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ORIGINAL RESEARCH – QUALITATIVE

Professional responses to post bureaucratic hospital reforms and their impact on care provision

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ABSTRACT

Background: Post bureaucracy is increasingly shaping how health care professionals work. Within hospital settings, post bureaucracy is frequently connected to loss of professional autonomy and protocol-based care. However, this development also affects relationships between care providers and care receivers.
Question: To explore experiences of post bureaucratic hospital reforms and their impact on care provision.
Method: Data builds on nine mini group interviews with midwives (n = three), nurses (n = three) and physiotherapists (n = three), in all thirty participants. Data was analysed using existing theories of professionalism and post bureaucracy.
Findings: Two overarching themes were identified: '*Time, tasks and institutional duties*' which referred to transformations in care practices, increased use of screening procedures, efficiency requirements and matching linear time to the psychosocial needs of patients. '*Managerial control of work*' which described rising administrative demands, engaging in protective measures, younger professionals pressured by documentation obligations and fear of disciplinary procedures.
Conclusion: The institutional context appears to play a key role shaping care practices. Although midwives, nurses and physiotherapists share similar experiences of post bureaucratic hospital reforms, changes in care provision can impact these professions in different ways. As a discipline, midwifery is founded on relationships between women and midwives. Standardised clinical care, performativity demands, litigation risks and rising administrative obligations are liable to challenge the provision of woman centred care. These changes may also result in increased inequity in maternity care by affecting some groups of women more than others.

1. Introduction

Since the 1990s Nordic countries, like other western countries, have restructured public health care.[1–4] In the Nordic countries, this change was initiated due to the costliness of the existing state-based welfare system.[1] The new welfare system was dominated by political interests of worker flexibility and the intensification of workloads.[1] As a response, marked-oriented and businesslike models were used to reorganise health care institutions,[1,4] among these maternity care. This shift also required a change from traditional bureaucratic to post bureaucratic forms of organisation in hospitals. Josserand et al. note that rather than disappearing, bureaucracy has resurfaced in a hybrid form by combining old rationalisation principles with novel political principles of democracy and organisational networks.[5] Post bureaucratic organisation involves the fragmentation of previous organisational structures and the decentralisation of authority.[5] Within the logic of post bureaucracy is also increased competition between different health care institutions and between different health care professions.[1,3–5] According to Davies, post bureaucratic governance models have been introduced into public health care in an effort to meet increasing client demands and simultaneously contain health care costs.[6] Among the components of these governance models are central standard settings, clinical accountability and increased inspection of service provision.[6] As a consequence, maternity care is becoming increasingly affected by the enforcement of standardised care and the

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monitoring of care provision.[7,8] This development is also resulting in a decrease in self professional regulation.[1]

Restructuring health care places new demands on health care managers and on health care employees alike. On one hand, the managerial role transforms to one of assuring that health care professionals undertake their responsibilities.[6] On the other hand, managers are dependent on an active commitment from employees.[5] For employees, restructuring health care demands that they modify their role and adjust their knowledge base to the new organisation.[1,5] This requirement can result in difficulties of making proper use of previous knowledge, skills and habits whilst at the same time necessitating new forms of discretionary choices.[1,5]

Maternity care reforms have in many western countries placed greater political focus on consumer rights and the provision of woman centred care.[7,8] Yet it has been argued that the present efficiency demands in maternity care, may instead result in increased inequity.[7,8] In the Nordic countries, births since the 1970s have been brought into shared institutional frameworks.[9] Despite the hospitalisation of births, surprisingly few studies have so far examined the midwifery profession alongside related care giving professions within hospital settings. Up to now, research has primarily focused on the impact of structural changes within the midwifery profession itself. In this paper, it is argued that midwifery care cannot be separated from the organisational structures and the institutional logics present within modern day hospitals. The paper demonstrates that midwives share a number of post bureaucratic challenges with other health care professions. Concurrently, these challenges are also liable to result in a range of consequences specific to the provision of maternity care.

The paper starts by exploring experiences of post bureaucratic hospital reforms and their impact on care provision among midwives, nurses and physiotherapists. The subsequent discussion examines the relevance of these findings for midwifery practice in hospitals.

1.1. Literature review

A literature search on post bureaucratic organisation in relation to care provision in hospitals, revealed a number of studies. Post bureaucracy is linked to institutional efficiency. Hunter asserts that when midwifery care is situated in a hospital, care provision is more likely to meet the needs of the institution than the needs of the individual woman.[10] Walsh claims that maternity care is influenced by values derived from traditional bureaucracy which are exemplified by a processing mentality in large hospitals.[11] Similar findings have been presented within nursing and social care. Hirvonen and Husso maintain that the economical-rationalistic framing of time contradicts the relational understanding of time in care giving practices.[12]

Relationships between protocol-based care and professional autonomy have also been previously addressed. Studies show that ongoing conflicts exist between evidence based practice favouring medicalized interventions and care giving practices based on values of holism and woman centeredness.[13,14] Protocol-based care is also perceived to restrict both the application of professional judgement and professional experience to clinical situations.[14–18] In addition, post bureaucratic care provision is connected to risk management due to increased clinical accountability and the risks of litigation.[6] Larsson et al. ascertains, that while institutional guidelines limit midwives' decision making responsibilities, these guidelines also increase midwives accountability to the institution.[18] Similarly, Porter et al. argue that changes in health care management, create concerns among midwives of having to defend their actions if these actions are not aligned with hospital guidelines.[19] Several studies show that perceptions of litigation risk affect midwives' decision-making processes and increase adherence to institutional rules.[17–21] Conformity to institutional rules has also been associated with positions within the hospital hierarchy. Midwives as well as nurses have been found to perceive protocol violations as being more inappropriate than do doctors.[17,22]

2. Methods

Data in this study was collected as part of the Scandinavian interdisciplinary research network "Phlegethon" between Oslo and Akershus University College, Metropolitan University College and Aalborg University. The overall purpose of "Phlegethon" was to investigate, how a health care sector undergoing change affects the work of semiprofessionals in Nordic health care institutions.

2.1. Participants

Convenience sampling was used to recruit participants.[23] However, by recruiting from a variety of hospital settings, the intent was to recruit participants from different wards and with varying degrees of professional experience. Number of years with professional experience ranged from one to thirty nine years. Average number of years with professional experience was 13.8 years. 50% of the participants had 10 years of professional experience or less. Participants were recruited at their place of employment and through various web announcements. Participants recruited outside their place of work were offered compensation to the equivalent of one hour's work for commute and interview time. Participants were all employed at large hospitals in Denmark and Norway respectively.

2.2. Data collection

Data is based on interviews with 30 health care professionals divided into nine mono professional mini groups. The number of interviews performed within each profession were midwives (n = three), nurses (n = three) and physiotherapists (n = three). A focus group approach was chosen to allow the professionals to compare experiences and confirm or reject participant statements.[24] To allow adequate time for sharing professional experiences, smaller focus groups were elected. A semi structured interview guide was used to collect data. Participants were encouraged to describe everyday situations including experiences of work standardizations and accounts of client encounters. Two moderators facilitated eight out of the nine interviews. One interview was facilitated by one moderator. Interviews had a duration of 60–80 min. Interviews were audio recorded and transcribed verbatim. Data was collected from 2012 to 2013.

2.3. Data analysis

To enhance transparency of data analysis, a theoretical template approach was used.[25] Prior to coding of data, mini group transcripts were discussed within the group of researchers. Data was coded by the author of this study. According to Crabtree and Miller, the role of the theoretical template varies depending on the goal of the analysis.[25] Freidsons' theories of the free market, bureaucratic managerialism and professionalism[26] were initially used to organise data. Dent and Whitehead's[27] work on performativity and knowledge and Iedema's[28] work on post bureaucracy also informed data analysis and the interpretation of study findings. Due to the explorative design of this study repeated data reading allowed for preliminary codes to be expanded and modified. Following recommendations for comparative analysis of professions, data from the three professions was first analysed separately and secondly subjected to a comparative analysis.[29] This method was used to identify similarities in experiences