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Provider perspectives

User involvement in hospital wards: Professionals negotiating user knowledge. A qualitative study

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ABSTRACT

Objective: To investigate how health professionals in hospital wards that have voluntarily initiated user involvement negotiate user knowledge into their professional knowledge.
Methods: Qualitative interviews were conducted with 18 health professionals from 12 hospital wards in Central Norway.
Results: The main value to health professionals of initiating user involvement was gaining access to user knowledge. Two functions of user knowledge were identified – user knowledge as an alternative to professional knowledge and user knowledge as support for professional knowledge. The need for good professional practice was used as an argument for closing professional fields to user involvement. Professionals were also under scrutiny from other discourses, such as scientific–bureaucratic medicine, which had a strong impact on how user involvement was carried out.
Conclusion: Health professionals saw knowledge transfer as valuable, but ultimately valued professional knowledge above user knowledge.
Practice implications: Even health personnel who embrace user involvement limit the influence of user knowledge on their own professional work. It seems necessary that user involvement be included in health policy and practice guidelines at hospital wards, if it is desirable that user knowledge influence professional knowledge and everyday work.

1. Introduction

User involvement in health care is a central part of the health policy agenda in Norway, as in other western countries. Norwegian health care had been governed by professionals during the post-war decades, but during the 1980s and 1990s, new public management inspired the government to initiate reforms to modernize public services [1], and the 1990s saw a rise in user involvement in health care [2]. Presently, user involvement is mandatory in hospital trusts and individual treatment, but is not mandatory at the hospital ward level. A goal for advocates of user involvement is to widen the influence of user perspectives on how wards are run [3]. Indeed, despite the fact that user involvement is not mandatory for them, many wards in Central Norway health region have user involvement [4]. Hence, studies of user involvement in hospital wards are needed.

Traditionally, hospitals and health services have been the hierarchical domains of health professionals, where patients have been seen as passive recipients of care [5], and expected to give professionals access to their experiences [6]. The health service system is an expert system whose functions are based on exclusive knowledge that is difficult for lay people to understand [7,8]. Controlling access to, and management of, medical knowledge has been one way of ensuring expert control [8,9]. A profession is an occupational group characterized by the sharing of skills based on knowledge, training and competence [10]. Such sharing enables the control of knowledge and the field in question [9,11].

However, in our post-modern era, medical knowledge is increasingly questioned and de-privileged [8,12–14]. One policy response to this phenomenon has been "scientific–bureaucratic medicine", where evidence-based medicine is translated into guidelines and mixed with clinical governance to achieve the best and most cost-effective treatments [15]. It is in this environment that the potentially oppositional trend of user involvement has emerged. One of the main goals of user involvement is to draw attention to user experiences by advocating for user voices and knowledge. The notion that user knowledge should influence health care practice is based on ideas of patient empowerment [16] and democratic or consumer rights [17,18].

Such new trends may be far from everyday realities at hospital wards. Professionals may believe that involving patients in practice will make their work more difficult [19]. Although

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professionals may become more positive toward user involvement when acquainted with it [20,21], there may be tensions between professional and user knowledge that is likely to be seen at hospital wards. Time constraints, resource scarcity and the irrelevance of user knowledge in particular clinical situations are all perceived by health professionals as barriers to user involvement [22–24]. Under such conditions, user involvement may end up as tokenism [24]. Staff may also feel that meeting users' requests is incompatible with providing appropriate care [25,26]. However, attitudes may vary according to professionals' backgrounds and career histories [27–30]. Though many health professionals remain ambivalent toward user knowledge [19,20,31], there has been resistance to increasing the influence of user knowledge on policy and practice [32,33]. Such resistance suggests that user knowledge may induce feelings of uncertainty in the professionals who possess power to define knowledge.

The aim of our study was to investigate how health professionals in hospital wards that have voluntarily initiated user involvement negotiated user knowledge into their professional work.

2. Methods

This study consisted of qualitative, semi-structured interviews with health professionals from hospital wards in Central Norway. The Central Norway Regional Health Authority is in charge of four geographically diverse hospital trusts, in addition to a pharmaceutical and a drug rehabilitation trust. Apart from the latter two, each trust consists of at least two hospitals with somatic and psychiatric units.

2.1. Participant recruitment and sample

Since this was an exploratory study, we opted to maximise variation in health professionals' experiences with user involvement. To recruit participants, a letter and questionnaire were sent to all hospital wards in the region, asking whether or not their wards relied on user involvement. The letter requested contact information for a person who had actively taken part in user involvement (described in detail in [4]). Based on the responses to the questionnaire, 12 wards were selected for a variety of types of user involvement and wards, as well as hospital size. The contact persons from one psychiatric and one somatic ward were unavailable, but all informants who where asked to participate agreed to be interviewed. In addition, we recruited two informants using information from users and employees who knew of relevant wards.

A total of 18 health professionals from 12 different wards were interviewed. Nine of these wards were from the trust that utilised about half of the health region's budget. Two other trusts were represented by one and two wards, respectively. Ten wards had both inpatient and outpatient units, while two wards only provided outpatient consultations. Four wards were psychiatric wards. Of the 18 persons interviewed, five were medical doctors, five were nurses, four were from other health professions and four had other professional backgrounds. The interviewees were heads of wards, quality advisors, head nurses and professional staff in non-managerial positions.

2.2. Procedure

Individual interviews were conducted in nine wards and as group interviews in three wards. All interviewees were informed about the project both verbally and in writing and gave their written consent to participate.

We used a semi-structured interview guide. All topics in the interview guide were covered in all interviews, but the order of the questions sometimes differed from the order of the questions presented in the preset guide (e.g. when interviewees initiated topics similar to upcoming questions). The questions in the interview guide had two aims – to gather information about user involvement activities on wards, and to gather information about health personnel's experiences with user involvement, the roles of user representatives and professional perspectives on user involvement. Interviewees also talked about how user involvement influenced their work and their wards. When talking about their work, these professionals focused primarily on decision-making at the ward level and routines for patient procedures.

2.3. Analysis

Interviews were tape-recorded and transcribed verbatim. Both authors read the transcripts to identify key topics. All interviews were categorized according to these topics, then interpreted [34]. We started with an open and explorative approach, writing detailed descriptions of each category and interpreting its meaning [35]. The categories and interpretations were discussed during the analytical process. Interview data can provide both facts and narratives, but data is constructed through interactions between interviewers and interviewees, in specific contexts [34]. With this in mind, we interpreted the data we collected as discursive statements, allowing us to identify the narratives that revealed how the health personnel in hospital wards view user involvement. The qualitative research process is a continuous alternation between empirical findings and theoretical concepts [34]. With regards to the data we gathered, the connection between user knowledge and professional knowledge helped situate the experiences of health personnel within the context of user involvement. After our initial analysis, we therefore re-read and reinterpreted the interviews through a lens of professionalism, defined as knowledge [10], and professional control over the field in question [9].

3. Results

In this study, health professionals had experiences with different types of user involvement. User involvement took a variety of forms – from user committees that met with management on regular bases, to project groups that worked for limited time periods. While some wards had user representatives in internal working groups that typically consisted of several health personnel and one user representative, other wards granted user representatives seats on their ward councils. More typical initiatives involved bringing experienced users into patient education.

Health professionals understood their own role as initiating user involvement. In their experience, user involvement was only feasible on their wards when they, themselves, accepted it. For them, the main value of user involvement was access to user knowledge. User involvement was seen as being particularly valuable when it provided alternatives to professional knowledge by identifying new viewpoints. User knowledge was also seen as valuable when it supported professional knowledge by creating consensus and providing support for professional viewpoints. However, health professionals also had to manoeuvre user knowledge in fields influenced by evidence-based medicine and bureaucratic demands while attending to their professional knowledge. These points are elaborated below.

3.1. User knowledge as an alternative perspective

User knowledge provided health professionals with alternative perspectives on ward practices. Since users were understood as having user-specific experiences, their knowledge afforded unique insight into questions discussed by the professionals we inter-