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Staff Relations in Psychiatric Hospitals

By AGNES MILES

Summary. This study is concerned with the roles of doctors, nurses, occupational therapists and social workers in psychiatric hospitals, as perceived by members of these occupations. Fifty-one respondents from three psychiatric hospitals were interviewed. Information was sought concerning the ways respondents evaluate (a) occupational importance, (b) occupational competence and (c) inter-group contacts. Most respondents regarded the occupational importance of psychiatrists as being higher than that of the non-medical occupations. There was, however, disagreement among the various groups regarding their specific roles and areas of occupational competence. Existing inter-group contacts were evaluated as much less satisfactory by non-medical staff than by psychiatrists.

Background and Aims of Study

Advances in medical knowledge, skills, and technology have brought about a proliferation of specialist occupational groups engaged in the treatment and care of the sick. In modern hospitals, departments of occupational therapy, physiotherapy, psychology, social work, speech-therapy and many others have been set up, staffed by workers with specialist skills. The presence of new occupational groups and the recent changes in the functions of the old occupations of doctors and nurses, have created a complex division of labour in psychiatric hospitals (Freidson, 1970).

Modern treatment programmes in psychiatry frequently require multidisciplinary participation (Jones, 1962; Martin, 1962), and representatives of the various occupational groups have often stressed the need for teamwork. But this current mood of co-operation does not necessarily mean that agreements have been reached on the ways in which members of these occupations should collaborate (Miles, 1972).

Studies of work situations in large organizations have shown that members of various occupational groups develop certain perceptions of occupational roles and form typical and specifiable interpersonal relationships. Beliefs held by members of different occupations about each other are likely to influence patterns of co-operation among them. (Hughes, 1958; Pavalko, 1971; Vollmer and Mills, 1966)

So far, little attention has been paid by researchers to the ways in which members of different occupations interact in psychiatric hospitals (with the notable exception of the study by Zander *et al*, 1957). Not enough is known about the factors that influence agreement and this is especially regrettable since staff co-operation, or the lack of it, may seriously affect the treatment of psychiatric patients (Stanton and Schwartz, 1954).

The aim of the present study was to obtain information on the ways in which members of different occupational groups:

1. evaluate the importance of their own occupation relative to others in the treatment process,
2. claim for their own group areas of general and exclusive work competence and,
3. evaluate the extent and nature of inter-group contacts.

Method of Study

Members of four occupational groups were included in the study: doctors, nurses, social workers and occupational therapists, 51 respon-

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dents in all, drawn from staff of three psychiatric hospitals.

Information was collected from them in depth interviews lasting on average about three hours. A slightly structured programme was used, consisting of topics to be covered during the interviews; respondents were also asked to rank occupations according to certain criteria and to name colleagues with whom they had working contact.

TABLE I
The Sample

	Male	Female	Total
Doctors ..	6	—	6
Nurses ..	4	12	16
Social workers	3	14	17
Occupational therapists ..	—	12	12
Total ..	13	38	51

All doctors were consultant psychiatrists. The 45 non-medical respondents worked with the patients of the six consultants.

Only those nurses, social workers and occupational therapists were asked to participate in the study who had been employed in psychiatric hospitals for at least three years and whose occupational gradings were above the student/assistant/trainee status.

The 17 social workers and 12 occupational therapists of the sample represent the total staff of these categories in the three hospitals. The 16 nursing respondents were drawn from six wards which were in the charge of the six participating consultants. Two psychiatrists and three members of the nursing staff declined to participate in the study.

Occupational Importance

The formal occupational aim of the health professions is to heal the sick; the formal organizational goal of psychiatric hospitals is the treatment of psychiatric patients (Caudill, 1958; Greenblatt *et al*, 1957; Stanton and Schwartz, 1954). To elicit information about perceived occupational importance and esteem, respondents' evaluation of the importance of their own and other occupational groups in the treatment process was sought. All respondents were asked to rank the four occupational groups according to how important they thought the contribution of each was to the treatment of psychiatric patients.

Of the 51 respondents 44 were willing to make such a ranking. The other seven were non-medical workers whose view was that all members of the health team were of equal importance. The most interesting feature of the ranking was that both medical and non-medical respondents were united on one point; all 44 emphatically said that the psychiatrists made the most important contribution. After such an unanimous vote for the medical profession, respondents tended to disagree on the ranking to be accorded to other groups. The doctors all regarded nurses as second only to themselves in importance, an opinion shared by the nurses, while social workers and occupational therapists ranked themselves equal second with the nurses.

Asked to elaborate on the ranking, most respondents said that without doctors there would be no treatment of patients, and consequently hospitals would not exist: only doctors could diagnose disorders and prescribe treatment. Nurses were considered important on the same basis: respondents said that hospitals could not function without nurses but could carry on without social workers and occupational therapists.

During the interviews, non-medical respondents expressed great respect for medical knowledge and medical training. (See also Katz, 1969; Zander *et al*, 1957.) Some of them also expressed regret that they themselves had not entered medical training on leaving school, and they regarded their own occupation as second best. Most non-medical workers said that working with the doctors was of benefit to themselves, providing opportunities to keep up with the development of modern medicine.

These responses were made by personnel from all three non-medical occupational groups. However, six respondents from these groups said that the doctors' function was no more important in the hospital than other health occupations, they all contributed to the treatment which could not be performed by any one group alone. These respondents felt that the

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TABLE II

Importance accorded to occupational groups by respondents

Ranking made by	Ranked first				Ranked second				Ranked third			
	Dr.	Nr.	SW.	OT.	Dr.	Nr.	SW.	OT.	Dr.	Nr.	SW.	OT.
6 Doctors	6	—	—	—	—	6	—	—	—	—	3	3
13 Nurses	13	—	—	—	—	13	—	—	—	—	3	10
13 Social workers	13	—	—	—	—	7	6	—	—	6	7	—
12 Occupational therapists	12	—	—	—	—	5	—	7	—	7	—	5

status of all health occupations should be the same and it was only the 'undue pride' of the medical profession, made possible by their powerful position and by the 'meek acceptance' of this by many health workers, that insisted on differential status. The respondents who expressed this view were the three male social workers, two male nurses and one female social worker.

Possibly, this pattern of responses is influenced by the sexual composition of the occupational groups. Traditionally, the medical profession has been a largely male occupation and the helping, non-medical workers, female. (Etzioni, 1969; Krause, 1971) This is slowly changing, but it still remains the overall position. Of the present sample all the consultant psychiatrists were male, whereas nearly 85 per cent of the other respondents were female. It is of interest to note that the importance of the medical profession was emphasized predominantly by female respondents and that the few who considered as equal medical and non-medical personnel were nearly all male (6 out of 7).

Thus, a main dividing line, between the medical profession on one side and all non-medical health occupations on the other, was acknowledged by the majority of interviewed personnel. A hierarchy of the non-medical occupations was not found in the responses.

OCCUPATIONAL COMPETENCE

It is not the practice of psychiatric hospitals to define the exact functions of the non-medical health workers. Given this absence of formal organizational rulings many tasks are performed by certain personnel because they wish to, or for historical reasons, i.e. they have done so in the past. Thus, tasks performed by a particular occupational group in one hospital, may in another be performed by a different group.

Respondents were asked for their views as to the specific competence which their own occupational training enabled them to contribute to psychiatric patient care.

A distinction was made between an occupation's 'area of competence' and its 'area of exclusive competence'; the former being knowledge and skills possessed by an occupational group in common with other groups, the latter, the knowledge and skills possessed by the occupation alone.

The six doctors interviewed expressed similar views. For them, the medical profession has exclusive competence in diagnosing illness, prescribing treatment, administering certain types of treatment and assessing patients' reactions. In addition, they claimed a general, though not exclusive, competence in all aspects of treating and caring for patients, holding that theirs is the ultimate responsibility which they could not undertake unless they they were competent to supervise, and in extreme need to perform, all activities concerned with treatment and care. This is a very important point, with far-reaching effects on inter-group relations in the hospitals: the doctors denied the possibility of exclusive competence for any health occupations other than the medical profession in any part of the treatment process.

The non-medical workers largely agreed with the doctors in regarding diagnosis, prescription and assessment of treatment effects and certain therapeutic skills as being the exclusive province of the medical profession. Many of them, however, emphatically disagreed with the second claim of the doctors, to have general competence in all areas of the treatment process. Respon-

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dents from all three non-medical occupations designated definite areas of exclusive competence to their own occupational group.

The nurses said that caring for the sick, the day-to-day management, physical enviroment, feeding and keeping clean of the patients were exclusively nursing skills and that doctors would be unable to carry out the tasks involved. Social workers maintained that they alone had knowledge of the patients' family and home environment, and of their bearing on the patients' illness; only they had a comprehensive understanding of community resources. Occupational therapists claimed that within the hospital's workshops only they possessed the competence to maximize the patients' ability to work and be active.

The doctors spoke with warm appreciation of the skills of these workers, but 'exclusive' competence was denied and medical supervision insisted upon.

There was another source of disagreement between the doctors and non-medical workers: some of the latter wanted to participate in the treatment programme in certain ways not acceptable to the doctors. This appeared most sharply during interviews with social workers. They expressed the view that their training equipped them with knowledge and skills that were not made use of in the treatment process; that talks with patients about their families, work and environment and the consequent personal relationships formed with them should be recognized by the doctors as having a definite therapeutic value and that taking the social histories of the patients also came within this category. This point was made by 13 out of the 16 social workers interviewed. Similarly, nurses argued that as most psychiatric patients are physically well and do not need nursing care in bed, the function of nurses is to take part in the treatment process by using their daily contact with patients therapeutically. Occupational therapists said that their training includes skills to develop interpersonal relationships amongst the patients, and that by the skilful arrangement of working groups and the selection of group or individual work tasks they could contribute to the treatment programme.

Clearly, in the hospital setting, where all activities centre around the treatment of patients, an occupational group gains importance the more it participates in this central activity. Some of the non-medical workers specified their interest in therapy as being an attempt to increase the standing of the occupation, others spoke of it in terms of personal work satisfaction.

The doctors showed themselves very much aware of these claims. More than one remarked that every health worker wanted to 'play doctor'. They made the point though that the functions of non-medical workers were to relieve doctors of some caring and administrative duties and to assist them by performing certain tasks, not to try to participate in clinical treatment, for which, according to medical opinion, these workers are not equipped.

In their efforts to broaden their area of work, the non-medical occupations clash not only with the medical profession but also with each other. Certain skills and tasks (e.g. 'therapeutic relationships' with patients, discussions with members of their families, developing patients' work-potentials) were claimed by more than one group to be their province.

Inter-group Contacts

All respondents were asked about the frequency of their contacts with members of the other occupational groups and whether they wished for more contact or not. The answers showed that the doctors had far more contact with personnel outside their own occupation than did any of the non-medical workers. The six doctors mentioned an average of 14 names, from the three non-medical groups of the study, with whom they considered that they had frequent work contact and close co-operation. In contrast, members of the non-medical groups mentioned an average of 5 names as regular work contacts from other occupational groups. This result confirms previous findings by Coser (1962), Wessen (1966) and Zander *et al* (1957).

The doctors expressed most satisfaction with the existing situation; although half of them said that ideally they would like to spend more time with their non-medical colleagues and discuss patients' progress, details of treatment etc, they all thought that it was only pressure of

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work that prevented them from doing so. They felt sure that the others were eager to co-operate more closely with them, if they, the doctors, could afford the time.

The non-medical groups all felt less satisfied with the existing situation than did the doctors. This is not surprising: lower status groups usually feel more dissatisfied with existing inter-group relationships than do higher status groups. From the responses of these workers it seemed that the psychiatrists were quite right to feel that more frequent contact with themselves would be welcomed. The majority of the non-medical workers, in fact, said that they would like to work more closely with the psychiatrists and felt that the doctors concerned could afford them more co-operation if only they thought it worthwhile. There were four non-medical respondents who did not agree with this majority view: they said that the extent of their contact with the psychiatrists was adequate, although the nature of the working relationship was unsatisfactory. All four of these respondents were males.

The various non-medical groups were far less eager for increased contact with each other: fewer than half of them (20) said that more co-ordination between these groups would be desirable. The non-medical groups in fact seem to have remarkably little contact with each other and that usually in the presence of doctors. Non-medical workers may meet each other at formal conferences, but other meetings, for example between occupational therapists and social workers, do not seem to be part of the usual work pattern. Indeed, when non-medical respondents were asked when they last discussed a patient with a member of another non-medical occupation, 22 of them could not remember such an occasion. The six doctors had no wish to change this situation: they did not regard discussions between various non-medical personnel as useful in the absence of the doctors.

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