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THE PROCESS OF FORGING LATERAL LINKAGES: A HOSPITAL EXPERIENCE

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Introduction

One of the major problems facing organisations at the level of their operations is that of integrating the work of different units. This has for long been the concern of practising managers and organisation theorists. A number of responses have been thought of. Better planning and control systems have been evolved to serve as integrating machanisms.[1] Structural devices such as Likerts' 'Linking Pins'[2] stressing the facilitation of inter-group processes have been suggested. Lawrence and Lorsch[3] have demonstrated the necessity to identify differentiated organisational structures for their management and to find means of integration for the purpose of working towards overall system goals. An important contribution has been Galbraith's[4] classification of lateral integrative devices within an organisation, from informal direct contact to matrix structures.

The report presented shares the experience of inducting lateral integrators in a voluntary hospital. It describes the background and the process of introducing newer forms in the existing structure of the outpatient services area of a 700-bed hospital. Lessons from the experience are also presented.

The Out-Patient Services (OPS)

The Director of Shanti Hospital was facing a problem with the patient service areas in the hospital. These were the In-Patient Services, the Out-Patient Services, the Operating Theatre and the Emergency Services. There were complaints from patients and staff that things were not well. Patients spoke of long waits in the OPS and insufficient attention in the wards.

The medical and nursing staff complained of inadequate or inappropriate material in the theatre, wards and in the OPS. Linen, gloves, drugs and patient records were some of the items pointed out. The supportive service staff (such as maintenance) were blamed for not attending to requisitions promptly. In turn, the health professionals were blamed for lack of understanding of the problems of other departments and wanting things that were simply not available. In conversationswith the patients and the heads of department, the Director got the impression that the patients still came to the hospital because of its reputation for dedicated staff and concern for the patient. There seemed to be a general feeling that the situation was changing unfavourably.

The Director was in any case thinking of taking a critical look at the way the entire hospital functioned. Since this would mean a great deal of time, thus delaying action, it was felt that a pilot study and action programme could start with the OPS.

With regard to the OPS, the patients said that they spent a long time in the hospital before they returned home with medicines. The doctors complained that the number of missing patient charts was on the increase- so they could not trace the history of the revisit patients. The Medical Records Department (MRD)* argued that several charts were indeed missing from the library since doctors took them out for research and did not return them for inordinately long periods. The nurses also did not return all the OPS charts after the clinics closed at noon. The Pharmacy group felt that if the Accounts speeded up its cash collection procedures, patient flow would be smoother; Accounts was of the opinion that the pharmacy had to tone up its pricing procedures

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* MRD has a library of patient records in the form of personal charts.

The OP Services functioned from 8.00 AM until noon. Registration started at 8 and closed at 11 AM. Patients waited for the counter to open before 8 O'clock. At the counter, new patients registered as fresh cases and got an OP card and a Personal Chart made. Old patients on a revisit obtained their charts on the basis of their OP card. The charts were retrieved from the medical records library. On paying the registration fee, depending on his symptoms, the patient was directed to the concerned clinic such as Medicine, Surgery, Skin etc. The chart was sent through an attender to the clinic. The nurse in the clinic stacked the charts in the order of their arrival time. Once the doctors arrived in the clinics, the patient was examined by them with the assistance of the nurse. The prescription was then taken by the patient to the Pharmacy, X-ray or Laboratory as the need may be. He purchased the medicines prescribed and left. If an X-ray or lab test was involved, he would go through the procedure and then leave, to return subsequently to collect the investigation report. If he was unable to pay for the services, he was interviewed by a medical social worker, who made his assessment of the financial condition of the patients and forwarded his recommendations to the Medical Superintendent who made the final decisions. (See Appendix 1 for a chart of the patient flow).

It was decided to study the OPS organisation which was responsible for the orderly and fast flow of patients and the delivery of quality services. The study showed that deficiencies existed in the structure, systems and processes of the OPS. It established that patient waiting time was the longest at two of the counters. The causes could be traced broadly to three sets of problems:

(1) Those relating to intra-group systems and processes.

(2) Those relating to the inter-group interface between two departments and processes of resolving conflicts.

(3) Those concerned with the organisational structure of the OPS as a whole.

The first set included problems such as absence of a monitoring and follow up system within the MRD for charts; inappropriate scheduling of doctors' time between OP and inpatient services; lack of communication within a department; inadequate staffing pattern etc.

The second set comprised of problems such as the absence of a system of priority for maintenance personnel in the OP area; absence of rules and regulations governing the use of charts by others; absence of mechanisms to route inter-departmental communication for problem solving etc.

The third set was constituted of problems such as lack of means to operationalise the goals of patient care and satisfaction within the OPS; inadequate supervision; the overload on the existing management hierarchy etc.

It is the third set of problems and specifically the consequence of the overload in the existing structure that shall be the focus of this report.

There were 26 functional departments involved in the OPS area of the hospital. The departments could be broadly classified as:

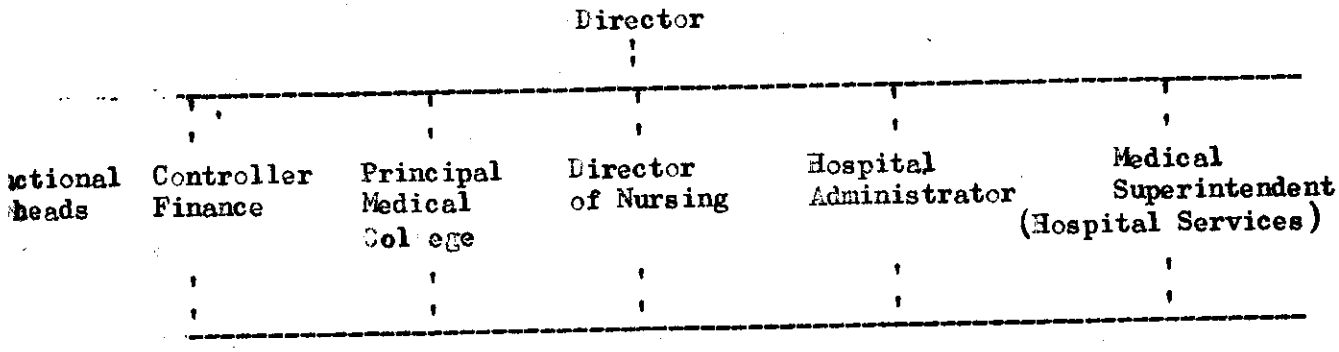
(1) Medical - Medicine, Surgery, Peediatrics etc.

(2) Nursing - Nursing Service and Education

(3) Paramedical - Pharmacy, Laboratory etc.

(4) Supportive - Maintenance, Accounts, Personnel etc.

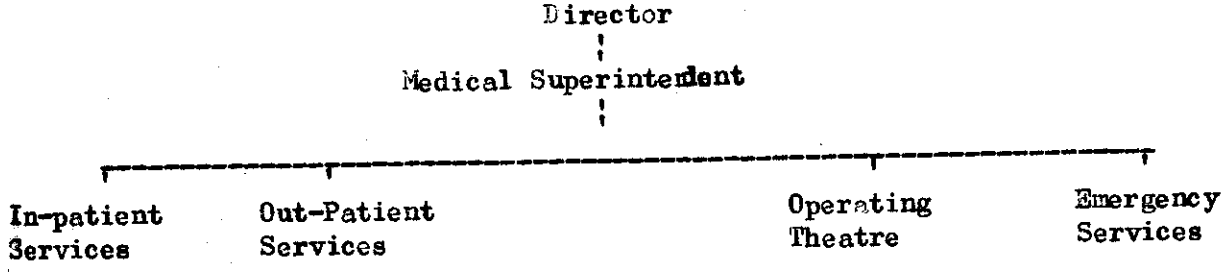
All of the 26 departments reported directly through their heads to the Medical Superintendent, who was the executive head of the OP Services (see figures below).



Heads of Departments

Functional Reporting Relationships Chart

Figure 1



Hospital Service Areas Responsibility Chart

Figure 2

As can be seen from Figure 2, the Medical Superintendent was the executive head of the total hospital services. Moreover, in the present case, he was also a head of a medical department (Opthalmology) and personally attended to at least 20-30 patients a day during 3 days of the week; performed operations on 3 days and taught medical students in the clinic and in the college whenever necessary.

One of the most serious problem areas was the day-to-day administration. Difficulties could arise due to the two sets of problems outlined earlier - systemic imbalances due to intra-departmental or inter-departmental deficiencies in problem-solving or work procedures. There were 4 avenues open to a member of a department who encountered a problem in his daily work: (1) Resolve it within the departmental group (2) Confront the concerned member of another group if necessary (3) report to his head who then took up the problem with the head of the other department alleged to be the problem source (4) report to his head who in turn took up the matter with the MS.

Since reporting to the MS was difficult due to his preoccupations with other service areas, clinical practice and teaching, the usual choice was to pursue the second or third alternative in the case of inter-departmental matters.

Both of these alternatives were easy when the hospital was smaller in size, offered fewer services and had fewer staff. With 400 patients a day and 26 departments, the criss-crossing of communication (or the lack of it) had led to compartmentalisation and attack-defence postures.

It was felt that a first step to respond to the problem would be to conceive of an integrating mechanism for 'lubricating' the system. The urgency was also due to the fact that patients and their escorts were quick with agitated complaints and anxious queries whenever anything went wrong. Not that the staff were less unhappy. Both of the groups could easily express their dissatisfaction while in the OPS area itself.

The first integrating mechanism decided upon was a new role, that of the OPS Coordinator. The second was a standing committee, called the OPS Committee.

The Coordinator was to ensure the smooth day-to-day operations of the OPS. To this end, she was to listen to patient complaints and initiate action for their investigation. She was to supervise patient traffic, identify bottlenecks and get the concerned departments to work towards removing them.

This was seen as a strictly 'facilitator' role where the Coordinator would actually be coordinating the process of problem-solving by getting the relevant parties together. She would have no authority over the departments she coordinated. To perform in this role, it had to be a person with a low key, 'not forceful' style of working with people. It would also have to be someone acceptable to the groups involved so that they consent to being linked to one another by this person. The choice was made in consultation with all the groups. Many of them seemed to be quite clear on the kind of 'non-threatening' person they would want. The management was anxious that, while the person

could be competent inter-personally, results would have to be shown soon and so, in their view, assertiveness could not be ruled out. It was finally agreed that it would have to be a person generally acceptable to the groups and one who is capable of persevering at the task of pushing others to the discussion table. The person would also have to know the OPS intimately. Specific names were suggested by the management to the groups and after formal and informal consultations, an experienced Nursing Supervisor was appointed.

It was also felt that the OPS coordinator would need help with recurring problems. These had to be studied in detail and alternatives for change outlined. An OPS Committee was formed for this purpose. Just as in the case of the coordinator, the OPS Committee was not an authority structure. Yet, it claimed the regard of all in the OPS due to the professional and interpersonal competence of the members. They were middle-level officers- 3 doctors, 1 nurse, 1 social worker and 1 administrative officer in charge of some of the supportive services. The OPS Coordinator was the secretary of the Committee. It met once a week and discussed its studies, findings, and recommendations. These were forwarded to the Medical Superintendent for approval and implementation.

A sample exercise of the Committee is described briefly below. Since there was a great deal of cross-fire between the Medical Records Department and the clinic personnel, the OPS Coordinator decided to confirm the allegations of the parties concerned. She found that indeed both had some substance to their complaints. The charts were taking a long time to reach the clinic after the patients' arrival. Many of them were also missing. Since an immediate solution to this was not possible, she

referred the problem to the OPS Committee.

The Committee found that the maximum time taken to retrieve an old chart was as high as 45 minutes. Since a well-ordered chart library ought not to take long for retrieval, the Committee inquired further to find that an effective monitoring system which is the mainstay of a library was needed. Information on charts leaving or entering the Records Department was not available. A system was devised in consultation with the department. For its continued use, the system required the formulation of rules and regulations for users such as medical and nursing staff and follow up action on the part of the Records Department Staff. An outline of rules and regulations and a note on follow up action were prepared by the Committee and given to the Coordinator. The Medical Superintendent was invited to a subsequent meeting of the Committee and the matter discussed with him. He accepted the suggestions and after discussions with department heads, announced the policies for use of the Records chart library and also requested the Records Department to implement the monitoring system and follow up action. The Coordinator ensured through her presence and persuasion that the rules and the monitoring system were in fact put into practice in a sustained manner. Three months of intensive follow up brought the maximum retrieval time down to about 30 minutes. (It was 17 minutes a year later)

A six-month review of the changes in the OPS offered the following salient experience:

(1) There was complete acceptance of the new role of the coordinator. Complaints had reduced during the period. More significantly, it was

noted that complaints were being posed as problems by the concerned departments. Heads of departments received 75% fewer complaints of the OPS from their own staff since these were routed to the OPS Coordinator. (2) While there was acceptance, there was not a total satisfaction with the role. Due to the pre-occupations of the Medical Superintendent, some decisions of a short term nature were not made. Consequently the Coordinator could not satisfactorily respond to some of the departmental concerns. An illustration may be the scheduling of use of public space in the OPS area. Requests were forwarded to the Medical Superintendent who had the authority to sanction the use. Delays in getting this approval caused hardships to the departments in planning their activities.

There was a feeling among the departments that some of the powers of the Medical Superintendent could be delegated to the Coordinator. The Coordinator also felt that though her functions could best be carried out without formal authority, there was a need to examine the issue of discretion. According to her the quality of patient care could be enhanced if powers of some of the general aspects of the OPS could be given to her. For instance, other than decisions on use of common space, there was the question of furniture in the cooridors, in the clinics and other patient waiting areas. Any repair or replacement now had to be effected through some department or the other even though none of them claimed the furniture as part of their departmental assets. Or it had to be done through the general housekeeping department which had the entire hospital to worry about

As a consequence of this review, it was decided to initiate a small budget for the OPS to be operated by the Coordinator. Depending on specific issues, the Medical Superintendent agreed to authorise the Coordinator to take decisions on some matters which required immediate action on a request and involved no major financial outlay.

(3) The morale of the OPS Committee varied directly with the rate of recommendations accepted and implemented. Some of the members, in the 'low days' spoke of the need for authority ("We need teeth to bite into the set-up" "Who listens to advice? Sometimes you have to force things" were some comments heard). In examining this, it was found that the problem was one of the group not receiving clear communication from the management on its importance and on follow up action taken by the management on recommendations. For instance, in the Records Department Case, the committee had completed its study in 10 days. The Medical Superintendent, however, took two weeks to respond to the study and another month to announce the policies.

Two steps taken were rewarding in this context: (1) a monthly review of the work done and publicising of the same to attract organisation-wide attention to changes in the OPS. (2) a monthly feedback session with the MS and the Director in which the Management discussed recommendations and shared its perceptions of the possibilities and constraints.

(4) The members of the Committee also felt that it could be a useful forum for developing an organisational rather than departmental perspective. Thus, many others could be given a chance to participate in this, either through cooption or rotation of membership. However, this

could wait until a year's experience.

(5) The Coordinator relied on the Committee to discuss a number of issues which she felt uncertain about. She stated that she found this sounding board function very useful in her starting period. She was now beginning to gain confidence to act on her own.

(6) The Coordinator and the Committee members unanimously felt the need for skills in problem analysis and collaborative studies. The health professionals' training involving the understanding of symptoms, diagnosis and prescription helped in their approach to problem solving. However, a managerial perspective was felt necessary.

The management responded by offering the services of a professional manager to work with the Coordinator and the Committee for a period of time so that there could be live demonstration of the problem solving process.

(7) Yet another development, not articulated but latent, was discernible. Increasingly, the problems studied pointed to the more basic one of faulty planning. While short run problems had to be sorted out, there still remained the need for preventive action and hence systematic planning.

C Discussion

The hospital seems to face all the difficulties of growing with a functional orientation and not responding adequately to a service area orientation. A functional organisation is trying to cope with the confusion of increasing services and volume of users. The question before the management appears to be one of dealing with the variations

due to differentiated functional segments in order to perform patient centred tasks. The OPS integrators seem to be small, important steps for the management in answering this question.

Lateral or horizontal linkages are a way of strengthening the ability of the system to process information.[5] Direct contact between persons or liaison devices between two departments may serve as possible links in an operational area of smaller size. The large number of services and departments involved in the OPS area required a stronger link. The two mechanisms - Coordinator and Committee were to fill the gap of information processing and action created by the functional diversity and the inability of the structure of management hierarchy to provide the coordination.

The category of integrators conceived of by Galbraith[6] that comes closest to the Coordinator is the 'Integrating Role'. Without formal authority, the Coordinator was to move the concerned departments towards solutions optimising the use of resources within the OPS area. In this task, she was to interpret groups to one another and work with more than twenty of them, cutting across technical and administrative lines of reporting. A more managerial role, with authority would have had little chance of success in a hospital setting composed of dominant professional groups. There is a caution in the hospital organization experiences that even the Chief Executives, unlike those of industrial enterprises, will need to play a role that is more facilitative rather than directive.[7]

The introduction of the integrating role required legitimisation and support from two groups: (1) the groups that were to be linked and (2) the management hierarchy. With their expectations likely to be different (as in this case where the management looked for a more assertive style), it seems essential for the choice of integrator to emerge from negotiations. Such opportunities offer a forum for a discussion of the criteria of choice and then looking for the best fit. Later, formal legitimisation followed through establishing the reporting links of the Coordinator with the Medical Superintendent.

The Coordinator was responding to the imbalances arising from daily operations. To lend a longer time perspective to the solving of OPS problems, an OPS Committee was resorted to. The Committee's tasks were in line with a 'research and advice' function. The question arises whether this was the most appropriate step. From the text, it does seem that the OPS Committee, in fact, acted partly as a task force. It took up specific problems and found ways of solving them. The management could well have appointed temporary task forces, their lives being limited to the completion of the given, specific task. Depending on their accomplishments and results, thought could have been given to a more formal permanent committee.

However, the Committee was conceivably of great help for the Coordinator due to the 'passive' nature of support of the Medical Superintendent. In the initial period of carrying out a difficult task, she found the committee a welcome consultative body. In this sense, the committee acted as a staff advisory body to the Coordinator. A task force may

not have helped her in this manner. In the search for lateral structures supportive to an integrating role, there needs to be a consideration of both the requirements of the task and the peculiarities of the organisational setting.

It also appears that, for lateral linkage roles to be effective the formal management systems have to be examined vis-a-vis the role. The overload on the Medical Superintendent was reduced by resorting to the integrating mechanism. However, the absence of a reappraisal of his role and functioning created problems for the Coordinator. Similarly, moving from a functional to a service area orientation would require the integration of formal systems of planning, reward and evaluation across functions.

The OPS Committee's dilemma seems to stem from the group's own search for a place in the organisation. Being used to formal structures and clearly defined technical tasks, the sudden exposure to tasks of data gathering, analysis and advising on solutions involving the participation of other work groups could be disturbing. The Medical Superintendent's preoccupations did not help in responding managerially to this situation. The Director had to be brought in to fill the gap. The response of 'rewarding' the committee through public recognition and constant feedback helped to tide over the uncertainty.

It would seem that while the management creates advisory cross-departmental teams, it would need to give timely support and feedback on the teams' performance if they are, in turn, to support the new integrator's role.

The trends towards training, cooption of other members and membership by rotation suggest that the Committee was moving more towards what Zand[8] calls a 'collateral organisation'. A collateral mode is a complement to the hierarchical mode of problem solving and is characterised by the use of knowledge rather than the use of authority and openness to enlist the participation of anyone with the resource of knowledge or skill to help in problem solving. Linkage with the formal hierarchy is however crucial since it is the hierarchy that must accept and implement the collateral organisation's ideas. The Director will have to decide on specific ways of bringing about this linkage in the context of a Medical Superintendent, whose attention is diverted from OPS. This is necessary if facilitator groups are not to be too anxious about their role.

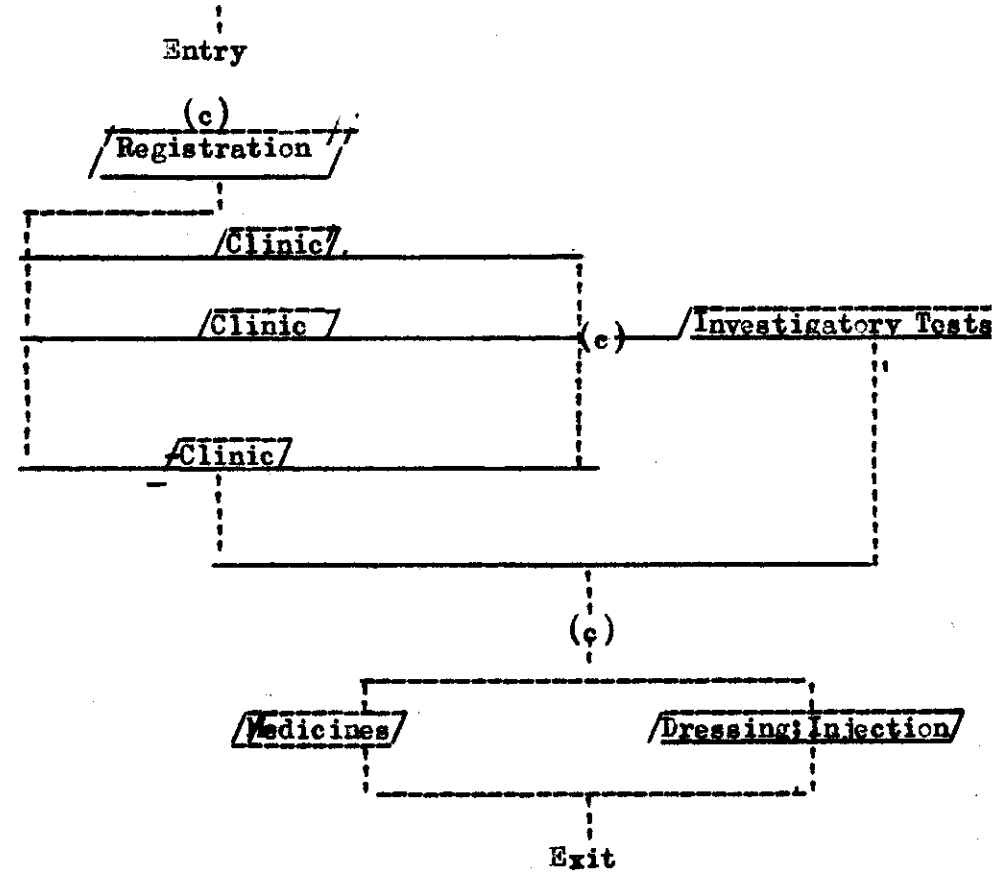
There is certainly a suggestion of the Coordinator moving from an integrating role to a more managerial one.[9] The move to allow for the allocation of some authority to the Coordinator and the desire of the management to think of better planning for the service area are likely to increase the area of influence of the Coordinator in the future. She would still have no authority over the departments at work in the OPS area. The range of diversity available in the OPS area may necessitate a more managerial and less facilitative role than the integrating role of the OPS Coordinator as initially designed. However, given the complexity of professional and other groups involved in the service area and the means of creating inter-dependent forms for better patient care, it would seem best to plan any enlargement of the role in stages after careful reviews.

Conclusion

An attempt has been made to review the process of creating and introducing integrating mechanisms through the role of a Coordinator and a Committee in the Out-Patient Service area of a hospital. This is part of an effort of the hospital to devise lateral linkages across functional specialities as it focusses attention on its service areas. The review suggests that certain conditions that take into account the nature of the organisation and its particular setting are necessary for the forging of effective lateral linkages. It also suggests that an appraisal of the functioning of the management hierarchy would still be crucial for the successful functioning of the integrating mechanism.

Appendix 1

Patient Flow in the OPS Area



[1] Registration included preparation of OP card and patient-chart for new patients and retrieving the old chart for the revisit patient.

[c] Cash payment required for registration, investigatory tests, medicines or minor treatment.

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