Tussen professionele autonomie en wederzijdse aanpassing
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BETWEEN PROFESSIONAL AUTONOMY AND MUTUAL ADJUSTMENT:

An analysis of multidisciplinary teams in a psychiatric centre: their rise and development in relation to the changing organizational structure since 1841 and their present functioning.

This study focuses on the structuring of psychiatric centres in the Netherlands, particularly the functioning of some multidisciplinary treatment teams within a psychiatric centre in the north of Holland.

With the aid of the generally applicable research instruments developed by us (see ch. 9) we show how the relations within and the functioning of multidisciplinary treatment teams can be described and evaluated systematically. In doing so we base our evaluation on the theory presented by Mintzberg (1979, 1983), which can be characterised as a kind of contingency approach.

Our theoretical standpoint is, that the structure of an organization, by which we mean "the sum total of the ways in which it divides its labor into distinct tasks and then achieves coordination among them" (Mintzberg, 1979, p.2) can be the consequence as well as the cause of certain contingencies.

By taking this view our standpoint differs from the contingency approach which states that the optimal structure of an organization is dependent or contingent on factors such as the environment, the technology, or its goals. We share with the contingency approach the view that there is no one best way to organize. The structure of an organization depends on the interaction between the organization and its relevant contingency factors. Moreover, "formal structures evolve in organizations much as roads do in forests - along well-trodden paths" (Mintzberg, 1979, p.11).

In order to trace back these "well-trodden paths" along which the organizational structure of a psychiatric centre has evolved, we thought a historical analysis of the "birth and development" of the Dutch psychiatric centre necessary. By so doing we hope to give an outline of the dynamic and interdependent relations between distinct structural and contextual characteristics, the actions of persons/groups and the way these interrelations have influenced and continue to influence treatment. In addition we make some recommendations regarding the direction towards which the organization may develop and predict the consequences of certain contingency factors (e.g. an increased regulation of the authorities) upon the structure, and consequently upon the treatment of psychiatric (in)patients.

The two major contingency factors we have analyzed are the environment of the organization and the power relations in and around it.

By considering power - i.e. "the capacity to effect (or affect) organizational outcomes" (Mintzberg, 1983, p.2) - as a major contingency factor we have tried to meet an important objection against the contingency approach. Namely, against the "one way traffic" between contingency factors and the structure of an organization. By employing certain forms of power, individuals and groups are able to influence the structure of an organization as well as certain aspects of its environment.

Next to power the environment of the organization as a major contingency factor is analyzed in relation to its structure, whereby we view technology - the knowledge and skills necessary for the treatment of psychiatric (in)patients - as part of that environment.
Three interdependent main features should be recognized in our study, viz.:
- the rise and development of the organizational structure of the Dutch psychiatric centre;
- the rise and development of psychiatrists as professionals and of other (professional) disciplines in the operating core, i.e. the multidisciplinary (treatment) team;
- environmental and power factors.

Furthermore we trace how the most important present coordinating mechanism functions in practice. Namely mutual adjustment by informal communication, effectuated through multidisciplinary teams and their patient oriented meetings (ch. 11). We also analyze aspects (from 'the past') which impede/further this functioning. The study concludes with some recommendations for further research regarding the possibilities to eliminate the obstacles that block the effective functioning of this coordinating mechanism (ch. 12).

The rise and development of the organizational structure of the Dutch psychiatric centre.

Our analysis begins in 1841, the year in which, by virtue of the first Dutch Insanity Law, the basis was laid for the specific medical in-patient services in the Netherlands. We describe the very simple structure of the private asylum (paragraph 2.1), and the somewhat less simple structure of the parish and municipal asylum (par. 2.2.), with as their most important parts: the operating core (the custodians) and the strategic apex (the owners). These were sometimes complemented by a middle line manager (the superintendent) and a medical practitioner as an adviser for somatic problems (the support staff). Coordination took place by standardization of behaviour and direct supervision.

We then delineate how - due to governmental measures, one of them being the 2nd Dutch Insanity Law of 1884 - the private asylums disappeared and the parish and municipal asylums were restructured mental institutions.

The most important characteristics of this structure were (ch. 3): the clustering of the enormously increased population of patients into groups based on sex and on the extent of rest (for the poor patients) or financial strength (for the better situated) and with their own custodial persona (the operating core). Because the different categories of patients and their custodians were housed in separate buildings the strategic apex could not directly control the work anymore, and so the middle line had to be enlarged.

At the level of the strategic apex there was a struggle for power between the church or municipal commissioners and the nerve doctors, which at the beginning of this century was decided in favour of the latter. This meant that the commissioners became a part of the External Coalition, and that the nerve doctor could restructure the mental institution to a psychiatric hospital, modelled after the somatic hospital (par. 3.2. and ch. 4). This found expression in the massive introduction of the bed-treatment.

In addition two different structures emerged: an authoritarian and hierarchical structure to which the non professional members of the organization were subjected, and a horizontally and vertically decentralized structure which benefitted the professional nerve doctors.

The overall management of the hospital and the maintenance of contacts with groups from the External Coalition were left to a colleague: the medical director.

In chapters 5 and 6 we consequent to the introduction of the medical treatment methods (the bed-treatment). The nerve doctor was an important member of the fairly autonomous department of the hospital. His working relationship with his fellow professionals (mutual adjustment) could change due to certain social circumstances.

In chapters 7 and 8 we analyze the organizational structure of the present structure of the hospital. This meant not only a change in the work to be done, but also in the way of doing it: differences for each of the medical specialties (and for some new or renewed related disciplines) the organizational structure of the hospital. This meant not only a change in the work to be done, but also in the way of doing it: differences in the organization of the psychiatric institutions.

In chapters 9 and 10 we describe the present structure of the hospital. Ch. 9 describes the present structure of the hospital. Ch. 11 traces the most important present coordinating mechanisms.
In chapters 5 and 6 we describe the further development of the organization consequent to the introduction of several more or less effective medical-psychiatric treatment methods (the insulin coma therapy, the electro convulsive therapy, etc.). The nerve doctor was now really able to treat patients and became the most important member of the operating core, as well as the highest manager of his, fairly autonomous department within the greater organization of the psychiatric hospital. His working method could be characterized as the application of a particular pigeonholing process, whereby coordination with his colleagues (through mutual adjustment) could be limited to a minimum.

Due to certain social changes after the Second World War and the introduction of some new or renewed treatment methods and disciplines in the operating core (ch. 7) the organizational structure of the psychiatric hospital was gradually altered to the present structure of the modern psychiatric centre. This meant not only a further differentiation and a more complex coordination of the work to be done, but also that these restructuring processes could turn out differently for each organization, depending on the specific circumstances (e.g. opinions about the most desirable methods of treatment, internal and external power relations, the psychiatric 'infrastructure' in the region, etc.). Thus it became possible for psychiatric centres (or parts of them) to differ in structure. In ch. 8 and 10 we describe the present organizational structure of a psychiatric centre, starting from the organization researched by us (see par. 10.3.).

Ch. 9 describes the framework of this research and the ways by which the data were collected. Ch. 11 gives an analysis of some of the data in relation to the most important present coordinating mechanism: mutual adjustment.

The rise and development of psychiatrists as medical professionals and of other (professional) disciplines in the operating core.

A central theme in our study is the analysis of the rise and development of the discipline of psychiatrist from a subordinate medical doctor to a dominant and autonomous professional. This is due to the fact that the profession had a considerable influence on the direction in which the organization developed.

The delineation of obtaining professional dominance is done notably according to the ideas of Freidson (1970).

In ch. 2 we describe how at the end of the 19th century the medical practitioner with the aid of the State through both Insanity Laws became an indispensable part of the mental institution. This notwithstanding his lack of knowledge and skills to treat psychiatric disorders.

We proceed our analysis in ch. 3 with a description of how at the end of the past century the nerve doctor - unlike his colleague in the somatic hospital who had obtained this status due to his successful interventions at the operating table - became a dominant and autonomous professional. This implied, that the nerve doctor himself could determine and control the contents of his own work and that of related disciplines. In addition, the management of the entire patient population including various material and immaterial matters which could overexcite their brains came within the specific medical expertise, and thereby within the specific area of control of this new autonomous profession.

Thus the mental institution could be restructured 'on medical grounds' in a direction which better fitted the needs and interests of the nerve doctor, namely in that of a somatic hospital where all patients were lying in bed (par. 3.2.). The custodians were now trained as nurses following the model of the somatic hospital, thereby
they received somewhat better status.

Ch. 4 and 5 are dedicated to the positions of the various disciplines in the organization and the management of it at about 1910. Here we look at forms of power the various 'parties' could mobilize in order to gain influence in the organization. The expert power of the nerve doctor was especially reinforced by the introduction of some new medical-psychiatric treatment methods by 1920. In addition different ways of thinking about the origin and treatment of psychiatric disorders emerged, which were incorporated in the existing pigeonholing process. However, this also meant that various nerve doctors in the same hospital could, on the basis of different theoretical insights, apply a different pigeonholing process, resulting in markedly different kinds of treatment (par. 6.2).

Due to the introduction of a number of professional or professionalizing disciplines to the post-war psychiatric hospital who claimed parts of the work of the nerve doctors and nurses, the professional hegemony of the former was set under pressure, and some of the more attractive aspects of the work of the latter were attacked (ch. 7 and 8).

As a consequence of the introduction of drug treatment (par. 7.1.5.) a growing number of patients could be submitted to other forms of (non)verbal therapies. This led to an expansion of the number of disciplines in the operating core, and the emergence of the multidisciplinary treatment team at about 1950 (par. 8.2.1.). Because the knowledge and skills of the various disciplines cannot be precisely circumscribed, a struggle over each other's domain exists, which led to a gap between the so-called inner core (the psychiatrist, resident, and nurses) and the peripheral team (nonverbal therapists, psychologist, and social worker). We describe this in par. 8.2.1. and ch. 11.

Environmental factors and factors of power.

This main feature bears upon the interplay between the organization and two for a psychiatric centre most important contingency factors, viz. its environment (including technology) and the power in and around the organization. Furthermore, we analyze how far certain characteristics of structure are in line with these contingency factors.

We describe how by means of the Insanity Laws of 1841 and 1884 the government gained influence upon the private, parish, and municipal asylums and the consequences this had for the position of both the medical practitioner and the function of the asylum (ch. 2 and 3). We also pay attention to a few social factors which were conducive to gaining autonomous-professional status by the medical practitioner.

Ch. 4 contains a description of the internal shifting of power in the psychiatric hospital around the turn of the century and the relation between the Internal and External Coalition.

In ch. 5 we go into some technological changes in psychiatry which took place before the Second World War and the influences these changes had upon the psychiatric hospital and the medical profession. We state that different technologies could co-exist and that the Dutch Psychiatric Association as part of the External Coalition exercised a great influence on whether new technologies could be accepted in practice (par. 6.3.). The technological aspect of the environment was thereby 'stabilized' and adapted to the existing organizational structure and the pigeonholing process (par. 6.2.). In other words, the technology became subordinate to the professional autonomy.

After the Second World War a social and scientific reorientation took place with major consequences for the structure and the power of the organization (ch. 7 and 8). In ch. 9 an analysis is made of the structure and the power of the multidisciplinary psychiatric centre. We present some functioning of multidisciplinary teams, as well as their functions and the difficulties they face (par. 7.1.5.).

In ch. 11 we present a functioning of multidisciplinary teams, as well as their functions and the difficulties they face (par. 7.1.5.).

Our main conclusions are that the treatment complex and its various members were due to the strivings of the various disciplines to protect their domains of influence which did not leave intact the functional domains of the individual therapeutic discipline. Consequently, the unclear rapidly changing environment made the task of the organization of the psychiatric centre difficult for at least a few years thereafter.

It is therefore necessary to present some suggestions for improving the functioning of multidisciplinary teams, as well as their functions and the difficulties they face (par. 7.1.5.).

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major consequences for psychiatry and the psychiatric hospital. We describe these in ch. 7 and 8. In ch. 9 and 11 we discuss the repercussions of these developments for the structure and the power relations with respect to the organization.

In ch. 11 we present some results of our empirical investigation of the present functioning of multidisciplinary teams during their patient oriented meetings in a psychiatric centre. We present some findings of our research concerning the present functioning of the coordinating mechanism 'mutual adjustment' within the operating core.

Our main conclusions are:

- since the treatment tasks are at the same time horizontally specialized, complex and interdependent, coordination of these tasks performed by the various members of a multidisciplinary team by mutual adjustment is called for:
- due to the strive for maintaining/obtaining professional autonomy the participants in patient oriented team meetings are inclined to give that information which does not threaten their own professional autonomy, or which underlines the importance of the occupation's share in the treatment;
- consequently the information given remains superficial, the decisions taken leave intact the freedom of treatment of the various disciplines and the individual therapeutic strategies are insufficiently integrated;
- the unclear rapidly changing technology, the sharing of knowledge and skills, the difficulty of (quantitatively) measuring the results of the treatment given, and an insufficient mutual knowledge of each others therapeutic skills plays an important part in this. Thus it remains unclear which knowledge and which information of which discipline(s) at which stage of the treatment is needed the most.

It is therefore necessary for the various disciplines to explicate their working methods, possibilities and 'ideologies', and that this is brought to bear on the treatment policy of the ward and the (problems in) interdisciplinary teamwork. Furthermore, the head of the ward should function more as an integrator than as a hierarchical line manager.

We further stated, that a friction exists between the decentralized horizontal structure of the primary process (the treatment) and the centralized vertical structure of the administration. This may lead to conflicts within and between teams, as well as between the operating core and the management which may be fought by political means. This applies also to the defending of autonomy (individual-professional as well as of the entire team) against an increasingly regulating government.

Lest the organization of a psychiatric centre ends up as a Political Arena (Mintzberg, 1983) we think it necessary for a reorientation to take place. In ch. 12 we give some suggestions how this can be done.