Creating, maintaining and disrupting practices and boundaries in Healthcare

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Aim of the Paper

Utilising institutional work theory we investigate and analyse the influence of actors (*key players*) on promotion, engagement or resistance to change and to explore how actors create, maintain or disrupt the institutions in which they work.
A focus on people: Is Lean Mean?

If *lean management* (LM) is to reduce impediments in production through continuous improvement & elimination of wasted time & motion, does LM provide workers with the skills to help them control their work environment.

Or is LM ‘management by stress’ ‘sweating workers’ through faster job processes, standardisation, workers doing more with less, marginalising unions (Parker and Slaughter 1995)?
Or is Lean Complex?

Beneficial for some, detrimental for others?

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<th>Enhanced Skills</th>
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<td>Improved teamwork</td>
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Increasing use of LM in healthcare: hospitals are complex organisations

Educated, skilled, altruistic clinical staff – in short supply

Powerful professional associations and unions

Roles bounded by professional jurisdictions, regulations and enterprise agreements

Clinical staff often organised into functionally differentiated units – based around different discipline groups

Nature of patient care often confounds attempts at ‘standardisation’

Context of increasing demand, improved quality of care, improved efficiencies and effectiveness and resource constraints
What do we mean by Institutional Work?

Institutional work is concerned with the mundane, purposeful practices of individuals and groups aimed at the maintenance and transformation of institutions.

“The getting by of individuals and groups who reproduce their roles, rites, and rituals at the same time that they challenge, modify, and disrupt them” Lawrence, Suddaby and Leca (2011).

Institutional work brings these ‘actors’ to the centre stage of institutional theory in the sense that they are seen as the principal drivers of institutional change.

An innovative framework to more completely understand ‘how and why actors may interpret, translate, transpose, edit and recombine institutions, and how these actions lead to unintended adaptions, mutations and other institutional consequences’ (Lawrence, Suddaby and Leca, 2011).
What we do we mean by healthcare institutions?

1. Institutional framework – industry structures, regulation, government funding, policies and practices, key stakeholders – insurance agencies, professional associations, unions, consumer organisations
2. Organisational level – hospitals, networks etc
3. Local Level – departments, teams, professional groups and individual actors

_Institutional Work focuses on Level 3 but is influenced by Levels 1 and 2_
Zietsma and Lawrence’s (2010) *Institutional work* framework examines the interplay of boundary work and practice work.

Boundaries – the distinction between people and groups (Bowker and Start, 1999), actors efforts to establish, expand, reinforce or undermine boundaries.

Practices – “shared routines of behaviour” (Whittington, 2006:619), kinds of objectives at which work is directed, and how actors affect the practices that are legitimate within the domain.

Zietsma and Lawrence (2006:190) argue that “the interplay of boundaries and practices is central to the work of actors”.

*We argue that this is particularly true in the health sector*
Institutional Work

Three major components of institutional work – creating, maintaining and disrupting Institutions.

• creating institutions may include forms of advocacy; defining, vesting, constructing identities, changing normative associations, constructing normative networks, mimicry, theorizing and education.

• maintaining institutions may include a number of individual and groups activities including enabling work, policing, deterring, valorising and demonizing, mythologizing, embedding and routinizing.

• disrupting institutions may include an array of activities that include disconnecting sanctions, disassociating moral foundations, undermining assumptions and beliefs.
Public hospitals funded by government
Financial constraints
Highly unionised
LSS promoted by govt – improve efficiency and effectiveness
Internal process improvement/quality improvement teams
Little union involvement unless agreements challenged

Canada most emergency department (ED) Drs fee for service, in Australia – most public hospital Drs employees except for VMOs
In Australia – hospital execs drove PI process not in Canadian hospital
In Canada no HR involvement in PI/QI
In Australia HR claim *some* involvement
Could be argued that the employment-relations structures while invisible were silent partners, in that many of the actors were members of professional associations, unions and discipline groups – sometimes more than one.

These structures can be seen as boundaries and are engrained in hospital environments. Some of these boundaries have a legal unpinning however, others are based around custom and practice often developed over many years and based around professional practice and shared understandings of the organisation of work. Hence, the rules of job regulation were invisible most of the time, but actors could still invoke the rules of job regulation if other actors broke the rules.
**Australia: Practice Change in the ED**

Introduction of Emergency Surgical Service:

Using evidence from overseas and good data, a senior clinician initiated and introduced a shift to surgical team diagnosis and treatment within ED. Junior doctors, registrars and consultants to simultaneously work on diagnosis and treatment, rather than the former system of sequential consultation.

Involved Consultants being paid to attend ED on a rotating model

First self funded and outside of the system, then supported by Hospital Exec through pilot funding, now embedded.
We had been trying to think – thinking of ways of achieving this Emergency Surgical Service for some time, because we kind of liked the concept of the model. And the eight hour thing gave us the political leverage that we felt we could change it, because we felt we could go to the hospital and say, ‘Well, look, we reckon we can help you with eight hours if you give us a look-in with this thing.’ Head of Surgical Team
The idea of setting that up was to actually quarantine and control our emergency work. Because before we set this up, the emergency work was actually dominating us. I mean, we regard ourselves as surgeons who are here to do elective surgery on cancer and stuff like that, and we were being overwhelmed by all this emergency work that was sort of non-stop. So the plan of this thing was to go, okay, we’d attended that for three weeks a year, you’d do this. You’d set aside three weeks, separated, and you know, you’d do your week of on-call at this thing, work hard, and then you hand that over, the whole cohort, to the next guy.
I mean, I’ve been part of a group of people. And they’ve been fabulous. And then there’s been another group of people who’ve been very opposed to it, and you know, the process of achieving the change against the – you know, with their opposition, has been very, very difficult.....
the process of achieving change with the surgeons, I guess when we initially started the trial, …some people said, ‘No, we’re not going to participate in this at all.’ So they were allowed to continue in the previous fashion they had. And then other people were willing to various extents. So it worked out that a number of us did a lot more weeks on call than would be the normal expectation.

We managed to coerce the sort of swinging voters do a moderate amount to see what it was like, and then we – and then another group left themselves out completely.

And then when the trial was proved successful, what did we do? Well, we did a bit more political skulduggery and we tried to sort of neutralise the older, senior surgeons by sort of putting a policy in place where after the age of 60 they didn’t have to do on-call.
Why was the change successful?

Innovative clinical leader (surgeon) who was able to get other surgeons on board and make things happen

Supported by Hospital Executives who saw the benefits

Sidelined, outflanked and neutralised the resistant surgeons – changes to their contracts, got the AMA on board

**Boundary Change**

Improvements for patients, improvements for the surgical wards, better relationships and some boundary change between ED and wards
In Canada: practice change in ED

In a medium sized community hospital bottlenecks had occurred because of the lack of ED clinicians and the way that work was organized. The Drs were reluctant to change and include more Drs, possibly because they feared that this would undermine their earnings.

The QI team spent time in ED, worked with both Drs and nurses explaining the situation and providing hard evidence of the demand and supply problems. The QI team did this without managers being present and worked to ensure two-way communication with clinicians to build trust and develop an improvement strategy.
When you get into the human element where, you know, the person…doesn’t follow the rules and not much happens to them as a result of it, then it’s pretty hard to – keep it going – … If you don’t get your hand slapped, you can keep doing it…. and I don’t see our docs’ behaviour changing that much on account of me reiterating stuff, you know, to them. (lead physician)

I would have one-on-one conversations with the Drs, and had been doing that half a month into the process, these were general conversations, icebreaker conversations… these were the one-on-one conversations… These conversations were crucial in making those changes. We have 17 ED Drs and I know each of them as well as any other. … The most important thing is listening and not pretending to be listening (QI team member).

I’m not under pressure to find a solution, there’s a whole bunch of these guys (ED staff) out there with their ideas and they seem to be engaged with us to come out with these ideas, and now I’ll do something to make it happen. So they actually feel more accomplished in a sense. (QI Team member)
Eventually, the *Drs* agreed to changes in the roster and another shift was included without the physicians losing money. Processes were put in place so that nurses were able to help physicians perform their tasks more efficiently, for example, making sure that patients were gowned before examination and suture trays were prepared.

Hence, the *Drs* were able to see more patients in the same amount of time so their remuneration levels did not suffer. In this situation, practice work was used to enable roster changes that increased *Dr* availability and nursing support. However, there was some impact on boundaries through boundary work undertaken by clinicians that improved relationships and trust between nurses, physicians and the improvement team.

However this did not last…increased throughput led to bottlenecks in transfer to Medical wards in particular – resistance to change, no boundary change and practice change undermined – extra shift no longer in place
What went wrong?

Increased throughput rather than better patient care

QI led rather than clinician led

Led to extra work for others compared to less work for others

Long standing conflict between ED and medical wards – personalities, fights over resources

Lack of support from the Hospital Executive
Discussion

Importance of leadership and spotting and supporting innovation

Involving clinicians – data, evidence and engagement – what’s in it for them?

Perceptions of justice and fairness – getting on the front foot

Innovation needs to be embedded with adequate resources

Impact on others

What insight does Institutional Work Theory give us in: Creating, Maintaining and Disrupting Change