

Managing the Care of Health and the Cure of Disease—Part I: Differentiation

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The clinical methods used in health care and disease cure are easily understood. Yet when combined into institutions and broadened into social systems, the management of them becomes surprisingly convoluted. Part I of this article presents a framework to help understand how this happens.

Why are the so-called systems of health care so notoriously difficult to manage? No country appears to be satisfied with the current state of its system; almost everywhere reforms are being contemplated, organized, or implemented, some in direct contradiction to others. Each is claimed to make the system more responsive to user needs, yet most are really designed to bring its component parts under control—particularly financial control. Still, nothing fundamental ever seems to change.

The obvious explanation is that this is one of the most complex systems known to contemporary society. Hospitals, in particular, are considered to be extraordinarily complicated organizations. Yet when considered one element at a time, their complexity seems to fall away. Put differently, even the most intricate medical intervention, no matter how difficult to execute, can be easily understood by the intelligent lay person. True, a good deal of the technology of medicine is “high.” But most of that is delivered in small, disconnected applications. (Compare all this with the operating processes of a nuclear power plant.) Why, then, does everything become so convoluted when these elements are embedded in an organizational context, and these organizations, in turn, are woven into a social context? Why is overall social control of this system so enormously difficult to effect?

Key words: *differentiation, integration, health care management, health care organization, health care system*

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This article is based on a variety of small research interventions. These include: the observation of a range of health system managers from the chief executive of the National Health Service in England to practicing clinical directors; visits to a wide variety of health system sites, and a series of seminars over several years conducted with the support of the King Edward's Hospital Fund for London. Our deep appreciation goes to the many thoughtful people in the English system, including those of the King's Fund, who participated in these experiences. We do not have the space to acknowledge all the individuals and groups who have contributed to this work, but we wish to mention the following who have been especially helpful: C. Karel Musch and his group in the Netherlands, Richard Higgins, Richard James, Anton Obholzer and members of the TMP Learning Set in the UK, Charles McDougall, Stephen Herbert, Harold Frank, and Lise Lamothe in Canada, and Jo Ivey Boufford in the United States.

We address these issues by introducing an integrative framework designed to help sort out this complexity. In our view, the “world” of health care has, in fact, long been differentiated into four different worlds—four sets of activities, four ways of organizing, four unreconciled mindsets. So long as these remain disconnected, in our opinion nothing fundamental will change. Our intention here is not to propose definitive solutions to these problems so much as to promote a new mindset whereby they can more easily be solved.

In Part I, we begin by identifying these four worlds, discussing the characteristics of each, especially their differentiation, and considering some of their dynamic relationships. Then in Part II, we address the fundamental management problems in the system, and in so doing, seek to stimulate more creative discussion of possible solutions.

FOUR WORLDS

Consider first the so-called acute care institution, the hospital. Management here is not one homogeneous process but several, usually quite distinct from one another.

We can identify these by distinguishing where management is practiced. Some people manage primarily *down*, directly into the clinical operations—that is, focusing on the treatment of patients. Others manage *up*, toward those who control and/or fund the institution—state agencies, insurance companies, and the like. Moreover, some management is practiced *in*, to units and people under clear control of the institution, while other management is practiced *out*, to those involved with the institution but technically independent of its formal authority. Put these together, as in Figure 1, and you end up with four quadrants of activity in the hospital—the four worlds to which we have referred.

In the bottom left is the world of *cure*—formally that of the medical community, which functions through its arrangement of chiefs and committees. They manage *down*—into the operations—but *out*, because the physicians do not report into the hospital’s hierarchy.

Supporting this, shown to its right, is the world of *care*, provided especially by the nurses, who function within their own hierarchy of authority, but also other specialists who provide basic care. Since that connects directly to the hospital administration, nursing and other care management can be described as *in* but also *down*, again focusing on the delivery of patient services.

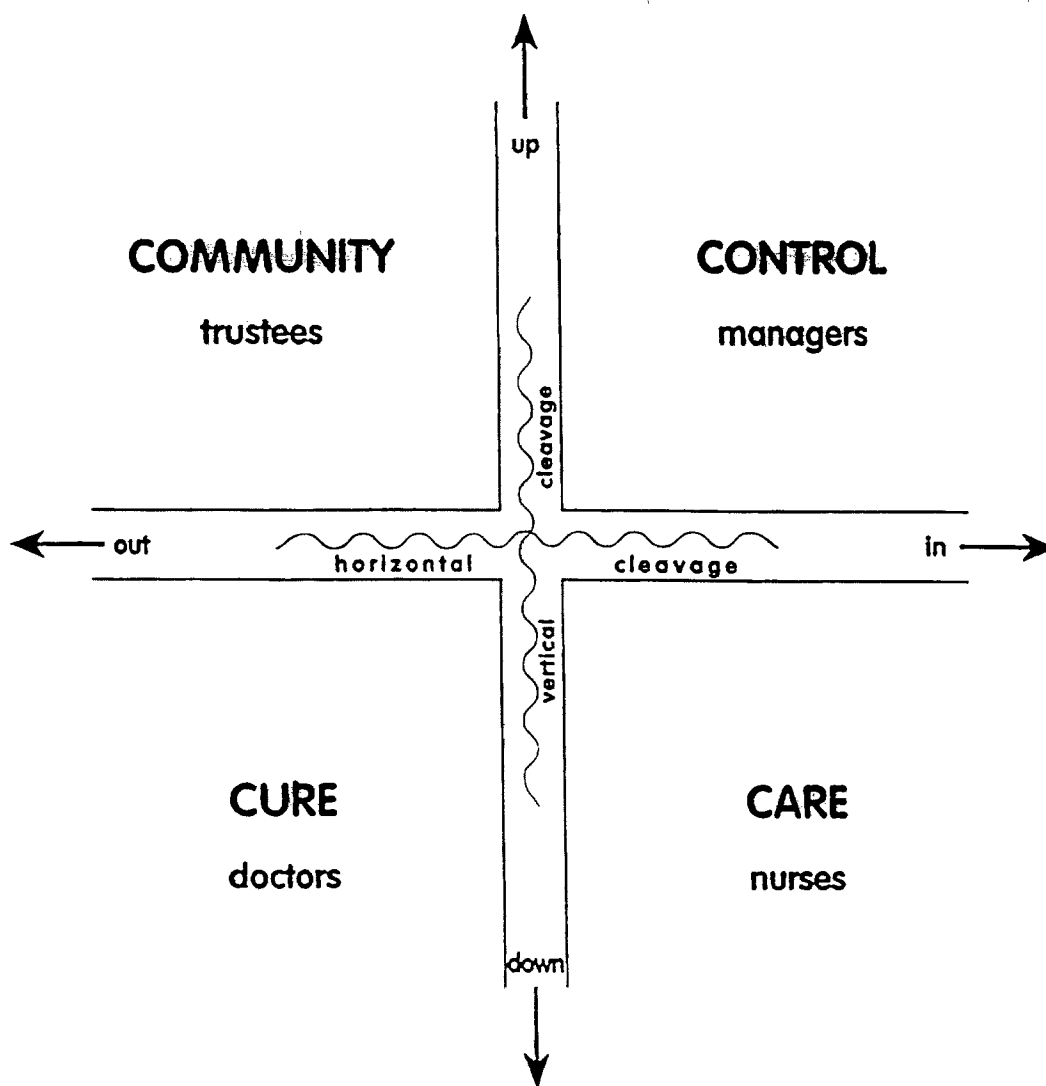
In the upper right is shown the world of *control*—that of conventional administration—most decidedly *in*, since the managers here are ostensibly responsible for the entire institution, but also equally clearly *up*, since they are also removed from direct involvement in the operations.

Finally, in the upper left is the world of *community*, formally represented by the trustees of the hospital, informally by those people who volunteer their efforts to it. They are neither directly connected to the hospital’s operation nor personally beholden to its hierarchy—they, in other words, are both *up* and *out*.

Cure, care, control, and community—physicians who look clinically down but act administratively out, nurses who likewise look down but remain in, managers who remain in but are forced to look largely up, and trustees who remain out and look up. (We wish to thank Karl Musch of the C3 Consulting firm in Holland for providing us with the idea for the first three of these four Cs.) The hospital ends up being not one organization but four, as each part structures itself in an independent way. Consider the words of an anesthesiologist during one of our interviews about his role in open-heart surgery: “When we take the clamp off . . . that is my moment. The shock can make the patient’s heart arrest and I am standing over him, like John Wayne, with a syringe in each hand, thinking ‘God I hate this bit!’ But when I look back, I say ‘God I love this bit!’ because it’s anxiety but there is very immediate reward. The patient arrested 20 minutes in total but we got him back. I get a tremendous reward out of that.” No care, no control, no community, just cure.

In particular, the system tends to rupture itself along two lines, as shown in Figure 1. A *horizontal cleavage* separates those who operate clinically, down into the system, from those who do not, but instead work up out of it, creating the “great divide” in health care. Underneath are those who respond to professional requirements as well as technological imperatives, while above are those sensitive to the needs for fiscal control. And a *vertical cleavage* separates those intimately connected to the institution, such as the nurses and the managers on one side, from those involved but not so formally committed, the physicians and the trustees, on the other.

Now consider the overall system in society, to which the same matrix can apply, simply bumped up one level, as shown in Figure 2. Cure is represented by the acute hospital itself, highly specialized to focus down on the delivery of services to the acutely ill yet itself somewhat beyond direct public control. Like their physicians, hospitals are not in the business of health

FIGURE 1**FOUR WORLDS OF THE GENERAL HOSPITAL**

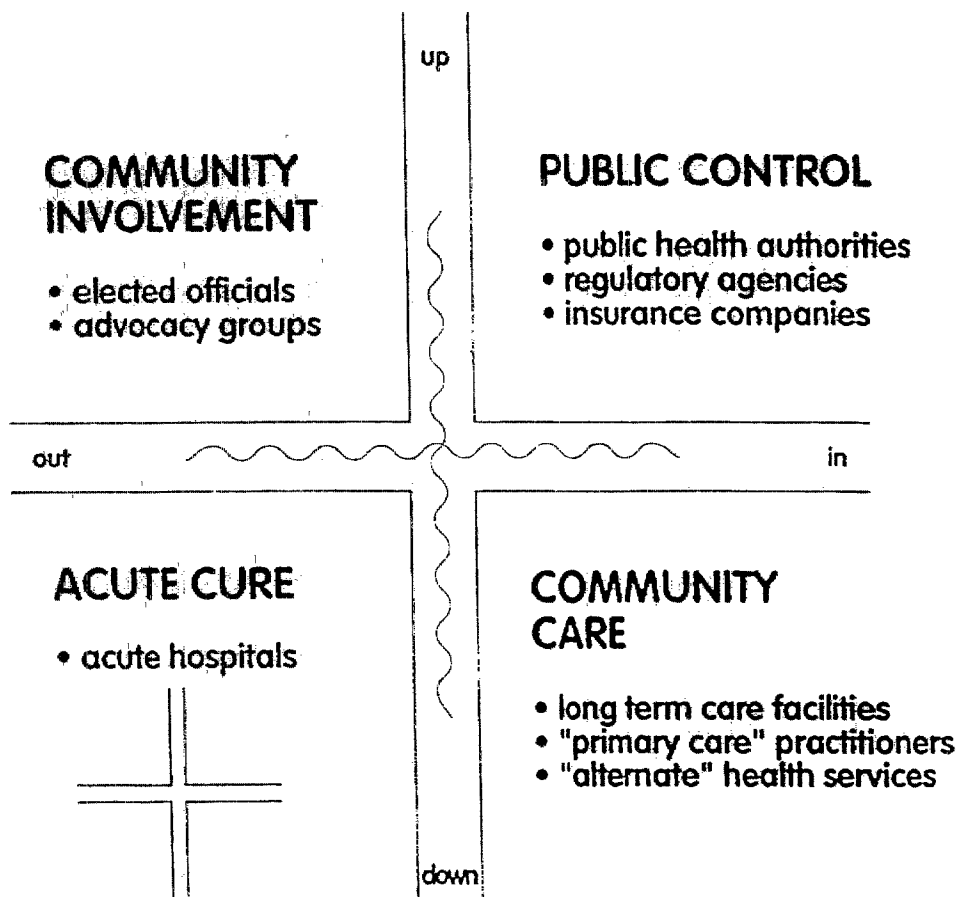
care but of disease cure. Such care, shown on the lower right, is in fact provided in society by a myriad of other institutions and specialists (often under the label of "community care"): long-term mental and geriatric hospitals, various home services, deliverers of "primary care," such as general practitioners and community health clinics, and other specialists, such as dietitians and independent physiotherapists, as well as the whole array of so-called "alternative" health services, such as chiropractic, midwifery, naturopathy, and

acupuncture. All focus down to the direct delivery of service to the public, and by the very nature of their practice may be less isolated from the recipients (perhaps explaining the label *community care*). In this sense, they may be more "in" than the acute hospitals.

Control at the societal level comes under the responsibility of administrative agencies charged with regulation of one sort or another, whether public health authorities in state systems or insurance companies in private ones. If the overall system can be

FIGURE 2

FOUR WORLDS IN SOCIETY AT LARGE



thought of as being managed at all, they come closest to so doing. Like the managers of the hospitals, they work above the services they are supposed to control, but within the overall system of the health care.

Finally, at the society level community is represented by the elected politicians and advocacy as well as advisory groups of various kinds. They seek to exercise influence but neither from within the system's institutions nor by the direct delivery of their service—in other words, like the hospital trustees, they are up and out.

Our main contention in this article is quite simple: To the extent that these four remain as disconnected worlds, in hospitals as well as society at large, the system rightly called health care and disease cure will continue to spiral out of control. Put differently, no

matter how necessary these divisions of *labor* may be, in our view it is the associated divisions of *organization* and of attitude, or *mindset*, that render the system unmanageable.

Below we describe the disparate organization of these four worlds, especially at the hospital level, where they most clearly manifest themselves.

CURE

Putting physicians in the down but out quadrant in no way is meant to imply that they are down *and* out! Physicians see the hospital as the location of their work if not specifically as their employer—as the saying goes, they work *in* the hospital but not *for* it. Yet that work is directly and intimately connected to the

hospital. For they are charged with effecting *cure*—intervening to change the condition of the patient. This is not to imply that physicians lack involvement in the institution—many are obviously deeply devoted—but that such involvement is not rooted in formal commitment. (As someone once said of bacon and eggs, the chicken may be involved, but the pig is committed!)

The word “intervention” (in fact, the French term for surgical operation) is most appropriate, for the physicians’ involvement is inevitably intermittent, unlike the nursing staff. They intervene with the patients in short, often scheduled bursts—in the operating rooms, in their offices, on clinic rounds—to administer some sort of cure, for example, to remove a gallbladder or change a prescription. Then they depart, leaving most of the “care” of the patient to the nursing staff. Thus “attending” physicians are really “intervening” physicians.

Medical interventions can be considered in four groups, which we call *incursion*, *ingestion*, *manipulation*, and *mediation*. In colloquial terms, physicians can cut, feed, touch, or talk to their patients. These are shown along a continuum in Figure 3, toward the left of which are the sharper, better defined, more radical as well as more programmed forms of intervention, while toward the right are those that require greater degrees of interpretation. These also form a continuum of intrusiveness: from the left, the first takes place

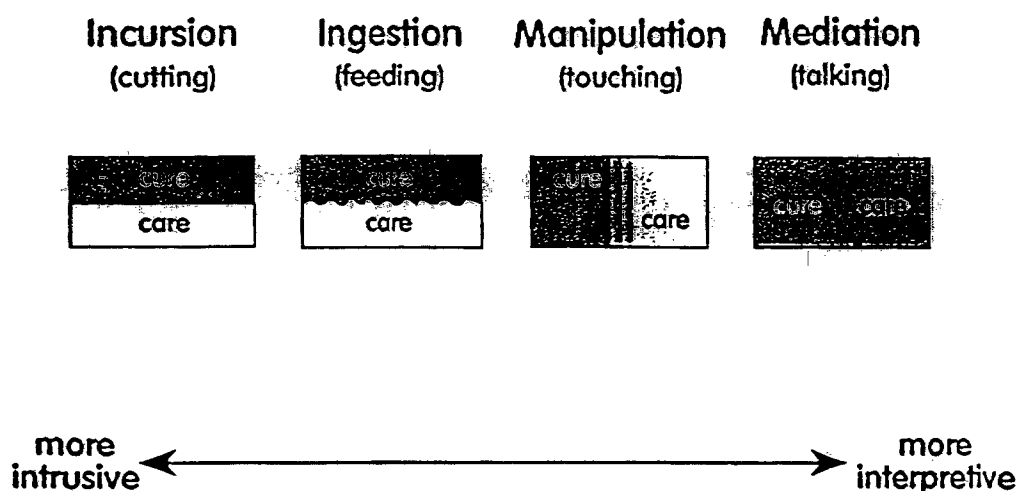
inside the body, as in surgery; the second passes a foreign substance *into* the body, as in medication or radiation; the third happens *on* the body, as in the setting of a displaced bone; and the last is verbally directed *to* the body, as in psychotherapy or dietary advice.

In fact, however, conventional medical practitioners seldom use manipulative techniques, at least for cure (although they frequently touch to diagnose, and sometimes to express caring). Such practices are, in fact, quite prevalent, but with a few exceptions, such as childbirth and the setting of broken limbs, physicians commonly leave them to other specialists, such as physiotherapists, or to alternate community practitioners, such as chiropractors. (In England, the vast majority of children are delivered by midwives, presumably reflecting a belief that this is an experience to be supported by care rather than a disease in need of cure.) Thus the medical profession seems systematically to eschew manipulatory kinds of interventions, perhaps because these cannot be taught scientifically. It is almost as if touching for cure *defines* a practice as unscientific, hence “alternate.” (One hospital nursing director quoted the physicians as using the word “scutwork” for any cure that involved touching the patient. “Touch has become a four letter word,” she told us.)

Similarly, cure by mediation, as in the example of psychotherapy, is hardly considered main-line medicine, especially in the acute hospitals. (For example,

FIGURE 3

FORMS OF MEDICAL INTERVENTION



the vast majority of research in psychiatry is about ingestion, not mediation.) Much of the mediation is increasingly left to nurses, psychologists, social workers, dietitians, and the like (who, in the hospitals, are considered support personnel to medicine). Physicians like to talk to their patients, to be sure, but hardly with the same care that they use to administer cure. (The relative lack of attention to diet in medicine may be the best example of this.) Thus medical intervention focuses largely on incursion and ingestion, especially in the acute hospitals, where the most radical forms of these can be carefully monitored and extensively supported. Hospitals do, of course, have their (manipulative) physiotherapy departments and their (partly mediative) psychiatric ones, but much of this kind of treatment, as well as some of the milder forms of surgery and medication, take place in the offices of community practitioners.

All of this treatment is dispensed through a carefully controlled system of *medical specialties*, which constitutes the organizing principle that most distinguishes the cure quadrant from the other three. Nurses can certainly be specialized, and indeed are so increasingly, as can be managers as well. But in neither case are the specialized “silos” (to use a word currently popular in management) taken as seriously as in medicine. Thus nurses retrain for new specialties relatively easily, and managers frequently move from one type of managerial job in the hospital to another, while physicians generally specialize for life around some body organ, disease, or type of patient. (Indeed, some seem barely able to appreciate the work of their colleagues in other specialties, let alone that of the nurses and managers.) What physicians do is climb their own specialized hierarchies of proficiency and professional status, whether through clinical service or published research.

Considering cure at the societal level, we can pursue much the same line of argument. As already noted, the acute care hospital is really an acute *cure*

hospital, highly interventionist itself (if physicians do their work in chunks of minutes or hours, then hospitals do it in chunks of days—even in “day” surgery!) and predisposed increasingly to the radical treatments of incursion and ingestion. Like its own physicians, the hospital can be described as down but out—administering its cures directly but with problematic social control. Moreover, like the medical community, the acute cure hospital has become increasingly specialized, inclined to shed the simpler and even more integrative forms of intervention to community care.

CARE

It is especially the nursing units of the hospital that are in and down—tightly committed to the institution and deeply connected to its operations. And in contrast to the interventionist cures of the physicians, the nurses provide care on a rather continuous basis.

Above all, the nurses run the wards, where they seek to coordinate the complex *workflows*. That is their organizing principle, although they too have their chimneys, like the physicians, and their hierarchies, like the managers. Somehow the comings and goings of all sorts of people around the patient must be coordinated—residents, interns, and specialized “attending” physicians of all sorts, physiotherapists, psychologists, orderlies, and specialized nurses of different kinds, and on and on, literally dozens of different people per day. A curiosity of hospitals is that often no one is formally charged with this coordination. But nurses do come the closest to effecting it, *de facto*, although this is not always a happy task. For the nurses often get caught between the physicians who claim responsibility for the patients, despite their absence, and the managers who claim responsibility for control, despite their distance. Yet, ironically, both commonly turn to the nursing administrators for coordination. (Thus one unit head nurse told us how the surgical subchiefs expected her to reconcile their conflicts over bed allocations, in order to avoid having to confront one another!)

Acute hospitals differentiate sharply between cure and care, with the latter ostensibly supporting the former. The nurses, who do most of the caring, are functionally subordinate to the physicians, who consider themselves solely responsible for the curing. This has turned the hospital into “the key battleground for the various forces arrayed in the division of labor in health care.”¹ Indeed, a study that examined

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the journals of two medical residents "written more than 100 years apart . . . revealed more similarities than differences in nurse-physician relationships."² Of course, other professionals contribute to the fabric of care, including the physiotherapists, psychologists, and social workers, with each of their disciplines sharply differentiated from the others.

Yet this distinction between the curing of the physicians and the caring of the nurses proves to have a curious property when considered in terms of the four forms of intervention. As shown in Figure 3, the distinction fades as we move along the continuum. At one end, under incursion, it is quite clear who cures (cuts) and who cares (applies the cotton), while at the other end, under mediation (as, say, in milieu therapy in a psychiatric ward), the roles of curing and caring become blurred, as treatment becomes less specialized. Thus, whereas the cure/care distinction may have some justification at one extreme of medical treatment, it becomes decidedly dysfunctional at the other.

That acute hospitals focus on radical forms of incursion and ingestion alleviates but does not eliminate this problem, because the lines of demarcation between cure and care are never perfect. One need only consider the curative effect of sympathetic care, or the long-standing battle by nurses to change protocols to gain some formal control over the adjustment of pharmaceutical doses.

At the societal level, much the same set of issues appears, indeed sometimes more pronounced. For example, if the acute hospitals intervene to cure serious illness, then the community institutions, such as geriatric hospitals, seem to provide rather more continuous and coordinated care. And, of course, across from the medical specialist of the hospital is the general practitioner in the community, more regularly in touch with the patients and, somewhat like the nurses on the wards, closest to coordinating the interventions of the different medical specialists. Similarly, on the community care side we find many more manipulative and mediative forms of treatment alongside less radical forms of incursion and ingestion.

Here, therefore, as we move beyond the hospitals with their focus on *acute cure*, the demarcation between cure and care becomes less useful (as can be seen, for example, in the more naturally occurring cooperative relationships between physicians and nurses in geriatric hospitals). This is the realm of *softer care*, where community work is depended upon to preempt a certain amount of expensive hospital cure. (There is, of course, cure in community activity too—although

"healing" is sometimes the preferred term—as well as purer forms of care, as in palliative treatments.) The result of this is that a society predisposed to radical cure—as ours tend to be—creates an artificially high demand for it, while driving community care into a corner of the health system, with insufficient resources and an excessively palliative orientation. At worst, much important softer care gets precluded altogether, as physicians are attracted away from general practice and the public away from reasonable "alternate" practices (such as dietary advice and acupuncture) that fall outside the boundaries, or the interests, of the medical establishment.

CONTROL

"Administrators" were first introduced to the hospitals to assist the chief physicians. Gradually they emerged as powers in their own right, taking over official responsibility for the system at large, in the process renaming themselves "managers."

But this is partly an illusion. In a sense, they are managers, sitting atop their *administrative hierarchies* of formal authority, which is their principle of organizing. But from the perspective of the most influential members of the hospital community, the physicians, this hierarchy of office is far less important than is their hierarchy of medical achievement. Of course, the managers do exercise formal authority over other members of the hospital community, especially those least able to claim professional status. So what the managers end up controlling directly is a patchwork quilt of more and less autonomous enclaves, which renders the management of the hospital as a single entity problematic at best.

We should note, however, that this is not merely a problem of credentials. To be a professional means to have the ability to use a body of established yet complex knowledge and skills. This renders the hospital managers outsiders with regard to the clinical operations (unless, of course, they have clinical experience themselves). So they are often unable to cross what we have called the great divide, where structure is determined by professional standards and the imperatives of technology, not administrative dictate. And if the managers do not control the clinical operations, can they really be said to manage the hospitals? Perhaps the obvious answer lies in the results of all those many reorganizations and restructurings to which hospitals are regularly subjected. Nothing much ever seems to change in what really matters—the direct delivery of service.

Countering this weakness, however, is the managers' control over resources—over budgets, beds, and many of the jobs. The managers may not be able to regulate process, at least inside medicine, but they can often limit and direct its application, and thereby gain support for their own agendas. But this too is no simple matter. When a physician calls and says, "I have a heart, a patient, and an operating room. I know there's no more money in the budget. Should I go ahead?" what manager can say no? What does "control" mean in this context?

Today, one is supposed to manage through measurement. But what does measurement itself mean here? A surgeon in a London hospital transplanted the livers of 10 patients. Two died, and 8 survived. One of the latter was a young woman, whose cancer of 5 years earlier had returned, while the liver of another was slowly being rejected, necessitating a second transplant. Of the remaining 6, only 3 were able to resume normal working lives. Asked about his success rate, the surgeon claimed 8 out of 10. Indeed, he was prepared to claim 9 out of 11 after the retransplant (since he counts livers, not people!). An immunologist, who felt the surgeon should not have operated on the young woman, put the rate at 7 out of 10, while an administrator put it at 6 out of 10. The nurses, most aware of the quality of the lives of those who could not return to work, put it at 3 out of 10. And the right answer? Take your pick. And then try to manage by the numbers!

In such a system, weak managers exploit their fiscal power blatantly, weaving themselves into a disconnected cocoon of formal authority based on arbitrary measurement, while strong ones know they have to nuance what influence they have, by playing the "corridors of comparative indifference."³ In the face of insatiable demands, they allocate some resources where they must, control the dispersal of others where they can, and above all work the lines where the various professionals, who like to pretend they can function independently, meet. But this is no easy job, sitting between the professional naysayers down and the demanding authorities up. The latter define the problem of managing upward and outward. The managers have to represent their hospital to the world, lobbying for its needs and advocating its causes, all the while, giving the illusion of internal harmony and central control.

Bump all this up to the societal level—the management of the whole system of health care and disease cure—and you end up with much the same problems, only perhaps more so. Control of hospitals themselves

is notoriously difficult to effect, much as it is for the clinical operations of those hospitals. This is especially true for administrative agencies removed from the hospitals, even when their formal control over financing is indisputable (as in the Canadian medicare system). So they too, much like the hospitals that are perpetually reorganizing with little effect, engage in their own dysfunctional activities. England concocted its game of "purchasers" and "providers," dropping radical changes into its National Health Service without thinking through the consequences, at the very same time that the largest Canadian provinces were taking their state systems in exactly the opposite direction—introducing the very regional structures that England was eliminating while trying to disempower the very institutions that England was seeking to empower (namely the hospitals, as "trusts"). Shouldn't the fact that different countries seek to solve the exact same problem by moving in diametrically opposed directions be telling us something? Meanwhile, both systems seem like paragons of tight management compared to an American system that for years escalated increasingly out of fiscal control.

Thus, as different countries stumble from one administrative intervention to another, with little effect (beyond the strictly fiscal) on the actual delivery of service, health care and disease cure continue along their merry ways, as activities quite apart from all of this (and from each other).

The term *intervention* also applies to the administration, whether at the level of the hospital or that of the system at large. Like the physicians, indeed ultimately perhaps *because* of the physicians, the managers intervene too, periodically dropping changes into the system—a reorganization here, a budget cut there—and hoping for the best. Those who have seen it all before—often many times before—know exactly

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what to do: They keep their heads down, for "this, too, shall pass." When things become truly difficult—when the managers feel they are really out of control—then that search for the magic solution takes over. It is a behavior increasingly common in all forms of organizations today, but especially so in the system of health care and disease cure. Management thus enters a state of perpetual crisis, or confusion, as everyone gets dragged back and forth between the wonders of some new technique on the one hand—"reengineering" and "total quality management," before that "strategic planning, etc."—and the bloodbath of the next budget cut on the other, with no attention paid to the inconsistencies.

But systems and institutions are like people in that they function best under steady care, not intermittent cure. The problem is not how to intervene across the great horizontal divide, but how to dissolve it into a cooperative network.

COMMUNITY

The organizing principle of the community might be thought of as the *board*, both literally (in part) and figuratively (in whole). For when the representatives of the community take their seats around it, in a committee structure, their behaviors suggest that hierarchy is the least pronounced here among the four quadrants (notwithstanding the hierarchical norms that many of the trustees bring to that table). And so too does one find here the least amount of differentiation as to task (again, no matter how differentiated may be their regular work). The board meets periodically, charged with overseeing the hospital's activities. Yet this it must do from its position of up and out, since its members are the most removed from its operations and the least dependent on its success (despite often-noble offerings of their time and energy, let alone money). The same is true of other involved members of the community, such as volunteers, advocacy groups, and press reporters. All have the capacity to contribute, although usually somewhat marginally, as well as the right to lobby and even the chance to meddle (both, again, often with marginal results). Of course, the patients should really be considered part of the hospital's community as well, although they are certainly dependent on its success (even if their capacity to lobby, even to contribute, is often minimal).

It may not be coincidental, therefore, that while care, cure, and control serve us here as verbs as well as

nouns—people in these three quadrants *do* these things as well accomplish them—community serves only as a noun. People can *represent* community, but in this system they cannot *do* a great deal about it, except, of course, through indirect attempts at influence. But because of their distance from care and cure, they usually direct their attention to control, specifically by bringing pressure to bear on the managers. After all, the one thing many of the trustees, in particular, do understand is hierarchy: managers are supposed to manage, are they not?

And when the trustees find that the managers do not, at least in the conventional ways, then the trustees tend to get drawn in, but in ways again akin to the physicians: they intervene, intermittently. They attack an expenditure, fire a chief executive, fund a new CAT scanner. As one trustee commented at a board meeting one of us attended, about an emergency department problem, "We declare war on the issue!" Worse still, much of this intervention tends to happen idiosyncratically, since board members often get their information selectively—notably from the high-status physicians they happen to know (leaving aside that carefully supplied to them by the managers).

Trustees cannot, of course, manage the hospital in place of its managers (however much some would like to try). It is not even clear that they can properly carry out their mandate to oversee that management, given the selectivity of their information and their limited time. Thus, some years ago, the Quebec government passed legislation mandating carefully conceived community representation on hospital boards of directors—one person to represent the patients, another to represent the volunteers, and so forth. It seemed to be exemplary legislation; it just hardly made any difference. To *be* a representative of some community is one thing, to *represent* truly that community's interests in such an organization is quite another. On our matrix, therefore, community remains boxed away in the upper left-hand quadrant.

Again, we see no significant differences when we consider the same issues at the societal level. Some community representatives believe they can influence the behavior of the overall system; ultimately few really do. For example, frustrated by the seeming impotence of those who administer health care and disease cure, the politicians intervene periodically, changing the administration one way or another without effecting much real change in the operations.

WORLDS APART

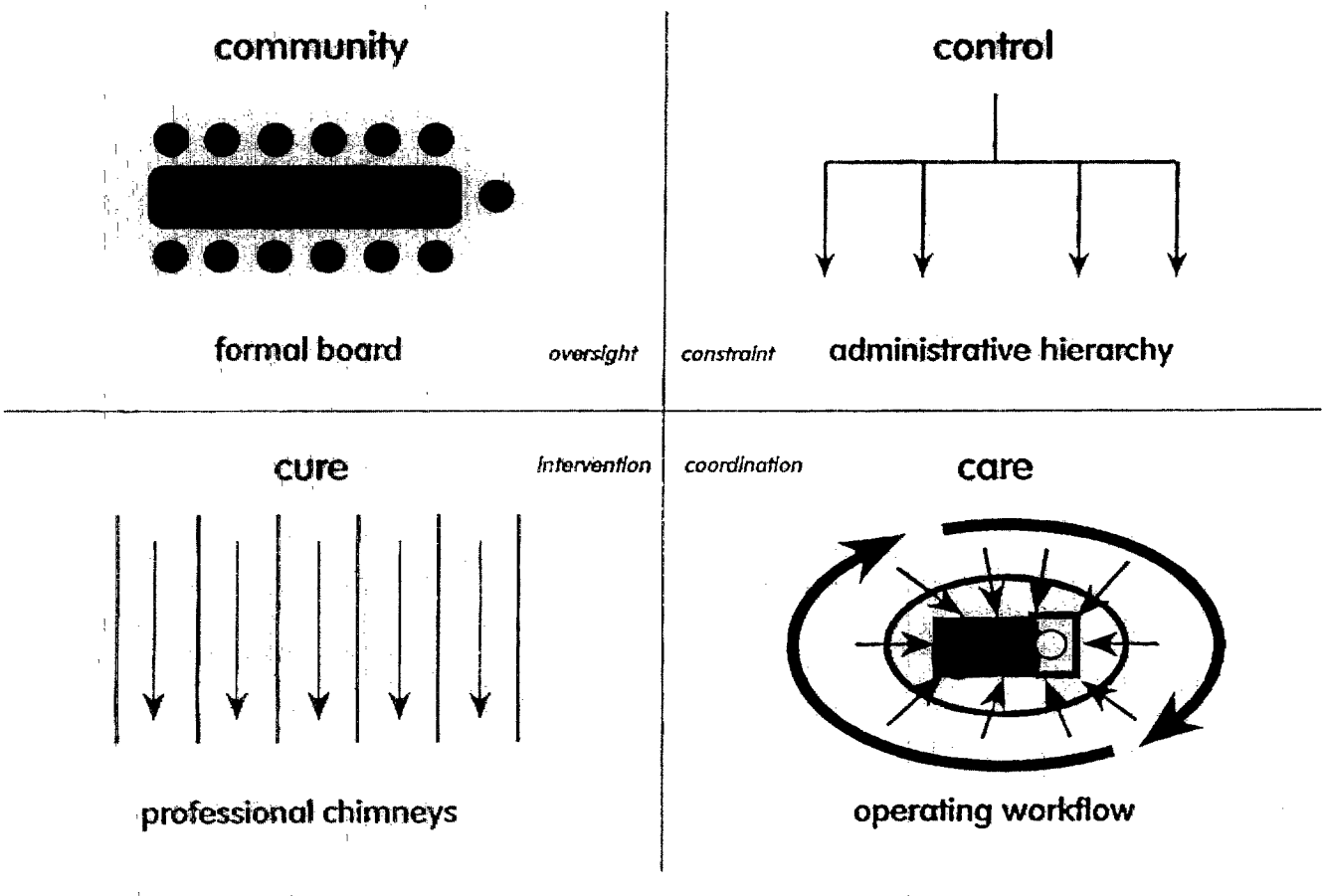
Thus we find four worlds, all necessary components of the system of health care and disease cure yet unnecessarily disconnected—by unreconciled values, incompatible structures, intransigent attitudes. Divisions of labor are necessary—the boundaries are inevitable—but the disconnections are destructive. Figure 4 summarizes our conclusions about the organizing principles of these four worlds—operating workflow in care, professional chimneys in cure, administrative hierarchy in control, and the formal board in community. We also include a key word to characterize the nature of each: intervention for cure, coordination for care, containment for control, and oversight (in both senses of that word) for community.

To highlight these differences, we propose a metaphor for each. Cure can be represented by the scalpel, to symbolize the interventionist nature of medicine and of the acute hospitals. Both use it for incursion—to slice something out of a patient, an institution, or society at large. Physicians and hospitals, in other words, intervene periodically to take what they want—a body organ, a new piece of equipment, an entirely new facility.

The managers intervene too, in order to exercise control, but their instrument is rather less sharp. It is the ax, used not to slice but to hack—jobs in a department, beds in a hospital, sometimes even whole

FIGURE 4

ORGANIZING PRINCIPLES AND THE KEY CHARACTERISTICS OF THE FOUR WORLDS



institutions. The community tries to intervene too, but its instrument is blunter still—the gavel. It can make a loud noise, but hardly more than to gain attention at meetings (except, of course, when used to beat the managers over the head).

Finally care, on behalf of the nurses and those concerned with the general health of the community, can be represented by the scissors, to prepare the cotton wool that soothes (or masks) the slicing of the physicians and the hacking of the administrators. (The care groups themselves might actually prefer the needle, to stick into the buttocks of contrary physicians and overbearing managers.)

We exaggerate our descriptions to be sure. All are stereotypes that belie a good deal of behavior to the contrary. But we have neither invented these problems nor do we believe we have overstated their consequences. What we have tried to do is trace their roots, which has taken us into these four quadrants. Our conclusion is straightforward: to the extent that these four worlds disengage from each other—see past each other due to their different perspectives—the comprehensible elements of health care and disease cure combine to form a system that is incomprehensible and unmanageable. And so it spirals increasingly out of control.

DIFFERENT FACES

We can begin to draw these worlds together by considering their interrelationships, first as different faces. For, like that character in the film *Three Faces of Eve*, each also reflects another side—a different personality—of a single entity, whether the hospital or the system at large. This perspective allows us to consider the framework dynamically.

First, let us consider power coalitions, for each face tends to form one with its partner to either side on the matrix. They seem less inclined to develop natural coalitions with the group diagonally opposite. In a sense, as shown in Figure 5, all of the actors in the system tend to be “two faced,” looking one way or the other, rather than across, which may help to explain a number of the conflicts.

The nurses tend to form an “insider” coalition with the managers (against the physicians) and a “clinical” coalition with the physicians (against the managers), while they are most distant from the board members. The physicians, who tend to be most distant from the managers, relate to the nurses for clinical purposes, but some also develop a kind of “status” coalition with

board members and other influential community members, sharing the prestige of being independent of the institution and yet at the top of its pecking order. Those influential outsiders get attention when they are ill, while the physicians get resources when they are demanding. (Thus there is the story of a physician in a London hospital who succeeded in getting grant funding to build a heliport on its roof without even consulting the hospital management!) For their part, the trustees vacillate between their status coalition with the physicians, their friends, who encourage them to spend, and a kind of “containment” coalition with the managers, their colleagues, who encourage them to restrict spending. What the board least relates to are the ward and the nurses.

At the broader level, we find an equivalent coalition of care and cure, at least in the medical profession, as its members, both inside and outside the hospitals, close ranks when threatened, as do the acute and community care institutions themselves, to protect the delivery of service. The acute hospitals often have special, and rather political, relationships with the high-status members of the community, while the latter, particularly as elected officials, will often work with the administrative agencies to contain costs. And sometimes these agencies will work with community health care interests to seek to redress the imbalance between acute cure and community care.

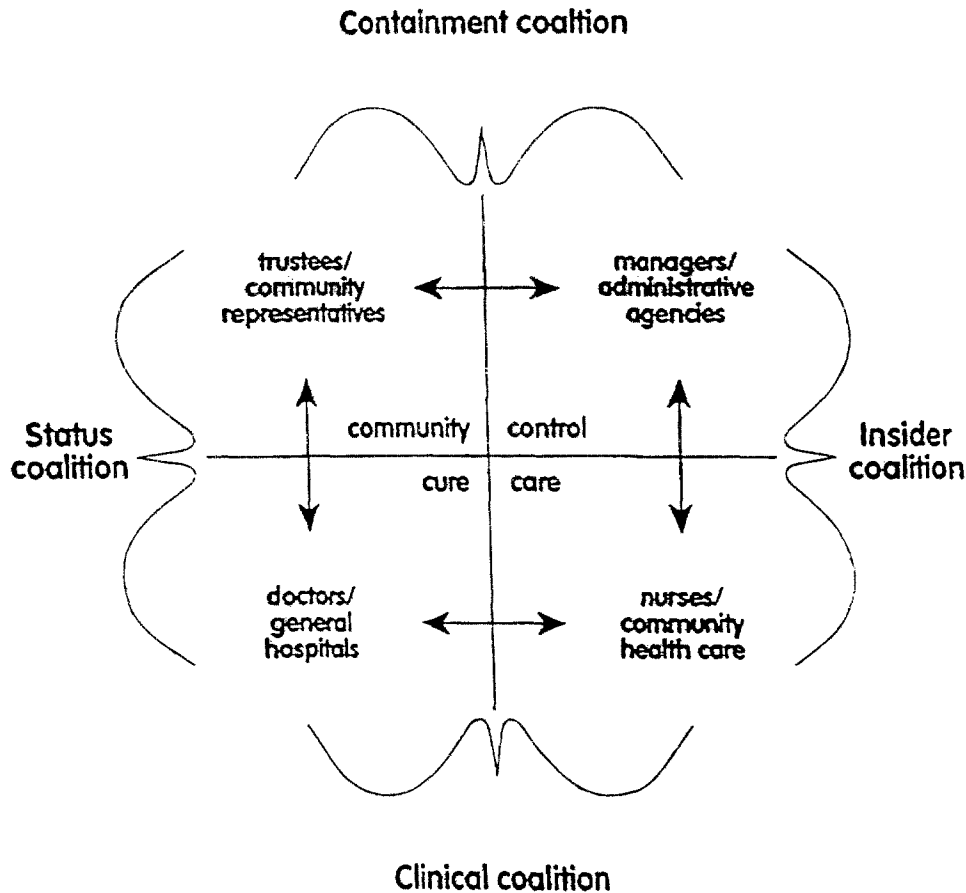
A second view of dynamic interrelationships considers the shifting lines of influence in the system over time, as power has passed from one quadrant to another. Here the pattern takes the form of a zigzag, as shown in Figure 6.

Nurses are fond of pointing out that hospitals were originally places where nurses cared for the sick, and called the physicians when they were needed. Physicians, of course, remember *their* good old days, when the chief medical officer ran things and administrators were hired to provide support. Now they see this as reversed, although this is hardly the perception of the managers, who still find the medical community intractable. Nonetheless, it is clear that considerable power has passed to the managers, especially with regard to the allocation of resources. But this has not stopped the escalation of costs, and so influence has begun to shift recently toward the fourth quadrant, as the idea spreads that somehow the community should gain control of its medical institutions.

At the societal level, the shifts have been rather parallel. Before the advent of the modern hospital, health care took place inside the community. As the methods

FIGURE 5

COALITIONS OF THE FORCES



of acute cure developed, so too did the hospital, to take the preeminent place in the system. But as the costs escalated, the power of administrative agencies increased steadily, and today, with the system often appearing to be out of financial control, community representatives, especially politicians, have been drawn into deeper involvement. Whether de facto or de jure, there is really no longer such a thing as a private system of health care.

ONE SYSTEM

Ultimately, however, all of this constitutes one system. Worlds divide for the convenience of work, which can face differently for status and influence. But the service in question is common to them all—

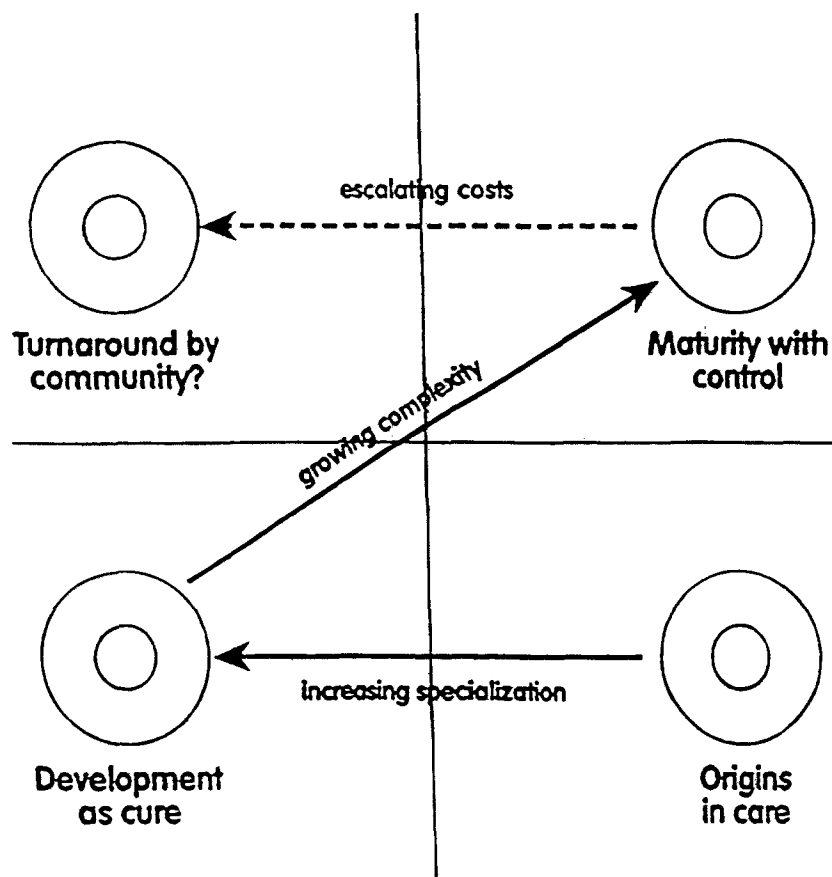
the overall health of the population. This is one issue, nothing more, nothing less, and nothing apart. Thus, as the system fractionates increasingly, with its zigs and zags of power and its coalitions facing every which way, it is the health of the community, as individuals and as a society that suffers.

We need to bring care and cure together more effectively, to coordinate patient services in the hospital and people services in the community, and we need to break down the barriers between care, cure, control, and community so that the institutions can function more collaboratively and the resources of the overall system can be allocated more effectively.

A popular theory of management some years ago⁴ argued that the greater the *differentiation* of the units of an organization, as to their goals, structures, and

FIGURE 6

THE ZIGS AND ZAGS OF FOCAL POWER



interpersonal orientations, the greater the need for *integration* among them. Here we have a system characterized by extraordinary, and increasing, differentiation, as well as a *lack* of integration.

All kinds of efforts have been made to achieve integration, yet few seem to have seriously penetrated the clinical operations. Many have taken place above the great divide, for example in the administrative reorganizations that shuffle boxes on charts but not much else, the "strategic planning" exercises that avoid the difficult tradeoffs by reducing serious problems to insatiable "wish lists" (or empty "mission statements"), and the government restructurings that evoke all manner of administrative frenzy in order simply to reduce budgets. Other changes do take place inside the operations, but all too often in one

quadrant or another, without influencing the relationships across them—good examples being "total quality management," led by nursing, and "patient-focused care," which often systematically excludes physicians.

Change has certainly become the steady state in the system,⁵ but all too often it is bifurcated change. The managers direct administrative change while the clinicians promote technological change. In other words, the technology continues to advance below the great divide, at its own pace, while the administration reorganizes above it. We end up with 2000s technologies embedded in 1940s structures.

There are forces that seem to draw these different worlds together, but they also help fragment them and emphasize their differences. One is commitment

to purpose. People who work in this field tend to be highly dedicated, often at significant personal sacrifice: physicians and nurses who enter what they see as callings, community representatives who generously donate their time and resources, managers who remain in their jobs despite terribly intensive pressures. Yet there is insufficient mutual acknowledgment of these altruistic tendencies and a great deal of defensiveness about areas of self-interest.

A second force for integration is the desire to advance knowledge, shared by all four worlds. Research and development are major activities in this field, in nursing as well as medicine, while community financial support for such activity is significant, as is the administrative support of managers. But this advancement of knowledge is one of the prime causes of the high degree of differentiation both within and between the clinical worlds of cure and care.

A third force is urgency. Crises do unite these worlds, most obviously in the case of clinical emergencies, where teams respond quickly to save lives. Administrative crises can sometimes engender the same behavior, to save institutions! (Similar behavior at the societal level may be less common, however, considering how long a state of crisis has existed in some systems.)

But, all too often, these behaviors only serve to highlight how rare such cooperation really is. Perhaps that is why people in hospitals seem to prefer urgent situations (and, probably why acute hospitals themselves, which intervene in the situations of greatest urgency, have tended to get the lion's share of the resources). Urgency provides a sense of shared purpose that is often absent during routine work. Once it passes, the usual fragmentation sets in again.

But as we have emphasized throughout this paper, health systems—at all levels, clinical, institutional, societal—need continuous, cooperative care, not just intermittent cure. We cannot continue to allow the system of disease cure to manage itself increasingly out of control while that of community cure seems hardly to be managed at all. The natural forces of cooperation must be exploited to bring integration to a level commensurate with that of differentiation.

There has, in fact, been a growing movement to re-integrate within each of the different worlds, reflected, for example, in revised medical school curricula, ongoing rethinking in nursing practice, and new forms of administrative and systems organization. But these efforts themselves must be cooperative, across the different worlds rather than inside of each,

and they must manifest themselves more profoundly in the operating behavior.

In Part II of this article, we shall extend our discussion beyond differentiation, seeking to open up thinking on the ways by which integration can take its rightful place—in the clinical operations of acute cure as well as the varied activities of community care, in the administration of institutions and in the functioning of the overall system.

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