Emergency physicians in the Netherlands
Kathan, C.D.

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2008

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):

Copyright
Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

Take-down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): http://www.rug.nl/research/portal. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.
4 Organizational Force Fields in the Development of EPs in Hospitals

Chapter 2 compared the development of EPs in two different countries. This section builds on the study design presented in chapter 3, narrows the focus to hospitals in the Netherlands and answers question (Q1-b), *which forces explain the implementation and development of EP roles in individual hospitals in the Netherlands?*

While several hospitals simultaneously started to train and implement EPs, differences in emerging practices and professional characteristics can be observed. We use a force-field analysis to investigate role-defining driving and restraining forces and we draw conclusions about forces that advance or hinder sustainable EP implementation.

Five hospitals were selected to conduct comparative case studies. While chapter 3.11.1 identifies only four +EP-cases, this chapter also investigates a fifth case. In -EP_L(I), EPs had started to be implemented; the implementation process, however, was broken off at some point and the appointed EPs left the hospital. This case is not regarded as a +EP case in the main part of this thesis due to the actual non-existence of EPs. However, its efforts to implement EPs and the forces coming in to play are investigated in the current section.

The following analysis is based on data gathered by means of interviews and observations. For details about the data collection see chapter 6.1.

4.1 A Rabsody\textsuperscript{10} based force field analysis (framework)

We define driving forces (Lewin 1951; Palmer et al. 2006) as factors or perceived circumstances that are currently considered to drive an ECU towards completely running with fully trained EPs. Restraining forces are defined as the opposite: factors or perceived circumstances that are currently considered to constrain the ECU towards completely running with fully trained EPs.

In order to systematically track and compare all of the relevant forces that play a role in the implementation of EPs, we use an existing typology of social and organizational risk factors in innovation processes. The typology distinguishes between problem-oriented considerations and solution-oriented considerations which

\textsuperscript{10} Risk Analysis Based on Social-Organizational Dynamics
can be approached with either cognitive-technical rationality or socio-political rationality (van Offenbeek and Koopman 1996a). Figure 4.1 presents the corresponding matrix. “Risks” can be described as kinds of restraining forces. We therefore use this typology and combine it with force field analysis in order to derive a classification of the forces.

<table>
<thead>
<tr>
<th>Problem-oriented considerations</th>
<th>Cognitive-technical rationality</th>
<th>Socio-political rationality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear-cut versus uncertain, unknown problem</td>
<td>Heterogeneity versus homogeneity resulting in consensus versus conflicting goals among stakeholders with approx. equal powers.</td>
<td></td>
</tr>
<tr>
<td>Solution-oriented Considerations</td>
<td>Proved concept versus experimental or emergent</td>
<td>Acceptance versus resistance of a solution by stakeholders with relatively less power.</td>
</tr>
</tbody>
</table>

Figure 4.1: Typology of situational factors in change processes (based on Van Offenbeek and Koopman 1996b)

Force field analysis, however, does not only take the restraining forces into account, i.e. the risk factors. It also identifies driving forces. The described risk typology therefore needs to be further developed in order to incorporate them as well. We hence conceptually mirror the four main risk areas, yielding a model of both restraining and driving forces (Table 4.1). Table 4.1 lists the pros and cons voiced in the EP debate across and within all cases. However, the extent to which these factors are actually experienced within the specific hospitals and the weights attached to them was found to differ considerably across the investigated cases. In the next section, we describe the forces influencing EP implementation in each case. The framing of the situation by the dominant actors may be quite influential in determining the developed role and its organizational impact (compare van Offenbeek and Koopman 1996b). Moreover, local realities may comprise additional forces that impact the actual feasibility of the intended EP introduction.
<table>
<thead>
<tr>
<th>Table 4.1: Considerations voiced in the for and against EP debate across cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROBLEM-ORIENTED CONSIDERATIONS</strong></td>
</tr>
<tr>
<td><strong>COGNITIVE-TECHNICAL DRIVING FORCES</strong></td>
</tr>
<tr>
<td>• Many self-referrals don’t need specialist care</td>
</tr>
<tr>
<td>• Heterogeneous patient population</td>
</tr>
<tr>
<td>• Increasing co-morbidity demands multidisciplinary care</td>
</tr>
<tr>
<td>• Long waiting times due to fragmentation</td>
</tr>
<tr>
<td>• Patients reject long throughput times</td>
</tr>
<tr>
<td>• Medical quality at ECU assessed as poor</td>
</tr>
<tr>
<td>• High physician turnover at ECU threatens quality and continuity of care</td>
</tr>
<tr>
<td>• Expensive specialists spend scarce time supervising at ECU</td>
</tr>
<tr>
<td>• Some specialties do not have sufficient residents to staff ECU</td>
</tr>
<tr>
<td>• New curriculum prevents residents from working fulltime at ECU</td>
</tr>
<tr>
<td>• Changed working hours law</td>
</tr>
<tr>
<td><strong>SOCIO-POLITICAL DRIVING FORCES</strong></td>
</tr>
<tr>
<td>• Specialists experience ECU supervision as unwelcome interruption</td>
</tr>
<tr>
<td>• Specialists want to focus on complex patients within their specialty and avoid the routine cases</td>
</tr>
<tr>
<td>• Specialists appreciate seeing patients restricted to their own specialty</td>
</tr>
<tr>
<td><strong>COGNITIVE-TECHNICAL RESTRAINING FORCES</strong></td>
</tr>
<tr>
<td>• If patient population is homogeneous only few specialties are needed</td>
</tr>
<tr>
<td>• If ECU sees few self-referring patients residents are more suitable</td>
</tr>
<tr>
<td>• If residents need on the job training at the ECU, they have to see ECU patients.</td>
</tr>
<tr>
<td><strong>SOCIO-POLITICAL RESTRAINING FORCES</strong></td>
</tr>
<tr>
<td>• Specialists demand opportunities to train their residents on emergency patients</td>
</tr>
<tr>
<td>• Specialists claim final authority over patients</td>
</tr>
<tr>
<td>• Specialists claim authority over patient domains</td>
</tr>
<tr>
<td>• Specialists wish to maintain income flow (if self-employed) or their department’s budget (if employed by the hospital)</td>
</tr>
</tbody>
</table>

4.2 A Rabsody“ based force field analysis (application)

The analysis of the forces’ occurrence and intensity can be found in Appendix I. Three different arrow sizes indicate the strengths of each specific force (weak – medium – strong), based on the intensity attributed in the conducted interviews.

Table 4.2 mirrors the categories from Table 4.1 and summarizes the most important categories per case. Driving forces are highlighted in grey. The comparison of the five cases reveals some remarkable similarities and differences in the overall pattern of strong and weak forces in the different defined force categories.

Table 4.2: Strongest driving/restraining force categories per case

<table>
<thead>
<tr>
<th>PROBLEM-ORIENTED CONSIDERATIONS</th>
<th>SOLUTION-ORIENTED CONSIDERATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>COGNITIVE-TECHNICAL RESTRAINING FORCES</td>
<td>+EP_S_EAR</td>
</tr>
<tr>
<td>SOCIO-POLITICAL RESTRAINING FORCES</td>
<td>-EP_L +EP_L_EAR</td>
</tr>
</tbody>
</table>

(1) Problem-oriented cognitive technical driving forces -like a heterogeneous patient population, experienced long waiting times, changing curricula for residents- are quite strong throughout nearly all cases. The main driving forces were expressed as follows:

“Patients don’t accept being pushed around between 12 different doctors any more. ... Today’s boundaries between specialists seem somewhat artificial and we are striving for some kind of realignment” (Director ECU, -EP_L(I)).

“Some time ago we were facing a manpower problem due to a working hours reduction law. […] Surgery residents were restricted to work only 48 hours – and in these 48 hours they need to focus on fulfilling their training requirements” (Specialist, +EP_L_EAR).

11 Risk Analysis Based on Social-Organizational Dynamics
4. Organizational Force Fields in the Development of EPs in Hospitals

“At some point a new problem occurred: [One] department was facing problems attracting residents. They didn’t have enough people to work in their department AND see emergency patients. That was how the idea to introduce EPs gained ground” (Specialist, +EP_L_ADV).

“Some time ago, our ECU was facing serious problems. We needed to change staff if we didn’t want to lose the right to treat certain patients. That was our starting point to introduce EPs” (ECU manager, +EP_S_EAR).

(2) Two large teaching hospitals, the one that failed to introduce EPs and the one in an early adoption stage, show rather strong problem-oriented socio-political restraining forces. These forces mainly refer to the resistance that EPs meet from other professionals. Most concern was reported from the medical specialists who want to keep EP patients for their residents’ training; they feel responsible for certain patient domains and therefore do not want to lose the authority over these patients’ treatment. Additionally they want to maintain their department’s budget, which, in hospitals with directly employed doctors, is based on the number of the department’s patients. These points were explicitly put forward by some interviewees:

“Most resistance that the ECU developments encounter result from specialists defending their patient domains” (Director ECU, -EP_L(I)).

“EP opponents have mainly two complaints: First, we have to organize our own medical training [during which residents need to see ECU patients]. The second one is financial: A new specialty will eat up our budget” (Specialist, +EP_L_EAR).

(3) In small non-teaching hospitals, problem-oriented socio-political restraining forces are much weaker, despite the fact that in these cases patient numbers are not only linked to the department’s budget but also to the specialists’ income (specialists in small hospitals are mostly organized in partnerships).
In the two hospitals in an advanced transition stage—one being a large teaching hospital, the other one a small non-teaching hospital—solution-oriented socio-political driving forces are quite strong. These forces mainly refer to the support that EPs receive from other specialties. Both, nurses as well as specialists appreciate the presence of EPs:

“Nobody is sceptical about the EPs any more. This development was really good” (Nurse, +EP_L_ADV).

“I wouldn’t want to work without EPs ever again. I think that EPs have been one of the best developments in emergency care in the last decade” (Nurse, +EP_S_ADV).

“We recently had a discussion about the specialists’ financial contribution to EPs. […] Although specialists may have to pay more, they explicitly stated that other doctors at the ECU are no alternative to us. They are really positive about us” (EP, +EP_S_ADV).

The problem-oriented socio-political driving forces, which refer to other professionals’ problems being eased by EPs, are strongest in the small non-teaching hospital in an advanced transition stage. Specialists, who as opposed to teaching hospitals do not necessarily experience supervision as one of their core tasks, regard less interruption by inexperienced interns as more convenient.

In the small non-teaching hospitals, specialists especially appreciate the EPs’ presence during late and night shifts, which reduces the specialists own work load during “out-of-office” hours. Specialists in large teaching hospitals are not much affected by this benefit as their late and nights shifts are mostly run by residents.

As an EP in +EP_S_ADV puts it: “The specialists from other departments were willing to buy themselves spare time by supporting the introduction of EPs.”
4. Organizational Force Fields in the Development of EPs in Hospitals

(7) The solution-oriented cognitive-technical restraining forces, which include higher costs and EPs’ availability, are strongest in the small non-teaching case in early transition. Since it does not train EPs itself, it has to attract trained EPs from other hospitals.

“EPs have a price tag attached to them. [...] Moreover, we have to follow a ‘natural’ process. There are not even enough EPs on the labor market yet”


4.3 Differences in the context and process of EP implementation

The different force field patterns are supported by the details about the EP implementation process. For a complete overview of the implementation details see chapter 7.1.3, Table 7.6 and Table 7.7. The following are the most salient case characteristics that help to understand the presented force fields.

(1) In the large teaching hospitals, the initiative to employ EPs was mainly based on an impending staffing shortage. In small non-teaching hospitals, the predominant reason was medical quality (poor quality with alternating doctors and increased quality with permanent doctors respectively).

(2) The support and facilitation of EPs differs substantially across cases. In one of the cases with strong socio-political restraining forces (+EP_L_EAR), the decision to implement EPs was top-down (i.e. by the hospital management). In the small non-teaching cases, in contrast, EP introduction was initiated and supported by the whole medical staff which is reflected by weak socio-political restraining forces and strong socio-political driving forces.

(3) While nurses generally welcome EPs, specialists’ appreciation of EPs differs across cases. In the hospital where management took the one-sided decision to implement EPs (+EP_L_EAR), specialists remain quite skeptical about EPs. In -EP_L(I), the implementation of EPs was stopped when specialists did not experience immediate benefit from the EPs. In the two small non-teaching hospitals, in contrast, EPs have been represented in the medical staff from the beginning.

(4) In hospitals with strong socio-political restraining forces (-EP_L(I) and +EP_L_EAR), EPs are used as add-ons to the existing work structure rather
than as substitutes for other doctors. In these cases, solution-oriented driving forces are rather weak.

(5) The patient groups that EPs are allowed to see and treat vary. In small non-teaching hospitals, few restrictions occur. In the large teaching cases with strong socio-political restraining forces, EPs are restricted to a few patient groups only.

**4.4 Conclusions and discussion**

Regarding problem-oriented driving forces, nearly all the hospitals in this study are driven towards EP adoption. They are expected to be better able to deal with a number of problems than other doctors, such as changing patient characteristics (e.g. many self-referrals who do not need specialist care; heterogeneous patients; increasing comorbidity), quality issues (e.g. long waiting times; insufficient medical quality), or changing labor policies (e.g. changed working hours law; new curricula for residents).

These driving forces are opposed by restraining forces, which, especially in large teaching hospitals, are mainly socio-political in nature and occur mainly in an early stage of EP implementation. Hospitals in an advanced stage of EP implementation show only little socio-political restraining forces but fairly strong socio-political driving forces. It therefore seems that turning socio-political restraining forces into driving forces is one of the keys to advancing EP implementation. This can only be achieved if EPs deliver work which is perceived to be good – and preferably better than the work delivered at the ECU before. EPs thus have to perform well before gaining professional recognition from their medical colleagues.

This finding suggests that hospitals should try to keep the ‘early-adoption-stage’ as short as possible and try to advance EP implementation as quickly as possible. Ideally they should reduce slow step-by-step implementation to a minimum and actively advance the implementation, following the suggestion of taking irreversible steps, an important recommendation in organizational change literature. Especially hospitals with a high potential for conflict –i.e. counteracting forces-, do not seem to organize the EP implementation irreversibly. Instead of following clear-cut implementation paths, tentative and halfhearted actions are being taken which may hinder driving forces from strengthening. A circumstance that unfortunately
counteracts the realization of taking irreversible steps is that up to now, not enough
trained EPs are available on the Dutch labor market to implement a completely EP-
based emergency care work system on a large scale.

EPs can only prove themselves if they are enabled to do so by the long-
established specialists. Specialists thus play an important role in the EP
implementation process. If they do not agree with the implementation and if EPs are
not allowed to see all kinds of patients, EPs may only form an additional layer in the
patient care process. Clear arrangements with existing specialists need to be found
about financial and educational implications; if these arrangements are not made,
specialists might regard EPs as a threat. In the existing work structures, specialists
have the power to counteract EP development towards an autonomous occupation and
the development of a self-confident medical role. Ways have to be found to strengthen
the socio-political driving forces and to make specialists aware of the potential
benefits of EPs for patient care.

Recognizing benefit brought by EPs is easier for specialists in small non-
teaching hospitals than in large teaching hospitals. In large teaching hospitals, late and
night shifts are normally run by residents. In addition, the number of specialists per
specialty outnumbers that of small non-teaching hospitals. Therefore, specialists are
less involved in irregular shifts and on-call duties. In small non-teaching hospitals,
doctors at the ECU are often the only doctor during late and night shifts. With EPs,
being more experienced than interns or GP-residents, specialists in these hospitals can
experience the benefit brought by EPs very directly by receiving less at-home-calls
and attending less irregular shifts. Turning restraining into driving forces of EP
implementation may thus be easier for small non-teaching than for large teaching
hospitals.

The weaker restraining forces in small non-teaching hospitals also enable EPs
to better establish their occupational role next to existing medical occupations. The
role of EPs in small non-teaching hospitals is, up to now, more far-reaching than in
large teaching hospitals. While in some large hospitals, they are restricted to seeing
only patients of a few specialties and conditions, their practical role covers nearly all
patients in small hospitals. With weaker restraining forces in these hospitals, this
prevailing occupational role may serve as a general EP role model. Still, the EPs’
training is provided in large teaching hospitals in which they perform a hitherto
different, more restricted occupational role. This dichotomy may cause difficulties for
the growing group of Dutch EPs to develop a consistent occupational role and boundary management.

In summary, we can state that some hospitals follow an innovative approach to implementing EPs while others pursue a rather adaptive approach. In the adaptive approach, EPs are implemented as a formal ‘innovation’ but actually turn out to adapt to existing work structures. The expectations linked to EPs are more likely to be realized when an innovative approach is followed, which enables the innovation EPs to bring about real work structure changes.