



Juggling efficiency. An ethnographic study exploring healthcare seeking practices and institutional logics in Danish primary care settings



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ABSTRACT

This article explores the mutually constituting relationship between healthcare seeking practices and the socio-political context of clinical encounters. On the basis of ethnographic fieldwork carried out in the context of Danish primary care (general practice) and inspired by recent writings on institutional logics, we illustrate how a logic of efficiency organise and give shape to healthcare seeking practices as they manifest in local clinical settings. Overall, patient concerns are reconfigured to fit the local clinical setting and healthcare professionals and patients are required to *juggle efficiency* in order to deal with uncertainties and meet more complex or unpredictable needs.

Lastly, building on the empirical case of cancer diagnostics, we discuss the implications of the pervasiveness of the logic of efficiency in the clinical setting and argue that provision of medical care in today's primary care settings requires careful balancing of increasing demands of efficiency, greater complexity of biomedical knowledge and consideration for individual patient needs.

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1. Introduction

This article explores the mutually constituting relationship between healthcare seeking practices and the socio-political context of Danish primary care. The work is based on fieldwork in the context of Danish primary care (general practice) and is inspired by recent writings on institutional logics (e.g. Thornton and Ocasio, 2008). Our empirical starting point is cancer diagnostics. In most parts of Western Europe, cancer survival rates have improved over the last two decades, though it has been argued that there is potential to further improve survival rates if people are less hesitant in seeking healthcare when experiencing potential signs or 'alarm symptoms' of cancer, and if such symptoms are investigated for an underlying cancer (Olesen et al., 2009; Torring et al., 2013). This may be of particular relevance in the UK and Denmark, where cancer patients experience poor relative survival in comparison to

other countries with comparable healthcare systems. In the UK, poor cancer survival rates have initiated comprehensive research initiatives such as the National Awareness and Early Diagnosis Initiative (NAEDI) and the International Cancer Benchmarking Partnership (ICBP) exploring the complex interaction between the publicly funded first- and second-line healthcare systems.

In the behavioural sciences of medicine exploring 'delays' in healthcare seeking for potential cancer symptoms (e.g. Scott et al., 2009; Levealahti et al., 2007; Macleod et al., 2009) and in certain parts of the anthropological research on healthcare seeking (e.g. Garro, 1998; Andersen et al., 2010), there has been a tendency to focus on the social life worlds of the patients or on patient characteristics such as gender, social status, and symptom awareness as explanatory for healthcare seeking practices. However, a still growing body of research suggests that a narrow focus on 'the patient' alone fails to consider certain issues when exploring healthcare seeking practices; these perspectives may include power and social control in the clinic as well as the social and cultural embeddedness of healthcare organisations and medical care.

This point is well illustrated by the body of literature departing in narrative research and clinical ethnography (e.g. Kleinman, 1980; Mishler, 1984; Risør, 2011; Brindle et al., 2012; Good, 1995). These

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studies are generally concerned with knowledge hierarchies, and how the socialisation of medical doctors into the field of biomedicine shape interaction with patients and feed into the construction of medical objects in the clinical setting. Studying medical students and American oncologists practicing at Harvard Good and colleagues for example illustrate how implicit social values and prevailing knowledge hierarchies in medicine are finely ingrained in the clinical encounter; and how patient concerns are transformed into clinical narratives that 'suit the treatment context', or what they have referred to as 'the medical machine' (Good, 1995, 2011).

Another line of research explores what we could call the organisational embeddedness of the clinical encounter, demonstrating how the socio-political framing of healthcare systems influences doctor–patient interactions (Nettleton et al., 2008; Waitzkin and Britt, 1993). Nettleton and colleagues show how current changes in the British healthcare system provide increased focus on cost-efficiency and performance audit and thereby alter the cultural context of the clinical encounter. Medical knowledge as it is applied or brought to use in the encounter is disembodied, they argue, and doctors 'feel obliged' to depend less on subjective experiences, such as pattern recognition and tacit knowledge, and more on general standards and guidelines (Nettleton et al., 2008).

Returning to healthcare seeking, evidence is thus accumulating, that linear views of patient concerns as somewhat static phenomenon that easily transport from the context of private life into the spheres of medical assessment are too simplistic. Both because seeking healthcare is not only a matter of going, but also a matter of how patient concerns are constructed and made meaningful in the clinical setting, and because the clinical setting is a site for patient socializing; 'teaching' people (in the widest sense of the word) how to be 'a good patients'. Therefore, healthcare seeking practices may benefit from being analysed as part of the entire biomedical field (Bourdieu, 1990) integrated into a specific historical framework.

As we have argued elsewhere (Andersen et al., *in press*), the case of cancer exemplifies how current developments in biomedical knowledge increasingly add to the complexity of deciding 'with what' to seek medical advice, as well as it exemplifies increasing demands on the public to be 'responsible, rational and health oriented consumers' as reflected in dominant health promotion discourses (Rose, 2007). Moreover, public healthcare services in many Western welfare states, including the Danish, have been subject to a range of regulatory practices and increasing demands of efficiency in recent years (Nettleton et al., 2008; Boyer and Lutfey, 2010). Overall, the current developments in biomedical thinking, in combination with an enhanced focus on regional efficiency standards, imply that healthcare professionals and patients are faced with increasingly complex types of care and diagnostic practices (Rose, 2007; Boyer and Lutfey, 2010). Therefore, it is pertinent to explore how healthcare seeking practices are negotiated in the first line of medical care, where contemporary medical realities materialise as social practices and knowledge hierarchies.

In this paper, we explore how healthcare seeking practices are negotiated and manifest in local clinical settings. We illustrate how healthcare seeking practices are organised around a logic of efficiency, in which patient concerns are reconfigured to fit the local clinical setting. Moreover, we demonstrate how healthcare professionals as well as patients must *juggle* the dominant logic of efficiency in order to deal with uncertainties and meet more complex or unpredictable needs.

In the case of cancer, we conclude that incentives to ensure timely diagnosis require a first-line system which can embrace patient concerns and yet carefully balance the organisation of clinical practice dominated by increasing demands of efficiency. On the whole, we argue that the case of cancer may be extended to illustrate potential mismatch between the current organisation of

primary medical care and the increasing complexity of biomedical knowledge and diagnostic practices.

2. The study

2.1. Medical care in primary care clinics

The Danish healthcare system forms part of the Danish welfare state in which each citizen (5.6 million) is basically guaranteed a minimum of welfare. The national healthcare system is tax-funded and offers a range of public services free of charge to citizens. Moreover, the primary care clinics serve as first-contact access to specialised care, referrals and coordination of treatment with other healthcare providers within the healthcare system (Moller Petersen et al., 2012).

Danish primary care clinics have undergone significant changes in the last few decades (Moller Petersen et al., 2012). Some of which may be indicative of more long-term shifts within Northern European healthcare and public services in general, where increased focus on cost-efficiency and performance audit is implemented to make organisations more effective and efficient in regard to quality assurance (Nettleton et al., 2008; McDonald et al., 2013). Due to centralisation and budget workarounds in the entire Danish healthcare system, primary care clinics have experienced a general increase in administrative and clinical work assignments, and still more tasks are subject to various forms of regulation and codification. Among other things, the clinics now provide acute as well as follow-up care for the increasing population with chronic diseases (patients with COPD, AMI, diabetes, etc.), and many care practices are rooted in disease management programmes and EBM guidelines created by external bodies such as the Danish Regions and the Danish College of General Practitioners. In addition, the clinics are encouraged to engage more actively and systematically in disease prevention (e.g. conversations on smoking cessation and lifestyle choices), and the advancement of risk assessment and profiling has led to a general increase in the potential patient population in primary care (e.g. blood-pressure and cholesterol measurements). Overall, Danish primary care clinics has experienced an increase of more than twenty per cent of patient encounters during the past 16 years (Moth et al., 2012).

As indicated above, some changes in the clinical setting are driven by changes in scientific biomedicine, which also influence the relationship between the population and the healthcare system. As argued by Barsky nearly three decades ago we live in a time where tolerance thresholds of discomfort are decreasing (Barsky, 1988), and continuing expansions in biomedical knowledge and technologies change what Good has referred to as 'the semantics of medicine' (Good, 1996). More and more bodily changes, feelings or sensations are designated as potential signs of disease, thus expanding the pool of 'potential symptoms' (Shorter, 1985; Rose, 2007). These changes may be illustrated by recent changes in cancer diagnostics (Andersen et al., *in press*). Developments in global technomedicine (Rose, 2007), exemplified by visualisation techniques ranging from CT and IMR scans to micro-imaging cameras, now allow identification of cancer tumours at increasingly earlier stages. Parallel to this, we have witnessed a search for markers (biomarkers or genetic-markers), intended to function as clues or triggers for action; identifying individuals at risk and in need of further investigations for underlying tumours. In cancer diagnostics, the search for markers has, however, also taken a 'sensorial' turn exemplified in the search for symptoms as signs of cancer disease; or the construction of realist scientific categories designated as 'alarm symptoms'. Seen from a biomedical or a cancer diagnostic-perspective, alarm symptoms are deemed valuable in assisting the organisation of diagnostics pathways

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