 73, Third Report: THE COMMUNITY MENTAL HOSPITAL. 1955.

[5]Kirkbride, T.: HOSPITALS FOR THE INSANE. Lippincott, Philadelphia, 2d edition, 1880.

[2]Brown, J.A.C.: Op. cit.

including patients, is set at a truly manageable figure, and if these units are given a high degree of autonomy, it should be possible to develop, even in very large and unwieldy hospitals, psychiatric care in keeping with the needs of patients and the aspirations of the professional staff.

Spatial Arrangements

Since we have assumed that psychotic people who have been confined to mental hospitals have a reduced or altered capacity for forming human relationships, this must be taken into account in designing new buildings or altering old ones. We suggest as axiomatic that *unless the structure of a building is an expression of its function, function may be gravely impeded by unsuitable or inappropriate structure.*

New structure must be planned and old structure changed to meet the needs of psychiatric patients, insofar as those needs are known. Where the required conditions cannot be quickly provided, and this obtains in the great majority of mental hospitals, the *functional approximation of those ideals* must be devised. If this is recognized, even very bad conditions can be considerably alleviated until necessary construction can be undertaken.

With some few exceptions, psychotic persons have reduced capacities for making and sustaining interpersonal relationships, combined with certain disturbances in perception, thinking and feeling (affectivity). This has some simple consequences. Psychiatric patients must not be *overcrowded* (that is, too many people in too small a place), because overcrowding will result in one person impinging very frequently on another, so that further damage is likely to occur to an already damaged personality. In addition, overconcentration must be guarded against. By this, we mean too many people together, irrespective of the amount of space provided. Clinical[6,7] and theoretical[8,9] evidence strongly suggests that day rooms

[6]Osmond, H.: "Function as the Basis for Psychiatric Ward Design." *A.P.A. Ment. Hosps.*, 8:4, 1957.

[7]Wolf, A., and Schwarz, E.K.: "The Psychoanalysis of Groups. Implications for Education." *Int. J. Soc. Psychiat.*, 1:2, 1955.

[8]Miller, G. A.: "The Magical Number Seven, Plus or Minus Two. Some Limits on Our Capacity for Processing Information." *Psychol., Rev.* 63:2, 1956.

[9]Roseborough, Mary E.: "Experimental Studies of Small Groups." *Psychol. Bull.*, 50:4, 1953.

should not contain more than eight to 10 people. Even a well person has difficulty in establishing relationships in a crowd.

Psychotic persons should be able to withdraw physically, rather than be forced to withdraw psychologically; the motor action of physical retreat is far less damaging and more easily reversible than the psychological act of withdrawing into the self. Hediger[10] has shown that this accords with psychobiological needs, and there are the strongest reasons to believe that a retreat (a personal space under the patient's control) must be provided.

Patients who show a reduced capacity for forming relationships can often regain this capacity by living in groups which provide maximal support against anxiety. Such groups may vary in size, perhaps from six to 10, including the therapist. Bettelheim[11] suggests that four to eight is sufficient. However, he considers that groups of less than four are likely to be harmful, and there are theoretical considerations supporting him. Briefly, these are that very often it is in the family situation where *intensive* interpersonal relationships develop between two or three people that many of our patients have been gravely harmed. In groups of four to 10 an extensive and supportive interpersonal relationship can form which may disperse anxiety through the group in a way that fosters support and tolerance without threatening the integrity of the group. Groups numbering more than 10 persons may split; with the anxiety produced by disintegration frightening the patients, and so establishing a vicious circle. The optimal size of these groups can be determined by empirical observation and theoretically. The design of a new hospital or the conversion of an old one should be calculated to encourage and make easy the formation and maintenance of groups of a suitable size.

Buildings designed to encourage and sustain small group interaction have been called *sociopetal.*[6] These can be contrasted with buildings, whose function is to discourage the occurence of small group interaction and to encourage movement, which have been called *sociofugal.*[6] These concepts are useful in studying design for psychiatric buildings. Previous generations of psychiatrists have recognized the great influence of the design of hospital buildings on

[10]Hediger, H.: Wild Animals in Captivity. Butterworth, London. 1950.
[11]Bettelheim, B.: Personal communication. 1957.
[6]Osmond, H.: Op. cit.

the care of the mentally ill. This theme was persuasively developed by Kirkbride.

The design of a psychiatric ward must take into account the disabilities from which patients suffer and surroundings must be planned to minimize the patients' incapacity. In schizophrenia, for instance, we suspect that perception is influenced in such a way that the auditory and visual tend to be displaced by the tactile and olfactory. Time sense[12] may be disturbed and constancy of perception changed.[13] Space may seem larger, and time longer. The feel and smell of things become especially important. Small space of the right sort can be reassuring. Long corridors should be avoided to reduce strain on the scanning mechanism used in this sort of perception. Textiles and colors must be chosen with care to reassure patients who are easily distressed by the ugly and ambiguous. The sick person's own room should be designed so that he has personal space under his own control for such things as possessions, which are very reassuring in maintaining his identity. Mirrors too should be provided to assist this.

It is ironical that a clear distinction is seldom made between seclusion to reduce interaction—which may be much needed and appreciated by patients—and isolation in a bare cell-like room, which acts as a reduced or impoverished environment in the sense that Heron, Bexton and Hebb,[14] and Lilley[15] discuss. Such an impoverished environment is likely to increase disturbances of perception.

If seclusion rooms are used, they should be comfortable, well furnished and conducive to quiet reflection. They should give ample stimulation and should be places of brief retreat, not permanent incarceration.

In adapting an already existing building, it should be kept in mind that a small functional change may accomplish the same as a structural alteration. An example of this is the reduction of *over-*

[12]Lhamon, W. T., and Goldstone, S.: *A.M.A. Arch. Neurol. and Psychiat.*, 76:625-629, 1956.
[13]Weckowicz, T. E.: *J. Ment. Sci.*, 102:432, 1957.
[14]Heron, W.; Bexton, W. H., and Hebb, D. O.: "Cognitive Effects of a Decreased Variation in the Sensory Environment." *Am. Psychol.*, 8:366, 1953.
[15]Lilley, J. G.: Remarks on Illustrative Strategies for Research on Psychopathy in Mental Health (Symposium No. 2). Group for the Advancement of Psychiatry. New York. 1957.

concentration. Overcrowding, by definition, can only be alleviated by new buildings or by getting patients out of hospital. *Overconcentration,* however, can be reduced by the skillful use of screens, room dividers and suitably placed furniture, so as to foster the development of small groups of patients who will interact together in a friendly way. By dividing large spaces in this manner, patients' perceptual and interpersonal difficulties can be reduced without waiting for major constructional change.

Furniture plays an important part in the way in which we perceive space. A bare room is different from a furnished room. In addition, furniture provides an occasion for using a variety of learned psychosocial skills. If these skills fall into disuse, social adjustment may be impaired. As small children grow up, they are taught to use furniture by exercising psychomotor control, and they learn not to break or handle certain objects. If they fail, they are punished by other members of the group, in this case usually the family. An insufficiency of furniture makes one likely to lose these skills. Heavy and conspicuously *"strong"* furniture encourages and abets a return to adolescent or childish clumsiness. It is certainly necessary for hospital furniture to be strong; but it should be light, so that when banged or pushed into, it will "behave" like a piece of furniture at home. By its arrangement, placing and color, furniture can be used to identify a patient's personal space on a ward.

The Number and Nature of the Staff

In a public hospital, the number and nature of the staff will be determined partly by what funds are made available by legislation and partly by what persons are available for employment; they will also depend to some extent on how imaginative is the use made of the staff. How much money is provided depends in large part on the cogency of the case made for increases in staff. The American Psychiatric Association has established minimal standards. The standards refer to the clinical staff and have been reached after much thought and care.

The number of clinical staff members is related to the vigor and effectiveness of the hospital program. Hospitals with limited programs often seem to function with fewer staff members. When there is little interaction—in such limited programs—between staff members and patients, patients and patients, staff members and staff members, patients are often quiet, dependent and "no trouble." In this condition, while they may seem docile, they are unlikely to leave the hospital and resume their places in the community, so that the supposed economy of a limited program and staff may be dearly bought. Apart from general understaffing, shortages in a particular area can vitiate the efforts of other staff members. Lack of a social work department, or a too small one, for instance, may prevent the leaving of patients who would otherwise be prepared to go, because their social requirements are not being met.

The number of business and maintenance staff members depends on several factors, such as the efficiency of the hospital plant, the number of patients in the hospital, the level of services offered, and the amount of invisible service derived from the unpaid labor of patients—the system so rightly labelled peonage.

While various rationalizations have been made to justify patient labor, most of them were exposed by Kirkbride[5] nearly 100 years ago for the shams which they often are. Many mental hospitals obtain the equivalent services of scores of paid employees by using patients instead. This exploitation of "the most helpless if not the most afflicted portion of the human race"[16] is defended in terms of both therapy and economy. There is, of course, a place in mental hospitals for organized and carefully planned industrial therapy, aimed at rehabilitating patients for return to the community. Services obtained by the hospital in this way may be useful, but labor which is clinically beneficial is commonly expensive. Apart from industrial and rehabilitative therapy of this sort, patient labor is rarely therapeutic; and it is clearly both uneconomical and unethical to keep patients in peonage for years, instead of *"re-abling"* them so that they can earn a decent living in the community. The superintendent should take steps to discover to what extent his hospital depends for its running and maintenance on peonage, and should make every effort to end this practice. To prevent patients from going from exploitation to complete idleness, the change must be brought about as part of a plan of useful activity which includes strengthening the clinical departments.

[5]Kirkbride, Thomas: Op. cit.

[16]Jones, H. K.: LUNACY, LAW AND CONSCIENCE. 1744-1845. Routledge Kegan Paul, London. 1955.

At the ward level, we suggest that a rational basis for ward (milieu) therapy would be to have not less than one person in a therapeutic role in contact with not more than eight patients at a given time. Other clinical staff members should be in proportion; and more would be needed for very sick patients. The supervisory pattern should be such that no supervisor has more than eight to 10 people under him, preferably the lower figure, because one of the requirements of the hospital is a high degree of interaction and communication.

This may suggest a heavily-staffed hospital according to our present low standards. But when allowance has been made for the reduction of hours of work since Kirkbride's day, and when the many departments which did not exist in his time are considered, there is strong evidence that the number of therapeutic staff members on the wards—in even the better mental hospitals—has decreased since the 1850's.

An ailment which does not presently afflict state mental hospitals in the presence of too many clinical staff members in proportion to patients. Psychiatrists have become so used to staff shortages that little consideration has been given to the effects of superfluity. Patients depend upon the quality of the relationships which they make in the hospital to ease their resocialization and so their return to the community. One wonders how they would be affected by therapeutic staff members competing for their favors. This seems worth considering.

It should be remembered that the presence of various sorts of trainees in the hospital, while undoubtedly valuable over the long haul, does not necessarily ease staffing requirements. Indeed, proper supervision of these trainees may prove to be costly. This, of course, will not deter an alert administration, determined to better the condition of the sick.

The Sex Distribution of Staff Members

It is conventional in large mental hospitals, a hangover from the early nineteenth century jail reformers, to hold the notion that one must have a male side where men are nursed by a male staff and a female side where women are nursed by a female staff. The implications of this staffing scheme, particularly for schizophrenic people, should be examined, where this practice is still in effect.

Schizophrenic persons in particular are often unsure of their sexual status. Suggestions as to causes are that schizophrenics have regressed to earlier stages in personality development, or that eruption of complex-determined material—of both a personal nature and of what Jung calls an archetypal sort—has occurred; or that these patients are attempting to suppress an unacceptable homosexual drive. In a schizophrenic, perception of the patient's own body is often disturbed. It would not be surprising if this in itself were to usher in or gravely aggrevate uncertainty about one's sexual status.

Whatever the cause may be, however, the consequences are fairly clear. Like other people, schizophrenics have sexual interests, and, since schizophrenia develops largely in young adults who are expected to have overt sexual activity, they have sexual difficulties, just as they have great difficulty in almost every other aspect of experience. Where a puzzling and mysterious object such as sex is combined with an equally mysterious illness, schizophrenia, is it surprising if the victims are confused? Schizophrenics often require surroundings where they can meet people of the other sex so that they can retain the social skills required to regulate the relationships between the sexes. Interaction with both nurses and patients of the opposite sex is therefore necessary for them. Both men and women tend to smarten themselves up in the presence of the opposite sex.

In the absence of women, a common but undesirable way of preventing masculine slovenliness is by strict discipline and regimentation. Unfortunately this is particularly harmful for schizophrenic patients. Further, both male patients and staff members are often threatened by the grooming and mothering care so helpful for the regressed schizophrenic—and by the bodily contact which, as Sechahaye[17] shows, mean so much. When one man treats another in this way in our culture, an intimacy is implied that is found only between fathers with infant sons and between homosexual partners. Neither of these relationships are likely to benefit the schizophrenic. When such activity is undertaken between two women, or by a woman for a man, the implications are entirely different. Mothers and sisters in our culture are expected to groom

[17]Sechehaye, M.: AUTOBIOGRAPHY OF A SCHIZOPHRENIC GIRL. Grune & Stratton, New York. 1951.

and smarten up the males who are dependent on them, as are daughters and wives with older people.

Ward staffs on most wards should include both men and women —particularly on wards where there are regressed schizophrenics. To do this successfully a clear definition of function will be required so that male and female staff members understand their roles. It is also clearly desirable that the administration and design of the hospital should not only allow, but should encourage, patients of different sexes to meet and mingle as they now do in general hospitals and in society at large.

Flexibility *v.* Rigidity of Program

Psychotic patients require flexibility in surroundings adapted to *their* needs. Large organizations tend to become rigid because they are inherently difficult to run. This conflict between need and administrative trend is one of the grave problems of mental hospitals. How can one reconcile the needs of the patients and the requirements of a large organization always liable to be gravely hampered if its regulations are not adhered to? Flexibility can only be obtained by clear goals and good communications, which will allow the humanity and common sense of the staff to keep the organization going in spite of irregularities. In a small organization, flexibility is much easier to develop because there are fewer steps between those who care for the patients and those who make administrative decisions.

Administrative measures should be taken to see that as far as possible no member of the staff has to go through more than three people before he reaches someone able to make a decision about the problem that faces him. Three has been suggested as the largest number of steps allowing proper flexibility. This could be a guide in the administrative pattern.

Program Capacity *v.* Need

Ideally, every patient should have the best possible care, with the object of rehabilitating him and getting him out of the hospital. Frequently this is not possible, and some distribution of effort must be made. How should the hospital's resources be allocated?

A common pattern is to concentrate all effort on new admissions, so that longer-stay patients are frequently more or less neglected. Before diverting resources in any particular direction, the superintendent is well advised to seek expert guidance from someone skilled in medical statistics, and to study the problem in the light of statistics. Where resources are limited, the deplorable fact remains that the objective must be to prevent the hospital population from increasing, for clearly this would deplete those resources still further.

III. WHAT THE ADMINISTRATOR DOES

Nature of Administrative Authority

An objective evaluation of formal social institutions will reveal that proper delegation of administrative authority is the key to effective organizational performance and is the hallmark of mature, competent administration. It is essential for the welfare of the patient that there be a clear-cut, mutually understandable distribution of organizational authority and predictable patterns of response to such authority. The development of a finely drawn hierarchal system of authority is therefore appropriate and necessary.

Creating the organizational structure of a mental hospital is the responsibility of the superintendent. To discharge this administrative obligation, there must be a logical distribution of functions. By making explicit what is to be done, and who is to do it, then accepting responsibility for the end results, the superintendent satisfies his responsibility for hospital function. This is the essence of administration and the method by which a formal organization is developed.

Formal organizational structure is, then, a framework for the distribution of administrative authority throughout the hospital. The reciprocal relationships, set up to make action for hospital purposes possible, should be made explicit in writing and may be diagrammed in charts. Charts and diagrams have, in themselves, no special value, in fact may be misleading, but they serve the purpose of letting people know where they stand. The relationship between supervisors and those supervised must be clearly delineated, and must be understood by both. Every hospital employee must know to whom he is responsible, for what he is to be accountable, and what are the limits of his authority to act. In this way, the formal structure provides a system of checks and balances, by means of which action is implemented and co-ordinated, and organizational purpose is achieved.

At all levels of administrative responsibility, authority is derived from legal, or contractual, authorization to accomplish explicit purposes required by superior authority. This is the delegation, or investment, of administrative authority in a position in an organizational structure, and is frequently spoken of as "structural" authority. Acceptance of a position obligates the administrator to decide what is to be done and when. He is obligated to require performance by those designated to do specific jobs, and is obligated ultimately to report and to stand accountable to his superiors for results.

In addition to the structural authority that administrators have in consequence of their positions in the organization, they have authority related to their specialized knowledge and skills. Technical knowledge or professional advice may also entitle an individual's opinion to be accepted. This kind of authority has been called sapiential authority. "Sapiential authority is the entitlement to be heard by reason of knowledge or experience. Such knowledge is personal, and therefore the authority is vested in a person and not in the position occupied by the person."[18]

In any medical organization sapiential authority—here equated with the opinions of medical consultants—is an essential element in patient-care. A supervisor's competence in the discharge of the delegated function, however, is essential in delegating leadership responsibility. In fact, the exercise of structural authority in a hospital requires that the administrator also be the bearer of sapiential authority.

Exercise of Administrative Authority

The sending and receiving of signals, which allow people to tell what others are thinking, feeling and perceiving, and further, what they intend to do, is essential in the creation and maintenance of an organization. Appropriate channels through which organizational communications are expected to flow are delineated when employees understand from whom they are to receive communications and to whom they are to direct their own signals.

Information must be transmitted through the communications system to mobilize action. The provision of relevant information is an essential administrative function and serves only one purpose, to inform. Motivation of subordinate personnel to support organizational needs, and to submit to administrative direction and control, can best be derived from the personnel's understanding of organization values and willingness to identify with the goals thus understood. Misunderstanding, through failure in proper communication,

[18]Paterson, T. T.: A METHECTIC THEORY OF SOCIAL ORGANIZATION. Department of Social and Economic Research, University of Glasgow.

lies at the root of many administrative failures. Orders are inappropriate if there is incomplete information as to what is to be done or if the available resources are inadequate to do the job. Compliance with directions may be delayed by lack of understanding of what is to be done, or of how the action ordered will contribute to organizational purpose.

Information is expected to flow in both directions through the formal organizational channels of communication, though blocks occur. Experience shows that there is far less volume in backflow, or feedback, from below upward through the authority hierarchy, then in the contrary direction. Information carries no administrative force, and does not obligate to action. Its value in facilitating purposeful direction and co-ordinating action is easily understood by supervisors and tends to keep the descending communication system open. Most supervisors are likely to be less conscious of the relevance of information in the ascending channels to the exercise of their administrative authority. Some seem to feel little need to take the feelings and attitudes of subordinates into consideration in the formulation of directives to which those subordinates are expected to respond. Consideration of feedback is essential, however, if group satisfaction with work performance is to be enhanced.

There is no one way to assure a two-way system in the communication of information. Examination of various patterns of administrative environment reveal, however, that the flow of appropriate information within the organization, especially the flow of feedback, depends in large measure upon the type of administrative environment itself. A democratic leadership pattern is usually more effective in establishing and maintaining a two-way informational channel than other patterns of administrative performance.

Orders, or directives, are the tools required for the exercise of administrative authority. Once given, and received, an order must be recognized. It may be questioned for clarification or to make personal objection a matter of record. Action on an order may be delayed so that information that may not have been taken into consideration in the formulation of the directive can be fed back to superior authority. Orders must, however, be obeyed and results reported.

Orders flow down through formal channels of communication from one supervisory level to another. Orders never flow back. This

motivates some individuals to seek and accept administrative authority. They want to give, not take, orders. Frequently, however, satisfaction of this need is not equally supported by willingness to accept accountability. Many prefer the protective aspects of taking orders. By accepting and carrying out the direction of another person, responsibility for the consequence falls upon the individual who gave the order. This is the occupational hazard of all administrators. Much may depend upon the judgment and skill of the administrator, but achievement of goals depends upon the actions of others. For this reason, the only valid measure of administrative competence is effectiveness, or organizational action, in serving hospital purposes.

In the final analysis, administrative authority rests upon mutual understanding that failure to carry out an order will result in disapproval or estrangement from the group. Dismissal represents the ultimate extension of this obligation. In this way, the value system of rewards and censure safeguards performance. Prompt exercise of this administrative obligation is required for group protection. Failure to act promptly will quickly destroy the effectiveness of leadership authority within the organization.

Advice is information derived from technical consultants and is appropriate communication to flow through the organizational structure. Advice is intended to inform or validate administrative authority. It may be accepted or rejected. Administrative directives, formulated with the assistance of appropriate sapiential authority, serve several purposes. Such orders carry the supplemental force of objective authority and objective approval of the action to be taken. The effectiveness of directives is enhanced by taking more than one point of view into consideration. When sapiential authority is heeded, accountability for results is shared, even though it is understood that the administrator need not accept or act upon the advice given.

Where an administrator is expected to seek the assistance of other sapiential authority and fails to do so, the consequence of failure falls wholly upon him. Success speaks for itself. An adviser, then, is both a helper and a protector in the exercise of administrative responsibility. To serve these functions, a reciprocal relationship is required. The administrator who is advised is expected to provide the adviser with adequate information. Some hospital ad-

ministrators designate a sapiential authority from whom a subordinate executive is expected to seek advice in administrative performance. While this may serve a purpose in controlling, or even improving, the administrative effectiveness of a supervisor, the wisdom of such a practice is open to question. Once organizational function has been defined, true delegation is an expression of willingness to permit a subordinate to do a job in his own way—with freedom to choose methods and means, as long as the task is accomplished. It is quite within the right of a hospital superintendent to encourage the use of sapiential advice by subordinates. He can do this by seeking the assistance of other sapiential authority in the discharge of his own administrative obligations. It is usually preferable to permit free choice in the selection of advisers; but it is within supervisory authority to require its own prior endorsement of the sapiential stature of the advisers selected by subordinates.

It is important that the superintendent of a mental hospital discriminate between his structural and sapiential authorities and limit the exercise of each authority to its appropriate function. As a physician, the superintendent is not vested with administrative authority. It is expected that his understanding of the psychiatric principles involved in group interaction will materially improve his effectiveness in the discharge of administrative authority to achieve hospital goals; but he violates the limits of his administrative position if he undertakes to deal with organizational situations as therapeutic problems. His effectiveness as an executive depends upon his capacity to influence people through understanding organizational purposes and goals, and to motivate them to ratify his administrative authority, by consenting to group action, rather than by being manipulated. As an administrator, a superintendent must examine organizational structure and the flow of administrative authority through it. Difficulties arise when there is a breakdown in the communication required for group interaction in the performance of function.

Definition of Administrative Potential

The superintendent of a hospital always has a responsibility to some person or group. Unless relationships between him and his superiors are clearly delineated, and mutually acceptable, he will not succeed as an administrator and the hospital cannot flourish.

The superintendent must know to whom he is accountable, and for what he is responsible; and he must know the nature and extent of his authority. He has a responsibility to himself, and his profession, to discover before appointment whether he can identify with and support hospital goals specified by his prospective employers. His superiors may have in mind a custodial care program, contrary to his own concept of psychiatric hospital function. It is the clear obligation of governing bodies to provide a setting in which the able administrator will do a medically creditable job.

The administrator should also ascertain whether he will have a free hand in program development. It is important that there be an understanding about immediate and long-range goals, as well as about the length of time acceptable for accomplishment. The superintendent's superiors must make explicit the controls and methods they propose to use in the management of hospital budget and personnel policies. If the superintendent is to have subordinate staff members who are expected to report to his own superiors regularly, the manner in which these transactions are to be conducted, and the purpose intended, should be fully clarified. While the line of authority is usually easy to delineate, there may be a number of ways in which the superintendent's administrative authority may be limited; and such restrictions can serve only as a handicap to his effectiveness in creating a hospital environment.

When the nature of the superintendent's authority and responsibility is clear, the superintendent and his superiors can assess each other's intentions and expectations. Each, then, has the reciprocal obligation to keep the other regularly informed about these intentions and expectations, particularly about any changes that may occur. The resources for the development of the public mental hospital's treatment program derive from governmental sources. This fact emphasizes the requirement that the administrator communicate his needs with clarity to the government, and that he educate its officials to the importance of having formulated goals.

Administrative Prototypes

In accepting appointment as superintendent of a mental hospital, an administrator will be confronted with one of two prototype situations. Usually the hospital is already an established institution. Here an image of organizational goals already exists, outside as

well as within, the organization. A structure for interpersonal interaction and communication has been created. Patterns of anticipated performance, related to function and work standards, are accepted by the staff and patients and are usually deeply ingrained. Staff members, many of whom feel entitled to their positions by right of tenure, as well as organizational structure, identify with existing traditions and environments. The new superintendent may be viewed as an intruder, often with hostility, and the hospital staff, at all levels is then more or less firmly bound together in determination to maintain the status quo. There will be some who will seek to establish a self-seeking relationship with the new administrator. He will do well to view such overtures with caution.

There is no one way for the new superintendent to achieve leadership recognition within the hospital. An experienced administrator will carefully evaluate the situation, remembering that anything he does, or says, may be viewed with suspicion and may be misinterpreted. There is temporary chaos in formal channels of communication. Changes may, at first, be resisted only because they are new, and because it is always easier to continue to follow habitual work patterns. During this phrase, the new superintendent must move with caution and must guard against expressions of opinion that register disapproval of performance, until he can be certain that he has all facts at hand. This is a time to formulate and establish an order of priority for creating change that will best enable hospital function to achieve the expectations of the new administrator's superiors. The superintendent can be sure that there is tacit understanding that change is inevitable.

The initial problem of a new superintendent taking over an established institution is, then, to obtain sufficient information to assess the hospital environment accurately, without further stimulating staff anxiety. He should make clear that his interest is directed to understanding and evaluating the existing organization, that his attention is directed toward hospital operations, and that personal issues are not involved. Once the superintendent has decided upon a course of action, his first directives should be concerned with limited goals where end-results can be most accurately predicted and where they are most likely to be accepted. Hospital food service may be a profitable area for the new superintendent to explore, and may be the best area for the first exercise of his administrative

authority. If it is possible, and it generally is, to bring about improvement in either the quality or the variety of the food served, many will be pleased.

An altogether different situation confronts the superintendent who is selected to develop the administrative environment of a new hospital. Here there is nothing to change. If the administrator is appointed during the planning phase of the hospital and its associated services, and is authorized to participate in advice given the architects, many future administrative difficulties can be avoided, and staff effectiveness in the achievement of hospital goals can be enhanced. The physical plant of the hospital is also more likely to be a reflection of function if the administrator has a voice in its planning.

Since the superintendent's administrative authority is not restricted in this instance by the culture of a pre-existing organization, he may guide the formulation of policies directly toward the performance of hospital function. The superintendent should have an opportunity to select key subordinates to whom he will delegate authority. The attitudes and aspirations of these top-level supervisors can be explored before their appointment. Those so selected are more likely than existing staff officers of an existing hospital to share in, and identify with, the superintendent's "ideal" in administrative environment, and share his understanding of the purpose the hospital is to serve. In these circumstances, goals can be made explicit and not confused with pre-existing ones. In no other situation can the superintendent expect a comparable opportunity to define administrative functions. As operations are implemented, the co-ordination of the working relationships of units can be tested. When it can be ascertained, from experience, what distribution of work load and operating method is most likely to produce effective results work patterns can be crystallized.

Once function has been defined, the superintendent should focus the further exercise of his authority on co-ordinating and evaluating hospital operations. Subordinates must be allowed choice in selecting staff members and methods for their jobs. They can only be responsible for their operation if granted autonomy in the discharge of delegated authority. If the superintendent—no matter how well-intentioned—arbitrarily restricts a subordinate's operating role, not only is there failure in the delegation of authority, but the

role of the restricted supervisor is distorted and may very well be destroyed. Such a distortion of administrative authority, through failure in delegation, can only lead to the creation of an environment that will retard, or even block, effective hospital operation.

There are, however, problems within this new administrative relationship, even when it is functioning well. At the outset, there is no real staff commitment to hospital purposes, since goals are tentative, though formally documented. Identification with supra-personal, organizational objectives is realized only in achievement. However, the administrator can do much to enhance the development of a cohesive cultural system by clearly specifying the function, or role, of the staff. The expected contribution of each member of the organization becomes explicit to all concerned. Performance serves to achieve recognition, as well as personal satisfaction. A value system that is directly related to effectiveness in organizational action is thereby created. Thus, staff dedication to hospital purposes is mobilized; and, in this environment, there is little need to develop a hierarchal structure related to social values outside the organization. The organizational stature of each individual is measured by success or failure in satisfying organizational function.

In both the new and the established hospital, the superintendent defines, directs, co-ordinates and controls the multiple functions of the hospital. In so doing, he creates an administrative environment in which predictable patterns of action develop, becoming fused into over-all hospital operations. In this manner, the superintendent creates the atmosphere, or conditions, for the discharge of administrative authority. Subordinates come to realize that, if they are to play their parts successfully, they must in turn exercise the administrative authority vested in their positions.

Patterns of Administration

A uniform leadership pattern is not necessary in all mental hospitals. Despite the superficial effectiveness of administrations that are strongly autocratic, though pseudo-democratic—with lip service the only expression of democratic principles—their deleterious effects are well-known and should be avoided. However, the most devastating pattern of organizational leadership is the atmosphere created by a laissez-faire administration. Here everybody "passes the buck," in decision-making and in accountability. Where such

an administrative pattern comes to exist, several things happen. First, there is frustration on the part of staff members who identify with hospital purposes and are motivated to accept and act upon appropriate administrative direction. Group anxiety is expressed in resentment and hostility directed toward the leader who is expected to provide information and issue instructions. When one group or person fails to perform his function, others may try to compensate for this, usually increasing the confusion and consequent anxiety. A familiar example of this situation occurs when a physician fails to provide leadership to those needing his support and direction in patient-care. The doctor's role will, at least in part, be taken over by other members of the ward personnel. Still other personnel resent this usurpation of authority and become increasingly disturbed because they will not accept the validity of such leadership in performing this function. There is, finally, complete dissolution of the clinical team. No matter where it exists within the hospital organization, dilatory handling of administrative responsibility must be quickly spotted and summarily eliminated. This is an urgent administrative problem, since, otherwise, a chain reaction develops. Failure of a superintendent to take corrective action will be interpreted as condoning the distorted administrative pattern.

Selection of a democratic, or temporarily autocratic, leadership pattern depends upon the problem at hand. In some instances, the situation requires direct, forceful action. However, the choice of an administrative approach is also an expression of the superintendent's subjective value system. Among effective alternatives, each administrator will function best in choosing the methods and techniques with which he feels most comfortable.

As an ideal, we advocate principles of democratic leadership. Here the leader leads. He permits, in fact encourages, staff participation in program planning and policy formulation, without confusing the limits of administrative authority, or the locus of responsibility for executive decision. New ideas for improving the effectiveness of hospital operations are accepted, evaluated, rewarded, and, when appropriate, incorporated into the hospital program. The staff's energies are directed toward their jobs, and attention is centered upon the achievement of hospital goals rather than on the cultivation of the good will of superiors and the satisfaction of personal needs. Where such an administrative pattern as

this exists, there is less tendency for blocks to occur in channels of communication, increasing the two-way flow of relevant information required for administrative co-ordination and direction. Hospital staff members have stronger motivation to identify with and support administrative authority. They feel that their ideas and suggestions have been considered at appropriate levels of administrative authority and have been used in directing action. In such a setting, there is likely to be a more general understanding of ultimate hospital goals and stronger identification with the ideals of transcendent medicine.

In democratic organizations, group discussion, as a preliminary to executive decision, has come to be improperly labeled "group decision-making." Where there is responsible administration, this kind of perversion in executive role does not occur. The administrator does not seek to hide behind the decisions of others. The purpose of such group discussions is clearly understood. The administrator recognizes his need to supplement his understanding in a field of specialized knowledge and seeks the advice of those competent to provide the information he requires; an appropriate answer to a problem may be forthcoming from any source. The responsible administrator is expected to implement his eventual decision with the necessary directive for action. Group discussion provides opportunity to develop understanding of what is to be done and why. Such conferences give the administrator opportunity to encourage "feedback" so that he may assess the extent to which goals under consideration are understood and accepted as purposeful—and the extent of anticipated concurring support. Once the leader decides, authority to implement action is delegated; but it is mutually understood that the administrator retains responsibility and accountability. He must, therefore, be kept informed of progress and of the end results attained.

Despite the fact that successful teamwork is rarely observed, lip service is generally devoted to the principle that everyone must contribute to all decisions. There is every reason to question such a practice. The housekeeper cannot be expected to express a valid opinion on the competence of a candidate for hospital fiscal officer. The chaplain is not qualified to advise on the purchase of x-ray equipment. Rational use of sapiential authority in administration requires only the use of appropriate knowledge and skills in the

resolution of problems. When the team concept is abused, formulation of executive decisions may be delayed because of lack of interest, or because of irrelevant comments of staff members who are present at a conference only because of a misunderstanding of a popular administrative technique. Executive determination of the knowledge required for administrative action is a fundamental right of executive authority. The appropriate, or selective, use of the energy, time and skill of associates is an administrative obligation. The true meaning of teamwork, then, is the purposeful use of relevant skills and knowledge, in the discharge of administrative authority.

Applications of Administrative Authority

Every administrative problem is different from the next one, but its resolution always involves the same processes. The issue must first be defined by the administrator, but its resolution ultimately requires group action. In simple terms, administration is getting things done through people.

In delegating authority to act, the superintendent develops a framework of working relationships. He formulates policies, or guideliness for supervisory direction and control of potential group action. It remains for this potential to be converted into the work performance anticipated. The organization will be greatly influenced by the way in which the superintendent exercises his own administrative authority. If he acts consistently, others in the organization will be encouraged to do likewise. If he behaves in an understandable and rational manner, this manner will tend to spread throughout the hospital. People will know that the channels of communication are working; and they will know what is expected of them and that the administrator will react reasonably.

Administrative methodology and techniques can be found in any standard textbook on the subject. It is not our intention to consider the details of their employment in the management of administrative problems. Our concern has to do with the creation of the sort of healthy environment which encourages predictable group response to leadership-direction with the aim of accomplishing organizational goals.

The first, and essential, step in the administrative process is to define the problem at issue. Either immediate or long-range situ-

ations may be considered. The kind and amount of information required for proper planning depends upon the judgment of the executive. Certainly, experience, or information from the past; current reality, or information from the present; and anticipated trends, or information from which to forecast the future, are usually taken into account for analysis and correlation. For example, in budget planning, it is helpful to know past and present operating costs. Priorities need to be established. Future budget planning will be significantly influenced by priorities set today, and the setting of such priorities requires understanding of political and economic trends. Unless channels of communication are open and the administrative environment is conducive to the flow of information, from below as well as from above, a clear defining of the presenting problem, and effective decision-making, are unlikely to result. A mental hospital superintendent must, therefore, remain in touch with conditions inside and outside the organization, and must satisfy himself of the adequacy of his communication systems. However, anxiety in this regard must not lead him to develop a cohort of stooges.

There are many feedback devices available to the resourceful and imaginative executive. For example, when a subordinate suddenly fails to consider advice in the exercise of administrative authority, the reason is worth examining. Study of the conference notes of staff meetings may point toward a cause in the failure of the backflow of information. In another area, failure on the part of the administrator's superiors to seek information about the progress of hospital programs, or failure of the superintendent to provide such information, is certainly a signal of disaster to come, unless the reason for such a block can be eliminated.

Once a problem has been isolated, and the need for action determined, the assessment of available resources is required. The best decision may be to refrain from the proposed action. For most administrators, this is far more difficult than to do something, but timing is essential to organizational effectiveness. Urgency of the situation requires consideration, as well as such questions as strategy and appropriate delegation of administrative authority. Objectives must be within the limits of available resources. Patient-care, the essential function of the hospital, should be kept in mind so that medical principles and therapeutic standards do not suffer.

Patient-labor must not be labeled "therapy" in order to supplement the hospital staff.

Once action has been determined and resources to accomplish an acceptable goal have been found adequate, the superintendent delegates administrative authority to act, designating the missions to be accomplished. Written documentation is particularly important in setting long-range goals. In such cases, it is usually desirable to designate a series of limited goals and set up a progress schedule. A written directive is also necessary when multiple hospital resources must be brought to bear upon the problem so that groups understand what each is to accomplish and how such divided action will contribute to the attainment of the ultimate objective. It is also desirable to specify standards of work performance when a job is assigned.

Failure to delegate authority to implement hospital function is the source of problems in many hospitals. When there is an inadequate staff, particularly in professional categories, there may be administrative reluctance to decide just who is responsible for many of the essential activities of patient-care. Failure to be specific because of inadequate personnel invariably aggravates an already difficult situation. Discrepancy between available resources and demands for service is no excuse for lack of administrative clarity in delegating authority and defining the mission assigned.

There has been little effort to develop realistic standards of work performance in mental hospitals. Because every hospitalized patient is entitled to care, an attempt is often made to distribute available resources for such care equally, no matter how limited the resources are in terms of personnel. This means that there is a tendency to assign duties without specifying a level of expectation as to the amount and quality of the work involved; and this tendency frequently defeats the very purpose intended. Patients receive unsatisfactory service; employees, in an unsuccessful attempt to satisfy the needs of too many patients, are overworked and frustrated; and the realistic standard of "doing as much as possible" may become accepted. The usual consequence of administrative failure to define operating goals is a lowering of staff morale.

The adminstrator is expected to keep himself informed. His follow-up of an administrative operation requires review and evaluation of progress, communication with those to whom responsibility

is assigned, and, when necessary, modification in the delegation of administrative authority. He may have to take account of a change in hospital resources, and must be mindful that hospital operations should reflect technical advances in medicine, such as occurred with the introduction of modern drug therapies. The point is, that, at all levels of supervision, the administrator must keep in mind that delegation of authority is not a technique by which he is relieved of accountability. Though he may not be expected to do a given job in person, he serves as a catalyst in transmuting group action into desired results. Supervision and follow-up should not be considered lack of confidence. Any expression of an administrative attitude that can be interpreted as lack of interest, withdrawal of support, or abdication of responsibility will set the stage for failure. An administrator may expect that a group will function on its own, once a course of action has been agreed upon. Unfortunately, this is not the case. Situations change from day to day. There are amazing differences in the interpretation of directives. There is a tendency on the part of even well-motivated, highly competent employees to test the limits of their authority and transgress boundaries assigned to them. Aggressiveness and initiative are desirable administrative attributes only if controlled and positively directed.

The hospital superintendent should discourage political patronage. Though this may be a means of resolving political debt, it wrecks a hospital. The insecurity, resentment and irritation of staff members that patronage can cause are transmitted directly to patients, and retard, if not actually jeopardize, progress to recovery. The unfortunate practice of patronage is gradually becoming a thing of the past, with the creation of civil service merit systems. The superintendent who makes appointments on merit, following careful evaluation and without the stigmata of favoritism or nepotism, is now likely to obtain the support and respect of politicians, particularly if he can explain his principles with patience and tact.

Many hospital employees are joining unions and other employees organizations. The superintendent must understand the psychological and social motivations of employee representatives and direct them wisely into useful channels. It must be understood, and mutually agreed, that the primary obligation of a hospital staff is to patients. This by no means implies lack of understanding or lack of willingness to meet the needs of employees. Employment

and promotion, however, must be determined by a combination of seniority, merit and special qualifications, and not upon any one of these criteria alone. Here there can be no administrative compromise. Personnel practices having to do with absenteeism, sick leave, annual leave, retirement and disciplinary actions should be made explicit in writing and strictly adhered to at all levels of supervision throughout the hospital. It must be further understood that such matters as wage scales and staffing patterns are, for the most part, determined by legislative action rather than by the hispital administration.

A superintendent must keep in mind the status needs of employees. There is a distinction between status and prestige. Status concerns the social positions accorded to the individual in the community at large, and is a carry-over of social stereotypes into the organizational hierarchy of the hospital. On this scale, a supervisor outranks those with no administrative authority; a professional employee expects precedence by virtue of training. On the other hand, prestige is derived from the individual's effectiveness in contributing to organizational goals. The staff esteems those associates who, in whatever capacity, do their job well. On this scale, a good housekeeper is, in fact, just as valued a hospital employee as any other. The superintendent can foster this attitude as an expression of administrative principle; and, gradually, the same understanding and emphasis upon effectiveness in function will pervade the hospital organization. The superintendent must guard against administrative acts that sanction the status needs of individuals at the expense of hospital welfare. For example, he must not speak to top-level supervisors only, and fail to make a favorable comment to an employee who is doing a good job sweeping the floor. A good environment exists when every employee is convinced that the hospital will cease to function if he fails to do his job well. However, the status needs of employees cannot be ignored. This fact must be handled with the realization that deference must be earned; it cannot be given. Cultivation of prestige as a means of achieving organizational stature will tend to enhance hospital effectiveness.

The success of an organization is predicated upon the use of incentives and sanctions which are understood and accepted by all employees. Control is facilitated when personnel practices are employed in a fair and efficient way. Employee relationships are par-

ticularly important, since discontent, insecurity, uncertainty and resentment have a direct influence on the attitudes and responses of patients.

Authority must be delegated to the personnel department to supervise and co-ordinate such matters as the recruitment and initial evaluation of new personnel, the handling of grievances, labor relations, discipline, promotion, separation, demotion and retirement. Some aspects of personnel training may also be the concern of the personnel department, although this does not mean responsibility for the implementation of training programs. The department will, however, serve in an advisory capacity to hospital supervisors. The personnel department must also insure that hospital departments abide by uniform practices, approved by the administrator, and that the management of employees does not become arbitrary, unfair or unpredictable. The personnel department must assure that the hospital program of evaluating work performance and setting work standards is fair and generally understood. A system should be developed to enhance the value of such understanding, so that employees may know where they stand and how they may best prepare themselves for advancement. It is an essential administrative policy to insist that grievances be referred through the formal chain of authority, until an equitable settlement is achieved. The employee must present his complaint first to his superior. There may be no bypassing in the handling of disciplinary matters, either up or down the system. If an employee fails to achieve satisfaction and resolve his difficulty properly with his supervisor, the supervisor will be required to refer the matter promptly to his own superior —without retaliation, either directly or indirectly, toward the individual requesting the hearing of a grievance at a higher level of authority. The personnel department will see to it that this procedure is recognized as an essential obligation of all supervisors.

A periodic counseling program achieves several purposes. A subordinate is made aware of his strengths, as well as of his weaknesses, in job performance. Positive steps are outlined for improvement in the individual's contribution to group action. If an employee's performance is less than acceptable, a counseling interview provides opportunity to prepare him for the supervisor's intention to recommend a change unless there is improvement. Though it is difficult to counsel a substandard employee without allowing the

problem to become a personal issue, a supervisor can develop skill in focusing attention upon the function expected, rather than on the individual. There is less tendency to evade this administrative responsibility if emphasis is devoted to the way an employee's performance may be improved, rather than to a simple list of shortcomings. When a supervisor waits until a crisis before calling substandard performance to a subordinate's attention, the problem almost always becomes a personal issue. Unfortunately the supervisor's failure to discharge his administrative function then becomes the more critical problem. When a disciplinary action of a department head must be overruled, because of a failure to give an employee the opportunity to improve performance before invoking administrative sanctions, the administrative authority-structure throughout the hospital suffers.

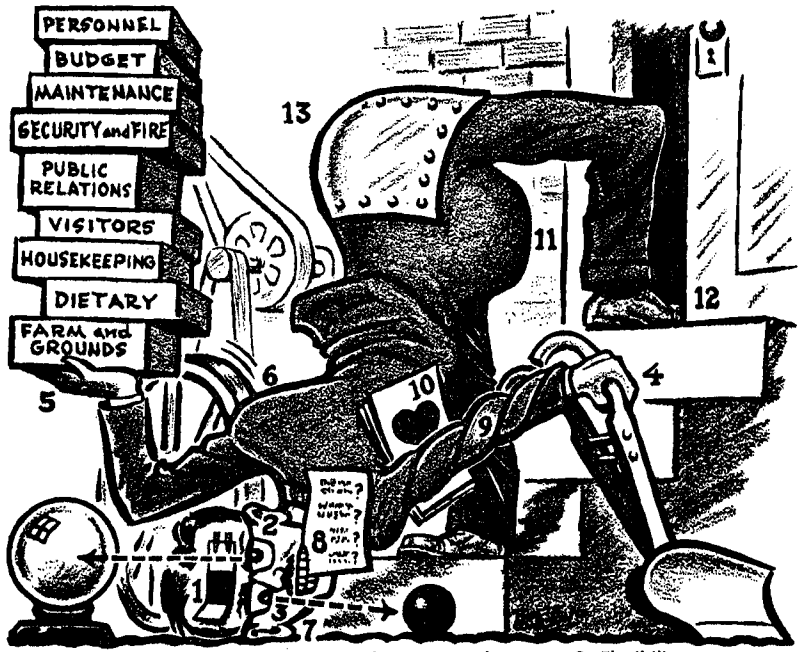
An equally important aspect of the counseling program has to do with improving hospital effectiveness. High work standards go hand-in-hand with high morale, and disciplinary actions are seldom necessary. The remiss employee has come to identify himself closely with the organization and is distressed simply by the knowledge that he is failing to achieve standards that will be tolerated by the group. Here no one believes that the hospital is content to "just get by." In such an environment, sanctions are remedial rather than punitive. When morale is low, a very different situation obtains. Though there are those who are unsuitable and should leave hospital employment, arbitrary action damages morale and is likely to do harm to the over-all program. Every separation of an employee from the hospital because of poor work performance should be considered as more or less of a failure in some aspect of evaluation, training, supervision or counseling.

Though many incentives for good performance can be employed, the simplest and most effective, as well as the easiest to understand, is consistent interest on the part of supervisors, with expressions of approval for work well done. Morale is stimulated when hospital administration provides in-service training that will permit employees to gain greater skill in their jobs and opportunity for advancement to more responsible positions. Every effort should be made to eliminate hospital jobs that do not, in some measure, serve to prepare employees for promotion. The hospital superintendent should support and encourage the aspirations of the pro-

fessional staff by supplementing in-service training programs with opportunity for formal training outside the hospital. Despite the ever-present, overwhelming work load, professional employees must be granted time, and, when possible, financial assistance, to advance their professional skills.

Promotion policy and criteria for advancement to assignments with greater responsibility should be clearly specified, and acquaintance with them should be disseminated throughout the hospital organization. All qualified individuals must feel that they have received equal consideration when a promotion is made. At the lower levels it is good practice to encourage promotion from within the hospital organization. This is not necessarily desirable or possible in the top administrative echelons. A superintendent must be able to reconcile himself to the loss of employees who are ready for advancement but for whom a job is not available within the organization. He should let it be generally known that he will encourage, and actively support, qualified employees in their aspirations for advancement to positions, outside as well as within, the hospital. Such a practice will, in the long run, benefit the hospital. In such an organization there are no "dead-end" jobs; there are no limits imposed upon ambitions.

THE COMPLEAT ADMINISTRATOR



1. An Open Mind
2. Eye to the Future
3. Eye on the Ball
4. Hand on the Plow
5. Everything in Hand
6. Shoulder to the Wheel
7. Ear to the Ground
8. Teeth in the Problem
9. Flexibility
10. Heart in His Work
11. Plenty of Guts
12. Foot in the Door
13. Armor Plated

IV. OBSTACLES TO GOOD ADMINISTRATION

Numerous circumstances that may serve as deterrents to good administration could be listed—not as examples of administrative shortcomings, but rather as obstacles before which administrators may falter. They may occur within the hospital itself, or originate outside of its direct sphere of influence. Few occur singly; they tend, rather, to appear as elements within an intricate constellation of relevant factors. Individually they can be seen both as the cause of certain identifiable problems, and as the result of others.

Factors Originating Outside the Mental Hospital

Inadequate Public Understanding and Support

The community expectations of what the hospital is supposed to do may differ widely from those entertained by the administrator. If the community wants to send to the public mental hospital all kinds of patients for whom no other disposition is apparent, and in whom mental illness may not be the sole, or even the primary, reason for referral, special staff and special facilities will need to be provided. Sex deviates, failing old folks, alcoholics, mental defectives, and emotionally disturbed children are some of the kinds of patients the community may wish to have confined.

Even when the expectations of the community and those of the administrator coincide, it is still possible for a patient to receive what the community considers poor treatment. The administrator fails when the hospital performance does not meet the community's expectation, or when it is not possible to alter the community's expectations to reflect the administrator's progressive efforts to offer better treatment. The community may not accept the hospital ("No decent girl would work there") or may accept it for the wrong reasons. It may be valued, for instance, principally as a source of additional income to local merchants.

When its presence in a community is resented and its medical function thought to be shameful, the hospital will experience unusual difficulties in establishing volunteer programs, in forming a constructive relationship with the press, in developing foster home care, and in bringing about community reintegration and productive employment of its patients.

Inconsistent or inadequate budgetary support may reflect the public's actual inability to defray the necessary costs of hospital operations, but more commonly results from lack of understanding or indifference. Or there may simply be lack of energetic efforts to find a way around the handicaps of an inadequate budget and lack of money in the community to support the hospital properly.

The administrator may find that essential tools and facilities needed to perform assigned tasks are lacking, making it impossible for him to do the job he knows how to do. Regrettable compromises and unsatisfactory half-way measures are the result.

Geographic isolation of a hospital, although not an insuperable handicap when counterbalanced by favorable departmental policies, can be an element in administrative inadequacy. Its very remoteness separates such a hospital from the main stream of public sympathy and from essential personnel resources. Exceedingly difficult operational problems are created when professional staff members in thinly manned categories cannot be recruited.

When a hospital is isolated geographically, physical separation from the flow of people seeking hospitalization for other than mental illnesses, as well as the lack of ready accessibility by public and private transportation, helps to perpetuate public fear of mental illness, and to hamper any interpretation of the hospital's proper mission. Distance from the community and cultural group that the hospital serves, remoteness from patients' families and from patients' places of employment, makes the supervision of aftercare, rehabilitation and casework difficult. When a mental hospital is successful in an isolated location, it is often at a great and unrecognized expenditure of energy and time.

For the isolated hospital, damaging public attitudes, damaging political developments, and damaging departmental policies may become unalterably set, if it is impossible to identify the forces of opposition early enough, or to interpret problems early enough for them to be understood and resolved.

Political Interference

An administrator may be forced to employ persons who are appointed as rewards for political service; and persons thus boosted into key positions may be incompetent. Also a political sponsor who is allowed to fill patronage jobs in a hospital may even support his nominees in refusal to accept administrative direction, thus making the exercise of authority and the discharge of responsibility impossible. Political appointments may also interfere with the promotion of persons who have demonstrated competence within the organization and who should justly be advanced to positions of higher responsibility. This is a circumstance even more detrimental to morale than the administrator's mere inability to provide tangible rewards for work well done.

The solicitation of campaign contributions from hospital employees by representatives of the controlling political party, or a preemployment "understanding" that a fixed percentage of the established salary is to be checked off as a party donation, is another example of the destructive political interference that has been experienced in the past and is not altogether eliminated from public hospital systems.

Political interference may take less flagrant form than this. Favoritism shown to suppliers of inferior merchandise; restrictive purchasing policies which prevent the hospital from obtaining needed equipment; failure to establish standards of quality for foodstuffs; and the employment in hospital construction work of second-rate architects and building contractors, as a reward for party support, are some of the indirect ways in which improper political practices can affect the hospital and contribute to administrative failure.

Partisan rivalries between political parties scrambling for credit for mental hospital improvements may also paralyze progress.

Governmental Infringement

The administrator may be left with little opportunity for essential decision-making. He may be unable to reward merit, weed out incompetence, or establish policies favorable to the development of organizational goals, not by reason of the extradepartmental political interference just referred to, but because his own superiors reserve these duties for themselves.

Legal and administrative policy at a central governmental level may be so medically unrealistic as to preclude the use of modern treatment methods, the establishment of profitable community relationships, or the development of hospital *esprit de corps.*

Other causes of faulty administration that are beyond the immediate control of the hospital director are: archaic commitment laws; cumbersome procurement regulations, particularly when the merit of the hospital's request is determined by lay officials not within the hospital's own authority; autonomous hospital architectural and construction divisions, unwilling or unable to profit by medical counsel in the design and planning of facilities for hospital use; and medically unregulated methods of food procurement.

Faulty Communication

When rapport is lacking between the administrator and the central authority, misunderstanding and inefficiency are almost inevitable. When rapport between the administrator and his staff fails, interpretation of the hospital's problems and needs to the community and to the central department is jeopardized.

A restrictive press policy, which prevents immediate and direct access to facts by qualified newspaper representatives, is another example of faulty communication that may prove damaging. The withholding of information may be on the insistence of the hospital administrator himself, or may be by order of the central mental health authority which may forbid the release of any statement to the press until it has been reviewed and approved.

In some institutional set-ups, it may be customary to "go over the head of the administrator" and thus undermine his effectiveness. Direct reporting of department heads to "higher" state authorities is an example of such "by-passing."

Failure on the part of the state medical society to understand the problem of the public mental hospital and the professional motivation of its staff may also stem from defective communication. The society may oppose needed legislation, prevent the employment of qualified physicians from other parts of the country, or impose handicapping licensure requirements, which serve to deny competent medical care to hospitalized patients, rather than to protect the public from poorly qualified practitioners.

Adverse Attitudes Toward Administrative Assignments

Many psychiatrists avoid positions carrying formal administrative responsibilities. This avoidance is not always due to their feeling of inadequacy in administrative situations or to genuine preference for other fields of professional activity.

Few medical schools and residency training programs encourage their graduates to seek careers in state hospitals. Some deprecate the public mental hospital as a place in which to secure training, and so do much to discourage young men from accepting positions of responsibility on mental hospital staffs. The *tacit* attitudes of faculty members in many schools also make it difficult for the student to weigh objectively the disadvantages of *all* types of professional activity—including those of private practice—against the real but varying advantages. *Thus, the student is hampered in* matching his preferences and personal needs accurately with his chosen career—*and the mental hospital may have less than fair consideration.*

Factors Originating Within the Hospital

Divided Authority

A common example of divided authority is the division of the hospital into business and professional autonomies. This is often defended on the ground that a medical administrator is necessarily unacquainted with the operation of steam generating plants, and that he will dilute his effectiveness in clinical areas, where he does have competency, if he must pay attention to the boilers. Such a division of authority fails, however, to take into account the fact that *all* functions of the hospital have an immediate or indirect bearing on patient-care. It is likely that co-equal administrators attempting to work toward a common goal will see that goal, subtly or obviously, in different ways. In the rare instances where they do work effectively together, it is not by reason of their administrative relationship, but rather in spite of it.

When dual administration is practiced, the establishment of clear-cut policy and the allocation of responsibility is particularly difficult for the many fringe departments, such as food service or housekeeping, which are not obviously clinical or clearly fiscal in character.

The assignment of patients in hospital industry constitutes another area in which divided authority at the top administrative levels creates almost inevitable difficulties. When such assignments are under enlightened medical direction, therapeutic goals can be effectively maintained. When, however, it is possible for a farmer to "order" a *corps* of "good patient-workers" from the charge nurse, "to get in my tomato crop," it is certain that production is being given a higher priority than treatment.

Even when an amicable working relation can be achieved between co-equal administrative heads of an institution, it is almost certain that conflicts between their subordinates will occur, since each looks to his own ultimate superior for final decision in controversial matters. The administrative heads must then divert an unwarranted amount of their own time to the resolution of constantly recurring crises that are generated by the administrative pattern itself.

Inept Administrative Patterns

There may be too many or too few department heads reporting to the administrator. In consequence, it may not be possible for information essential for organizational purposes to be transmitted, or for decision-making to occur.

Heads of hospital departments may not be responsible to the administrator, but instead may report to some higher control authority. Operational decisions made by individuals not in continuous touch with local needs cannot, in most instances, be harmoniously integrated into hospital policy.

Although appropriate safeguards of job security are essential to the effective operation of the hospital, ill-considered awards of tenure or unduly cumbersome administrative methods for the dismissal of unsatisfactory employees may compel the retention of poor workers with consequent breakdown in services, or the development of isolated power systems by individual units.

Some administrative patterns may adversely affect therapeutic goals. Housekeeping practices that are excellent in a hotel may be inappropriate in a hospital. The day hall that may not be entered for fear it will look disorderly, and the bed that cannot be used by a patient for a needed daytime rest, are examples. It may be important also to distinguish between psychopathology and sociopathology. Faulty administrative structure is a common cause for an individual's poor performance.

Failure to Delegate

Unless subordinates are given responsibility and commensurate authority for the accomplishment of their assignments, their contribution will not be maximal. Even when authority is properly delegated, sources of difficulty may lie in the administrator's failure to hold his department heads accountable for performance, or in his refusal to support decisions which they have made in good faith.

It is the job of the administrator to define and to co-ordinate the functions of his department heads. He insures that the policies they develop within their respective departments accord with or derive from the over-all hospital policy. Then the administrator leaves the departments alone to carry out their operations. He can become an obstacle to successful operation if he does not recognize where his decision-making and coordinating function ends and where other persons' responsibilities to "get on with the job" begin.

Even when the administrator of the psychiatric hospital derives satisfaction from his administrative role and is apparently willing to delegate medical authority, there are subtle and frequently unconscious devices by which its exercise may be restricted. For example, undue emphasis may be placed on environmental safeguards; or the director may decide, without reference to the clinical facts, that patients leaving the hospital without permission are to be sent to a closed ward on their return. Such policies are defended by pointing out the frequent necessity of subordinating the needs of the patients, and of the staff to those of society. Actually, the administrator's own needs are frequently paramount in such decisions. Another administrator, dealing with the same community attitudes and the same population of patients, might arrive at a different action from the same facts.

With mistaken altruism, a director may decide to share the medical burden of an overworked staff and temporarily "take over" direct responsibility for patient-care. The entire staff is immediately placed in an uncomfortable position. Physicians may hesitate to express medical opinions at variance with the director's. Even

though he naively maintains that on the wards he is just another doctor, his administrative authority has, in fact, been extended to the clinical area. His requests for laboratory examinations, social service reports, medical consultations, or office supplies are apt to take priority over all other hospital business. Members of the personnel find their established routines displaced, as each supporting department moves toward the efficient execution of one individual's request to the neglect of others which may, in fact, have greater urgency.

The deteriorating effect on hospital function when administrators fail to delegate medical authority properly has often been overlooked or minimized. It is perhaps not surprising that administrators have failed to face the reality of this situation, since the block in insight is usually due to their personal needs.

Improper or Poorly Defined Goals

The absence of clearly defined organizational goals with which the employee can identify is a common source of administrative ineptitude. Goals can be attained only when they are understood, and the chances of being understood are poor indeed unless they are clear in the mind of the administrator and are lucidly and repeatedly explained. For the majority, immediate objectives are more readily grasped than long-term purposes, and the wise administrator will sharply differentiate between the two.

Conflicting, inadequate or unclear goals may also be a cause of difficulty. For example, the protection of the public may consciously or unconsciously dominate all administrative decisions and find expression in all hospital policies. Employees whose primary orientation is toward the recovery and rehabilitation of the patient cannot wholly identify with the alternative purpose, and find it difficult to support the administration.

A more subtly disruptive difficulty arises out of the not uncommon tendency for a top administrator to give verbal endorsement to the therapeutic mission of the organization, but, in fact, to support only those practices which perpetuate a custodial—or even a penal—hospital atmosphere.

When goals change, confusion, misapplied effort and lowered morale will ensue, unless the administrator carefully and repeatedly interprets the new developments to all individuals concerned. They

may not be able to change. There may be no proper course open except to retire, with adequate financial benefits, persons who have served faithfully in advancing the earlier goals, but who cannot make the required change.

Consistent exclusion of the hospital staff from participation in the development of new programs and in identification with stimulating new goals not only cuts the administrator off from an important source of ideas and enthusiasm, but, when coupled with other faulty administrative practices, jeopardizes his continued effectiveness.

Goals require interpretation attuned to the understanding of persons asked to accept them. Their immediacy or remoteness is also of importance, when they are interpreted with relevance to any particular job. For some individuals, the only goals which have relevance are those that influence present practice. For others, a persuasively presented long-term goal can stimulate the capacity for idealization. Periodic repetition and restatement of goals is almost always necessary to insure action.

Factors Originating Within the Administrator Himself

Personal Inadequacies

The administrator may be deficient in the qualities of leadership that are essential to organizational solidarity. He may lack interest, or a sense of dedication to the established goals, and so fail to inspire others to join in the pursuit of these same goals. He may lack the courage necessary to defend his beliefs.

At times, the administrator's personal ambitions may be so compelling, outside of the organizational goals, that interest in the hospital is withdrawn.

The administrator may lack the ability to come to a decision, or may show indefiniteness of purpose, or inability to focus on a given problem. If he is personally insecure, his lack of self-esteem may make the discharge of a leadership role impossible. The fear of removal by whim of higher authority may undermine his effectiveness.

He may fail to take necessary action; and, when others, in a crisis, make decisions, he may disown them. He may be too easily influenced by outside pressures, or so inflexible that adjustment to

change is difficult. "My mind is already made up, don't confuse me with facts" calls attention to the individual whose rigidities separate him from reality. Such an administrator lacks the adaptive capacity to adjust to changing situations within his hospital.

The administrator may not have sufficient energy for the aggressive action needed to keep things moving. Through inertia, he may fail to discharge incompetent employees, or discipline those who are not doing their jobs properly. Frustration over the complexity of his task may rouse excessive anxiety, which culminates in an everpresent fear of failure. This anxiety infects others and often results in a loss of institutional morale.

Failure may stem from personality and character defects. The administrator may project the consequence of his faulty decisions onto subordinates or upon higher authority. Traits of sadistic aggression may lead him to punitive and repressive measures against his associates and subordinates, with distressing impact on morale and the achievement of organizational goals. On the other hand, pathological vacillation, with too much dependence upon others for decision, is equally ruinous.

Amoral trends in the administrator invariably undermine the respect in which he is held, and are peculiarly disruptive of group solidarity.

An administrator's neurotic need for approval may make him unable to accept the inevitable hostility consequent on his responsibility for decision-making. This results in fragmentation and eventual abandonment of organizational policy. Almost every leadership role imposes some degree of isolation that many find difficult to bear.

Mental or handicapping physical illness will, of course, interfere with his fulfillment of his job requirements. Old age may make him unable to meet the challenges of the day. There is an appropriate time for retirement.

Insufficient Training

His job may have been given to the administrator before he was ready for it. A knowledge of administrative techniques and a period of supervised training under a good leader are essential to success. Insufficient training and inadequate experience are formidable obstacles to success.

Excessive Reliance on Operational Directives

The administrator may seek to operate remotely by means of written orders, policy manuals, and printed rules of procedure; but personal interpretation and discussion with the persons called upon to carry out such procedures are essential. Remote direction rarely succeeds. The need for explanation and discussion occurs at all levels of the organization. As has been noted before, there must be, in any successful administration, appropriate communication and "feedback" of information.

Harmful as the lack of appropriate communication may be, overcommunication is also dangerous. At times, the administrator transmits his own anxieties and needlessly burdens his organization with problems which only he can solve.

Excessive Discipline Structured in Regulations

Overconformity or overdevotion to rules may lead to sterile formalism in the organization. Excessive discipline creates timidity, undue conservatism and emphasis on technicalities. While a reprimand or other penalty for failure to do an assigned task is sometimes necessary, it has been pointed out already that it is equally important to give praise or other rewards when the job is well done.

Each of the factors just touched upon has validity, not alone for the chief administrator, but for each member of the staff who carries administrative or supervisory responsibility. Of all sources of difficulty originating within the administrator himself, the most important appears to be his failure to delegate proper authority to those who work under his direction, with resultant by-passing, undercutting, overruling, or abandoning of his subordinates.

By-passing as a manipulative device may attain serious proportions when it is indulgently regarded by the administrator. For the insecure and inadequate administrator, it constitutes a means for holding the support of trusted staff members and for purchasing the allegiance of those who wield influential connections in the community. In the operation of by-passing, a favored employee, disliking a policy or ruling legitimately affirmed by an immediate supervisor, appeals to the administrator and is permitted to have the ruling countermanded, or to ignore it.

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3. The more effective the formal structure, the less reliance will be placed on gossip and rumor.
4. The supporting role of the informal system is positively related to the amount and extent of the identification of all individuals with the goals of the organization.
5. Informal structure assumes greater significance as the formal structure falters.
6. The subversive role of the informal system is negatively related to the effective management of problems within the formal system. The understanding of administrative relationships within the formal system tends to reduce the likelihood of subversive informal interaction.
7. When significant decisions and actions habitually derive from the informal system, the health of the formal administrative structure must be seriously questioned.

The informal organization, whether supportive or subversive, is a recognizable substructure within the larger framework of the hospital. It is commonly made up of a variety of more or less autonomous groups, whose composition may be loose and changeable or highly selective and carefully structured. Such groups form naturally around assignments in the formal organization; they may be made up of office workers, ward personnel, medical staff members, or maintenance employees. Persons working in propinquity with their fellows and sharing responsibilities for similar tasks, tend toward feelings of kinship and common interest. In-group loyalties may be associated with a sense of competitiveness which finds expression in healthy rivalry with other groups, or, alternatively, are associated with a sense of insecurity and suspicion which sees any outsider as a threat to the group's welfare.

Subgroups may form around personal interests, often of a social or recreational nature, with little emphasis on a person's assignment in the formal organization. Bowling, poker, music, and hobby groups are common examples. Subgroups, better classified as cliques, are also formed to emphasize and safeguard real or pretended status, while others are formed in protest at not having this status accorded them.

Insecurity, lack of competence, shared dissatisfactions, neuroti problems over authority, and other inadequacies or abnormaliti in individual personalities or in the organizational environmer may be sufficient basis for the development of additional inform subgroups. Members of these have less share in each other's sati factions and accomplishments than in their resentments and di couragements.

Leadership patterns in the informal organization vary fro the essentially leaderless subgroup to that directed by the chari matic individual whose influence approaches the absolute.

Under certain circumstances, anyone may attempt to use th system to promote his personal aims. When his understanding c human motivation is sufficiently keen and his manipulative ski well developed, his efforts may meet with considerable success.

A variety of reasons determine whether a person will ally hir self with a subgroup which is supportive of, or antagonistic to, th aims of the organization. Some reasons are fixed by the accident of geography and time, the intellectual level of the individual, an his social, racial, and religious background. Others derive from hi personality and may include frustration or friendliness, dissatis faction or tolerance, and hunger for power, or a humble determina tion to serve his fellow men.

A staff member given to projecting his own difficulties may vie the leader of a harmful group as persecuted by the formal adminis tration, and may identify wholly with him. Another may derive s much support from his association with a socially respected indivi dual or group that he unrealistically maintains his faith in an estab lished administration against all evidence of its manifest weakness

There is substantial evidence of the supportive and creative con tribution of spontaneous small groups. They provide an importan safeguard against management's blind-spots. Freedom from tyranny may be protected. The employee's status as a group member is botl a source of job satisfaction and of motivation to work towards or ganizational purposes.

Communication in the informal system may be confined to th subgroup or broadcast freely as rumor or gossip through what every body knows as the grapevine. When things are going well with th organization this grapevine channel is used primarily to clarify expand and humanize the information transmitted by official routes

The content alters when institutional matters are going badly. Not uncommonly, the wives of staff members are active in the transmission of both constructive and destructive information. Informal communications thus serve as a barometer in the assessment of public opinion and the general *esprit de corps* of the organization.

Sometimes—as just noted—informal communication is not constructive. For example, workers or messengers in an administrative area may overhear bits of conversation or fragments of discussion. Their tendency is to pass along their own interpretations as settled policy.

Both rumor and gossip are susceptible to secondary elaboration and distortion as they are transmitted. It is rumor, more loaded than mere gossip with hopes for what is possible or fear of what may be imminent, that is likely to suffer the greater embellishment, depending upon the abilities and needs of those transmitting the message.

In many hospitals, certain individuals enjoy a considerable reputation as rumor sources. They are often to be found in strategic locations through which many persons must pass. Telephone operators, particularly when they serve as receptionists or information clerks, are much in demand by people seeking the latest rumors. Countermen or cashiers in a hospital canteen enjoy a similar reputation. Key figures may develop a large following, with many employees dependent upon them—for instance in hospitals where there is no established routine for announcing pay days, holidays or inspections.

Some adminstrators unwisely use these key figures to circulate test rumors, in the hope of determining whether some proposed innovation is generally accepted as sufficiently sound to be established as formal policy. This device, which measures policy determinations against reactions to implanted rumor, undermines the administrator's formal organization and leads to capricious and unwise decisions.

An unhealthy, and regrettable, manifestation of the informal organization is the spy system. If one is developed for the convenience of the administrator, it is evidence of a poorly functioning communication system.

In hospitals operated under an autocratic philosophy of administration, a spy system is likely to be created by the staff. The where-

abouts and movements of all authoritative figures—the superintendent, the supervisor, the ward physician—are promptly noted; and information is efficiently transmitted from one area to another.

At one hospital it was observed that when the administrator left his home in the evening his dogs invariably barked their good-byes. Thus alerted, the telephone operator on duty watched to see into which division of the hospital the administrator drove his car and promptly transmitted the coded signal, "Laundry bag is being delivered," to the office of the supervisor concerned. If there was enough time, the supervisor then passed the word to the adjoining building by means of a flashlight, and from there it traveled from building to building.

At another hospital a psychotic patient was given a permanent seat at the bay window of the ward and charged with the responsibility of immediately notifying the attendant personnel when any person of importance appeared. He rarely moved his eyes from the appointed field of survey and developed a politician's knowledge of the names and faces of all visiting committee members associated with the institution. The vigor with which ward personnel resisted all recommendations for his transfer, and later for a trial visit, puzzled the authorities until the nature of his contribution to the ward service was uncovered.

Sycophancy, ego aggrandizement, or personal friendship may be the motivating force behind the transmission of significant information. For example, when the commissary department receives a shipment of choice stores, favored individuals at the hospital are often able to place their orders before a general announcement is made. Similarly, when an employment vacancy is anticipated, applications are sometimes received before there is public announcement of the opening.

Although an informal system may at times operate in a harmful manner within a reasonably well-administered organization, its full malignancy is realized only in hospitals where the administration is grossly at fault, and where distrust, uncertainty, fear, and jockeying for power are commonplace. A well-organized action group may then develop, operating underground and in secrecy. Institutional "civil war," although rare, may indeed occur.

When the medical superintendent of one hospital became ill and could not personally acquaint himself with what was going on in

the institution, the business manager took over. A political appointee on the staff relayed to the state capitol, on specific orders from the governor, information which was deliberately calculated to remove the business manager from office. This appointee attracted a personal following among the staff who anticipated his eventual nomination as business manager.

As the conspirators gained strength, they became bolder in their operation. They filled obscure crevices in cafeteria tables with molasses to attract cockroaches. Several days later, when photographers appeared, they banged the tables in appropriate places to show the presence of the vermin. Pots and pans were pounded with hammers; kitchens were put in a state of disorder; and ragged patients' underwear was used to wipe kitchen pots. New linens and bedding were removed and buried in the hospital dump so that the lack of reserve supplies could be cited as evidence of poor management. As a consequence of these activities, the political appointee became the new business manager.

Later a counter-movement developed with the aim of removing *him* from office. By careful observation, his vulnerable areas were detected. One of these was carelessness in filing purchase orders and in reading what was presented to him. Capitalizing on this weakness, the action group ordered a ton of pepper and an enormous quantity of tomato catsup. The business manager was subjected to considerable derision when these fantastic quantities were delivered and subsequent investigation revealed his error. He was dismissed shortly thereafter.

Relationships between the formal and informal systems of organization are restricted and indirect at the highest administrative level, since the superintendent is automatically excluded from direct contact with the informal system because of his position.

He has, however, indirect access to it by a number of channels. It is likely that his executive committee will contain persons who, in their own right or through subordinates or secretaries, are in direct contact with one or more subgroups in the informal system and are reasonably well acquainted with its attitudes.

Interdisciplinary meetings of an informal nature, which deal with common problems in the conduct of organizational affairs, are a particularly rich source of information on the informal organization. They serve not only to acquaint the administrator with trends,

sentiments and previously unexpressed opinions, but also provide him with the opportunity of introducing a certain amount of corrective information into the informal communications system.

The administrator's own secretary will, of course, remain a constant source of communications from the informal system. The validity of her data must, however, be carefully weighed, since information which the secretary receives will ordinarily have been given with the expectation that it will reach the administrator.

Through membership in fraternal organizations, service clubs and church groups in the community, as well as through his various social activities, the administrator will have frequent opportunity to note the ramifications of the hospital's informal organization. And he will not be long in office before he has occasion to observe the startling familiarity shown by the patients with all phases of the informal system, and with its most confidential communications.

The nature and quality of formal ties between hospital and community will vary, depending on geography, local culture, the level of interest in collaborative effort and other factors. Whatever the pattern, an informal relationship is inevitable. Members of the hospital's board of trustees and some, at least, of the employees will have roots in the community, and will be regarded by their neighbors as responsible sources of information on hospital affairs.

Volunteers working at the hospital, community organizations sponsoring hospital drives, students, relatives of patients and visitors all develop impressions of the staff and of the institution's function. These views and attitudes, transmitted to associates in the community, strongly influence opinion in general, and determine in no small degree the community support which hospital programs receive.

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Psychiatric Principles Behind Administrative Techniques

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CURRENT PRACTICES IN MENTAL HEALTH ADMINISTRATION. American Psychiatric Association, 1700 18th St., N.W., Washington 9, D.C. This book is a compilation of 22 articles which appeared in *Mental Hospitals* from March 1956 to June 1957. The series covers vital areas of knowledge for the psychiatric hospital administrator and includes such topics as organization, medico-legal problems, budget, public relations, supply, physical plant, and training programs. There are also chapters on the psychiatric unit in the general hospital, the private psychiatric hospital, and hospitals for the retarded.

Stanton, A. H., and Schwartz, M. S.: THE MENTAL HOSPITAL. Basic Books, New York, 1954. Stanton and Schwartz base their book on a research study carried out in a small mental hospital; important principles emerge as determinants in hospital administration.

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Anderson, R. C.: "A Function of Administration, Psychiatric Treatment." *Bulletin, Menninger Clinic,* 19 (5), September 1955. This paper is a summation of elements of administration with reference to the social processes involved.

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Paterson, T. T.: MORALE IN WAR AND WORK. Max Parrish, London, 1955. An account is presented of function and role on an air force base in wartime. This is the first account of the author's theory of authority which he is now developing.

SYMPOSIUM: PREVENTIVE AND SOCIAL PSYCHIATRY. Sponsored by Walter Reed Army Institute of Research, Medical Center and National Research Council, April 1957. Superintendent of Documents, Government Printing Office, Washington 25, D.C. This is a 529-page verbatim report of a symposium covering the following topics: Communication of values, influence and group structure, ecology and epidemiology of mental illness, industrial psychology and psychiatry, significance of leadership for the mental health of groups, social psychiatry in the community, and development of a therapeutic milieu in the mental hospital.

Caudill, William: THE PSYCHIATRIC HOSPITAL AS A SMALL SOCIETY. Commonwealth Fund, Harvard University Press, Cambridge, Mass. 1958. An anthropologist studies intensively the social structure of a 50-bed psychiatric hospital and attempts to relate the complex interactions of patients, staff and institution to behavior and therapeutic outcome.

Group Dynamics Within the Hospital Setting With Examples of Methods and Techniques

Boag, T. G.: READING LIST ON SOCIAL FORCES IN THE MENTAL HOSPITAL. Supplementary Mailing to Mental Hospitals, May 1954, Mental Hospital Service, American Psychiatric Association, 1700 18th St., N.W., Washington 9, D.C. Twenty references to pertinent articles are given here.

Greenblatt, M., Levinson, D. J., and Williams, R. H.: THE PATIENT AND THE MENTAL HOSPITAL. The Free Press, Glencoe, Ill., 1957. A lengthy book presents the papers and discussions of a conference on socio-environmental aspects of patient-treatment in mental hospitals. Psychiatrists and social scientists participated. The book is divided into four sections: mental hospital organization and its implications for treatment; therapeutic personnel; the ward; and the patient and the extra-hospital world. The discussions encompass philosophy, theory, practice, and research, with reference to many facets of the problem of the patient and the mental hospital.

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Jones, Maxwell, and Rapoport, R.N.: "Administrative and Social Psychiatry." *Lancet* (London), 269:68-86, August 20, 1955. This paper reviews Stanton and Schwartz' book, THE MENTAL HOSPITAL, and uses it as a basis for reviewing the dynamics behind group processes.

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Robinson, A., and Man, J.: "Praise, Blame and Gossip." *Nursing Outlook*, 2:644, December 19, 1954. This article describes the origins and effects of some aspects of the informal structure of the hospital.

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The Group for the Advancement of Psychiatry has a membership of approximately 185 psychiatrists, organized in the form of a number of working committees which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations. GAP is an independent group and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

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