# ESTABLISHING A MULTIDISCIPLINARY DAY CARE SURGERY DEPARTMENT: CHALLENGES FOR NURSING MANAGEMENT

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## ABSTRACT

**Aim** To increase our understanding of challenges in implementing multidisciplinary organisational models in hospitals.

**Background** While health service policies internationally are pushing for multidisciplinary and patient centred organising models, there are challenges involved in moving from profession and discipline based organising to the new solutions.

**Method** Qualitative case study, interview and document data collected in real time following the implementation process.

**Results** It was possible to place arguments for and against the new department within either a business-like logic, or a professional logic. The respective logics gave different prescriptions for how a hospital department should be organised.

**Conclusion and implications for nursing management** The institutional logics perspective enables managers to understand resistance to new ways of organising work, and may be useful in trying to foresee and handle challenges in implementing new organisation models. Managers need to carefully analyse models in terms of which parts may be seen as problematic in their own organisation, and invite all relevant stakeholders into participatory change processes. If the goal is to gather multiple professions and disciplines under one manager in order to increase patient centeredness, arrangements must be made for professionals to stay connected to the wider community of practice centred around their specialized knowledge and skills.

#### Key words:

Organisational change; health service professionals; institutional logics; multidisciplinary hospital departments; nursing management

## INTRODUCTION

This case study follows the establishing of a day care surgery (DCS) department at a Norwegian hospital. The hospital leadership set out to create a multidisciplinary, patient centred department where elective surgery was shielded from emergency operations in order to increase effectiveness and efficiency. The study explores challenges for nursing management in implementing and managing such a department.

The hospital setting has been described as a particularly “messy” world where multiple groups representing a wide range of values, interests and expertise compete for influence (Denis, Langley et al. 2010). An important differentiation runs along the divide between medical and managerial staff and cultures, representing what is often described as distinct, opposing and mutually exclusive logics (Llewellyn 2001). The business-like logic is presented as a driver in the current search for more cost-efficient and patient centred ways of organising health services.

While health service policies internationally are pushing for multidisciplinary and patient centred organising models, there are challenges involved in moving away from professional and discipline based organising. The traditionally most powerful professional group in hospitals, the physicians, have been able to successfully resist changes that break with profession-controlled organising models (Currie, Lockett et al. 2012). This case study focuses on challenges for nursing management by documenting reactions from nursing disciplines to the new organising model of the DCS department, describing the organising model that was eventually implemented, and highlighting the challenges embedded in this model. We use concepts from institutional theory to understand the studied case.

## RESEARCH SETTING

Table 1 (see page 20) presents the objectives of the new department. The DCS had higher productivity targets and more professional groups gathered under one manager than what was the case in the existing model in the hospital. However, conflicts regarding the intended multidisciplinary organising model in which all professional groups were to be gathered under one manager made it necessary to adjust the intended model.

***(Insert Table 1 about here)***

## THEORY

Traditionally hospitals operate as an intricate web of role divisions between physicians, nurses, specialists, support staff, and managers. There are also subgroups within each group based on seniority, expertise levels and disciplinary specialties, each of which may operate in a distinct community of practice (Ferlie, Fitzgerald et al. 2005, Currie, Lockett et al. 2012).

Institutional theory is one of the leading perspectives in organisation studies (Heugens and Lander 2009). Institutions are defined as “those (more or less) enduring elements of social life that affect the behaviour and beliefs of individuals and collective actors by providing templates for action, cognition and emotion, nonconformity with which is associated with some kind of costs” (Lawrence, Suddaby et al. 2011). Institutional logics guide the behaviour of actors through assumptions, values, beliefs and taken-for-granted rules (Friedland and Alford 1991, Thornton and Ocasio 1999, Reay and Hinings 2009). The logics link social-level institutions with organisations and individual action, and form the basis for a sense of common purpose and unity within an organisational field (Thornton and Ocasio 2008, Reay and Hinings 2009). When individuals or organisations identify with an institutionalized group, such as a profession, they will most likely cooperate with the group by following its norms and prescriptions (Thornton and Ocasio 2008).

The professional, market and corporate logics are three, distinct ideal type institutional logics (Thornton, Ocasio et al. 2012). The market and corporate logics are sometimes combined in descriptions of the health care field as business-like (Reay and Hinings 2009). Nurses have been identified as adhering to a professional logic (Van den Broek, Boselie et al. 2014, Kristiansen, Obstfelder et al. 2015). Traditionally, the medical professional logic has entailed autonomy and authority over the clinical content and organisation of medical practice (Reay and Hinings 2009, Martin, Currie et al. 2017). Consideration of costs has been secondary to autonomy and time spent directly on patients providing the best possible care (Kitchener 2002).

A move towards a more business-like health care field has challenged this logic. The market logic represents competition among service providers and the use of market signals to improve services and contain costs, whereas the corporate logic represents the managerial control of professional activities through performance management regimes, standardization, surveillance and audit (Martin, Currie et al. 2017). The turn towards a corporate logic has been more prominent than the market logic influence in Norwegian health care (Kristiansen, Obstfelder et al. 2015), but while standard competition plays a very limited role in this national health system, policies for patient choice, activity-based funding and private provider contracting indirectly introduces competition (Brekke and Straume 2017).

The cultural rules and cognitive structures associated with each logic shape organisational structures by focusing the attention of decision makers on issues and solutions, such as alternative organisational forms, that are consistent with the prevailing logic (Friedland and Alford 1991, Thornton and Ocasio 2008). A professional logic will not only influence decisions about clinical patient treatment and care, but also opinions and decisions about how to organise services, most probably according to the principle of unidisciplinary departments. Decision makers influenced by a business-like logic will strive to organise professionals for maximum efficiency as defined by the number and measured quality of treatments, and put the customer demands in the centre when organising services.

The health care field is influenced by contending logics (Thornton and Ocasio 2008, Reay and Hinings 2009). The actions of physicians and nurses tend to be based on the professional logic, whereas managers and directors adhere to the business-like logic (Ruef and Scott 1998). It is challenging and often conflictual for organisations to operate in fields where several logics compete for influence (Pache and Santos 2013). When rivalry is caused by the implementation of a new organising model, such as in the case of attempting to reorganise health care professionals into multidisciplinary departments, professionals may also work to maintain or strengthen their positions by maintaining their existing organising model (Currie, Lockett et al. 2012). Physicians, the elite and traditionally most powerful professional group (Nancarrow and Borthwick 2005, Battilana 2011), have proven able to fend off attempts at introducing new logics to their field (Reay and Hinings 2009). However, actors who do not hold traditional elite positions are also active in shaping the organisational outcomes of change (Battilana 2011, Kristiansen, Obstfelder et al. 2015).

This study focuses on challenges for nursing management in introducing new organising models, the role of nursing staff reactions in shaping change outcomes, and the challenges embedded in the organising model that resulted from conflicts and compromises on the intended, multidisciplinary model. We ask *what were the arguments for and against the establishment of the multidisciplinary DCS department, and how did these relate to the professional and business-like institutional logics*? This first research question regards the challenges, and their underlying rationale. In our second research question we ask *how did the resulting organising model bridge the challenges, and what were the challenges embedded in it*?

## METHODS

### Research design and data collection

This was a qualitative case study with the unit of analysis being a single, within-site case (Creswell 2012). An interpretive approach has been adopted, empirically investigating the experience of the participants through semi-structured interviews and documents produced by stakeholders. The research approach was initially inductive in order to capture the organisational activities, and to link theory to the experience of the practitioners (Gioia and Chittipeddi 1991, Bansal and Corley 2012). Further analysis was undertaken iteratively going back and forth between data and established theories (Spiggle 1994).

Real time data was collected in the period of October 2013 until May 2014. The stakeholders involved in the implementation process were identified as the regional health authority as hospital owners; the Director of the surgical division in a capacity as project owner; a Project Manager in charge of the process; the Director of the medical division; physicians representing endocrine, orthopaedic, urology, gynaecology and anaesthesiology specialties; registered nurses and nurses with specialities in surgery and anaesthesiology; and secretarial staff. The existing DCS department, as well as the home departments of the professional groups were heavily involved in the process. We collected data from all stakeholder groups, in interviews during the project phase and the first year of operation, and by attending project meetings where representatives from all groups were present. Interviews were performed by the third author, who is a trained clinical and organisational psychologist and a PhD student in management studies at the time of the data collection. She had specific experience with interviewing hospital management and staff about issues of organisational change from previous data collection in the same health region, and was also the one who attended project meetings in the DCS implementation process. Two group workshops with DCS regular staff were conducted in the new department’s first operative year, where challenges and positive experiences of working in the new organising model were discussed in groups and summarised in plenum. These workshops were facilitated by the first and third authors.

The data consisted of 16 semi-structured interviews, written input from the staff workshops, and project documents that provided further insight to the process proceeding the start of the research. Interviews ranged between 30 and 90 minutes in length. The participants were chosen after a stakeholder analysis and came from all relevant hospital departments affected by the new DCS, and from all administrative departments having a role in the process. participants were selected based on their organisational positions, making sure that those especially relevant to the project were interviewed. Interviews with participants directly involved in the change process were conducted during the fall and winter of 2013-2014. The main goals identified in project documents were implemented in the interview guide. The participants were asked about the background for implementing the new department, to share their arguments in favour of or against the chosen model, thoughts about the department goals, to describe their experience of the change process, what had worked, what the challenges were, and how the challenges had been handled. Department employees and its manager were interviewed starting 5 months after the department had opened. They were asked about the background for the new department, the multidisciplinary model and what the successes and challenges were so far. In workshops, all regular staff members were divided into groups and discussed and presented their opinions on what worked, what the challenges were and how challenges could be solved regarding being in a new location, the personnel situation, work flow, potential conflicts, collaborating with the main hospital, and their internal culture. The interviews took place in the participants’ normal work environment, and the interview guide consisted of open-ended questions, and were adapted to each situation and participant.

Although the number of interviews is low, we are confident that the important themes have been elicited. The number of stakeholders directly involved in the implementation project was also relatively low. All of the involved parties and professions have been either interviewed or observed repeatedly in project meetings by one author. The analysis of project documents also strengthens our confidence in the findings. 190 pages of project documents including goal, risk analysis and planning documents, internal information newsletters, e-mail exchanges and project committee meetings minutes were collated. Finally, the group workshops including all regular DCS staff as participants allowed us to gain insight into the experiences of those working in the department. In sum, we consider the data as appropriately saturated (Glaser & Strauss, 1967).

The research project was approved by the Norwegian Centre for Research Data[[1]](#footnote-1). All interviewees, meeting participants and workshop attendees were informed about the project intent and extent, and consented to participating.

### Data analysis

The data analysis was performed by the first author. The qualitative data analysis software NVivo was used to code and sort the data, but none of the automated coding functions were utilized. Hence, all of the data were carefully considered by the first author. There was no pre-defined coding-tree or template at the outset of the analysis, but a broad question of what drove and hindered the implementation of the department was used as a guiding focus. First, a preliminary, mainly inductive analysis of the data noting key issues was undertaken. The difficulty of organising the different disciplines under one umbrella stood out as particularly challenging, and hence as a theme for further analysis. The second step included a narrative analysis of raw document data and interview data, where the focus was the emerging purpose of the research, trailing the story of why gathering multiple disciplines under one manager was so complicated. A chronological account of the process and the proceeding history up until the opening of the new department was established based on documentary data. Furthermore, a narrative pulling together accounts provided by each research participants was generated in order to create a thick description of the process and its main issues (Lincoln and Guba 1985, Langley 1999).

Further, first order concepts that revealed themes and patterns in the data were identified (Van Maanen 1979, Gioia and Chittipeddi 1991). The trustworthiness of the specification of issues was ensured by discussion with a key informant, triangulation of data, and constant comparison within the data set (Glaser and Strauss 1967). By combining first-order concepts to construct a set of second-order themes a more abstract and robust description of the arguments was established. Finally, this iterative but largely inductive description was subjected to analysis utilising concepts from institutional theory. In sum, this method of analysis results in a data tree which is constructed inductively from the data (see Tables 2 and 3).

While data collection was performed by the third author and the analysis was done by the first author, concepts, issues and themes were discussed among the authors throughout the whole research process. The longitudinal design, and the repeated contact with a key informant, enabled us to constantly compare emerging issues of interest. In instances of disagreements on how to interpret the analysed data, the first author would go back to the data and to related literature to consider the evidence anew. In this way, we sought to adopt an awareness of potentially disconfirming evidence throughout the research process from data collection until reaching our conclusions.

## FINDINGS

### What are the challenges? Arguments and their underlying logics.

Medical and technological developments made it possible to organise surgical treatment in an external location to the main hospital, with a multidisciplinary organising model. The existing department was too small and not functional, and the hospital building itself had no available space for a new department. Resources had been added in terms of a temporary increase in rates that the hospital received for performing DCS treatments, and some extra staff positions.

In addition to this, increasing patient demands regarding receiving efficient treatment without having to wait long were considered as driving the hospital towards the new DCS model.

*“There are trends related to organising, everyone knows that, and all these directors*

*they travel and see other places. And it’s something that you read about. And this idea for organising in centres has come as a result of patients feeling like they are being shuffled around the system between different professions. So there needs to be a holism, you need to see the patient holistically and not as just an organ, and not send them to one department after another.”* Nurse anaesthesiologist.

The Division Director and the Project Manager highlighted arguments regarding efficiency and economic goals of increasing the capacity, efficiency and volume of day care surgical activities, reducing waiting times for patients, retrieving patients who were currently going elsewhere - consequently causing the hospital to lose reimbursement income, reducing costly overnight stays, and shielding elective services to avoid cancellations.

*“We need to become more efficient, and streamline our processes. That way we can reduce the waiting times for patients’ surgeries.”* Project Manager.

They also perceived the organisation of professionals around the patient as a way of moving the focus to patient needs. By gathering multiple professional groups in one department under one manager, there would be clear lines of leadership and communication, increased levels of collaboration and less unnecessary division between the groupings in terms of task distribution.

*“We will contribute with our specialities in a community around a patient. That’s the department I wanted to create.”* Project Manager.

The importance of and positive valence associated with efficiency, economic goals, patient centeredness, and multidisciplinarity represents a business-like logic (Lægreid, Opedal et al. 2005, Reay and Hinings 2009, Kristiansen, Obstfelder et al. 2015). Table 2 (see page 21) provides a full presentation of the arguments in favour of the new organising model.

***(Insert Table 2 about here)***

The decision to create the dedicated DCS with a multidisciplinary organisational model at a location separate from the main hospital was met with resistance from nurse specialists. Some were hesitant about the attractiveness of working exclusively with DCS, as it was considered less diverse and exciting than the work in a regular surgical department, or more broadly across all hospital departments as the nurse anaesthesiologists would normally do.

The main points of resistance concerned the external location, and the multidisciplinary organising model. The arguments against the external location were that it would be a small and less diverse working environment than the hospital as such, and that there were risks to patient safety associated with being removed from the emergency facilities in the hospital. The resistance against the multidisciplinary model was associated with a sense of professional identity and belonging that each group had with their home departments, a scepticism towards a new distribution of tasks, towards being managed by other disciplines, no longer controlling the staff resources within each discipline, and a fear of reduced competency building if not all staff was grouped within discipline-based departments.

*“(They said) “We cannot be managed by a surgical nurse”. And they actually cannot. It’s as simple as that. And it has nothing to do with… we like surgical nurses, and we work closely with them, but we have a different profession.”* Anaesthesiology Department Head Nurse.

*“The anaesthesia staff is spread all over the hospital. They are not tied to surgical work exclusively. In order for that whole puzzle to work, it would be good to keep them as one group. Because that means less strain. People are very happy with working in different places.”* Nurse Anaesthesiologist Manager.

*“And I think there is an honest fear that their professional competency will be reduced. That their opportunity to do structured competency building, and always secure that they can perform their services in the best possible way, that it will weaken. I think that’s a real fear.”* Director of the surgical division.

These arguments were all associated with a professional logic of letting the organising of health care services be guided by the professionals’ needs and priorities (Reay & Hinings, 2009).

Table 3 (see page 22) provides a full presentation of the arguments against the new organising model.

***(Insert Table 3 about here)***

### The resulting model: compromise and challenges.

With regards to line management, it was considered impossible to suggest physicians to be managed by the one new Department Manager. Hence, this was not attempted. Physicians were not to be included in the department’s regular staff, but rather be on rotation from their home departments. The remaining staff, including registered nurses, nurses with specialties in surgery and anaesthesiology, and secretarial staff, were to be brought together as one multidisciplinary department staff reporting to one Department Manager in the new DCS.

Both surgical and anaesthesiology nursing specialties were opposed to being managed solely by the DCS Manager. The surgical nurse group and its manager in the hospital eventually conformed to the new model after pressure from the Division Director. The nurse anaesthesiologist group and its manager on the other hand resisted to the point that a compromise had to be reached, and they were able to keep most of their staff in their own department. After time consuming and contentious negotiations between the Project Manager and the Head Nurse anaesthesiologist, the resulting model was a compromise where three nurses would belong to the new department, whereas the rest would be on rotation from the hospital. For the nurses who would belong to the new department, they would stay linked to their professional community in the hospital, and follow the same procedures, guidelines and competency building processes as the nurses based at the main hospital.

In the department’s first year of operation a few challenges stood out. Staff members reported that there was a sense of two teams developing – one consisting of the nursing staff that was employed by the new unit, and one consisting of the nurses who were on rotation from their home department. There were also challenges related to staff shortages in the anaesthesia department, as they were not always able to offer a sufficient number of nurses to the DCS department. Also, there was a sense that the conflict over the organising of these nurses during the project period had left scars that made the collaboration between the two departments difficult. Nurses belonging to the new department experienced getting insufficient assistance in instances when they had to bring patients from the DCS department to the hospital surgical department, and the DCS Department Manager sometimes experienced the Anaesthesiologist Manager as less than helpful in staffing issues.

## DISCUSSION

After having worked to strengthen the DCS activities for several years and failed at implementing a multidisciplinary department before, the new organising model was finally implemented. Interprofessional collaboration is a key element in achieving greater integration between the different parts of health care services. Several studies find that such collaboration falls short of achieving the intended level of information and knowledge sharing. Disciplinary roles and boundaries, professional autonomy and the disproportionate power relations between physicians and other health service professional groups is pointed out as an important reason for this (Atwal and Caldwell 2002, Atwal and Caldwell 2006, Oborn and Dawson 2010, Gadolin and Wikström 2016, Karam, Brault et al. 2018). The literature on interprofessional collaboration is largely based on studies of multiprofessional teams, bringing together individuals from a wide range of health and social care professions that may be employed by different departments or organisations in order to translate knowledge across professional boundaries and avoid fragmentation of services for particular groups of patients or clients (Oborn and Dawson 2010, Liff and Andersson 2013, Gadolin and Wikström 2016). Our study, however, highlights challenges for nursing management in implementing and managing a department where several disciplines within the single profession of nursing were to be combined under common management.

#### The implementation challenge: conflicting logics – both of which make powerful arguments.

In primary health care, shifting towards multidisciplinary models for organising care has been found to be agreed upon as a good idea by both managers and health professionals, but adoption is slow (Reay, Goodrick et al. 2013). This case study is illustrative of how agreement on general goals of strengthening certain aspects of hospital services, such as a more patient centred DCS service, is challenged by the realities of actually having to adopt new organisational structures.

Analysing arguments for and against the new organising model illustrates how institutional logics impacted on the implementation process. It was possible to place arguments within either a business-like logic, or a professional logic. In studies of institutional logics in healthcare, a division is sometimes drawn between physicians who base their actions on a logic of cure, whereas nurses base theirs on a logic of care (Andersson and Liff 2018). In this study, however, we found that managers and directors argued on the basis of a business-like logic, whereas physicians and nurses both argued similarly on the basis of a professional logic which foregrounded the organisational and competence needs of their professional group. This similarity between physician and nurse arguments may be an indication of the move towards a higher nursing professional status (Iley 2004, Currie, Finn et al. 2010). The business-like and professional logic arguments gave different prescriptions for how a hospital department should be organised.

Motivated by a professional logic of organising work based on what is seen as appropriate from the perspective of professional judgment, it was unlikely that the physicians would agree with a model that opposed the working arrangements that they deemed most efficient according to their needs. This phenomenon has also been identified in studying the non-implementation of evidence based best medical practice. Adoption is more likely to happen if the risks and benefits of new practices are compatible with the interests, values and power of the actors involved in implementation (Denis, Hébert et al. 2002). Another recent study from the Norwegian hospital context found that a management initiated restructuring process of moving three clinics into one building sparked boundary conflicts between different physician specialties (Heldal 2015). Our study highlights the fact that nurses can also oppose new organising models on the basis of similar professional logic arguments, and that they may be powerful enough to take part in shaping the outcome of organisational change.

Management perceived multidisciplinarity as a necessary development in order to create a more modern and patient centred department prioritising the needs of patients rather than the needs of any individual professional group. Also being perceived as an improvement in the coherency of managing a surgical department, their arguments were in line with a business-like logic and drive towards delivering on targets. Their positions within the organisation shaped what they saw as favourable, and the effort they made to implement a department consistent with business-like logic principles.

Both of the involved nursing specialties were opposed to being managed solely by the DCS Manager. The nurse anaesthesiologists’ arguments against having full employee status in the new department were both professional and organisational. They worried that they would not have proper professional guidance and development in the new department, and felt that it was more efficient to have all nurse anaesthesiologist as part of the same staff resource planning throughout the hospital. Motivated by professional logic principles of unidisciplinarity as the most convenient organisational model, they strongly resisted the proposed model.

Management attempted to enforce the new model with the nurses, stakeholders who, even when specialists, traditionally have a lower level of recognition and protection than medical specialists (Nancarrow and Borthwick 2005). This strategy worked as intended in relation to the registered nurses, but sparked counter-strategies from the relatively more elite groups within the nursing profession. The collective role of nurses is changing from being regarded as doctor´s assistants to more independent practitioners (Goodrick and Reay 2010). There is also a move towards a more technical, specialized and fragmented nursing profession identified in the literature (Dingwall and Allen 2001, While 2005). The Division Director successfully employed the power vested in her formal position to include the surgical nurses in the multidisciplinary model. The nurse anaesthesiologists, however, proved to be more resistant and more powerful than what the management initially expected.

#### The management challenge: dealing with challenges caused by compromise

The outcome of the negotiations was that actors adhering both to the business-like and the professional logic partially won. Management were able to implement the new model, which was more multidisciplinary if not to the extent they had hoped. The compromises to the model resulted in some challenges at the organisational level. Managing the new DCS department required continuous adaptations regarding issues of staffing and collaboration with the stakeholders still affiliated with the main hospital. The problems experienced in the first year of operations were caused at least partly by the compromises that were necessary in order to get everyone on board. Other studies have found that interprofessional collaboration is difficult to achieve unless there is a real commitment to open communication, information sharing, collaborative goal setting and understanding of the values of other professional groups (Atwal and Caldwell 2002). Our study adds to this point by illustrating how the collaboration between multiple nursing disciplines is challenged when the process of joining the groups in a multidisciplinary department creates conflicts between the groups.

## CONCLUSION AND IMPLICATIONS FOR NURSING MANAGEMENT

Having reported on an organisational change initiative of establishing a multidisciplinary day care surgery department, this article provides a number of contributions and recommendations. Implementing a model associated with business-logic in a hospital organisation resulted in a collision of logics that sparked conflicts. The negotiated solutions and the consequences of these for the operation of the department, demonstrates how processes of institutional logic conflicts manifests on the organisational level as forces impacting the working arrangements on the ground. The study offers perspectives on why the re-organisation of professional groups is challenging and anything but a straightforward task, the potential compromises required, and insight into how the implementation process may create arrangements that remain as challenges in the foreseeable future.

The institutional logics perspective is valuable to managers in organisations where professional groups, such as nurses, are guided by other logics than the logic represented by proposed new organisation models. The perspective enables managers to understand resistance to new ways of organising work, and may be useful in trying to foresee and handle challenges in implementing new models. Health service professionals are able to recognize new models as threats to their preferred ways of organising work, to identify potential future challenges embedded in new models, and they are in a position to seriously protract or even veto the proposed changes. This ability and position may be held by more groups than expected from a traditional understanding of power relations in organisations, as illustrated in this case by the nurse anaesthesiologists.

Managers need to carefully analyse organisation models in terms of which parts may be seen as problematic in their own organisation, and invite all relevant stakeholders into participatory change processes. If the goal is to gather multiple professions and disciplines under one manager in order to increase patient centeredness, arrangements must be made for professionals to stay connected to the wider community of practice centred around their specialized knowledge and skills. At the same time, managers need to pay attention to developing department staff into one, coherent team.

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## TABLES

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| Objectives set for the new DCS department |
| * increase operational capacity
 |
| * reduce waiting lists for surgical patients as measured by average waiting time
 |
| * convert hospitalized patients to day care treatment measured by the percentage increase in DCS annually
 |
| * reduce number of cancelled surgeries
 |
| * halt the movement of patients choosing other hospitals with shorter waiting times for their procedures
 |
| * provide safer treatment and reduce risk of infections
 |
| * provide flexible patient care
 |
| * secure satisfied patients
 |
| * increase employee satisfaction
 |

**TABLE 1.** Objectives set for the new DCS department.

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| Arguments on favour of the implementation of a new, external DCS department with a multidisciplinary organisation model. |
| First order concepts and example quotes | **Second order themes** | **Aggregate dimensions** |
| Medical developments*…it really is developing so fast. From when they began to plan this more and more and more diagnosis can be handled by day care surgery, you know. You kind of see that… a few years ago, I would not have even thought that you could have breast cancer surgery and go home that same day. I would have thought “ehm…what?” - I would have thought that seemed scary. But, you know, development moves along. So I’m thinking that they – that this idea has grown over time.* Project Manager. | Progress in methods | Technology and resource factors in organisational field |
| Technological developments*It’s made me think a lot about that type of center and organising. They make it work in other places. In radiology, with new intervention technology, radiologists and medical specialists are sitting together, working. Where the patient is. And that’s a bit of the idea around the center. So it’s really the technology which is also driving the ways to think.* Project Manager. |
| Increase in funding for DCS*When they started this process, there was a lot of money put in increasing the rates paid for day care surgery in order to free up space in the hospitals.* Project Manager | Added resources |
| Increase in DCS staff*They’ve added staff positions in order to go through with this (the new DCS department).* Project Manager |
| Existing department too small and not functional*In my time, the existing DCS department has been re-built and expanded.But it quickly became too small again.* Senior Consultant, existing DCS department. | Space constraints in existing department | Resource factors in organisation |
| Not possible to find new space inside the hospital*It’s too small here, there is no space for it.* Project Manager.  |
| Other hospitals building up their DCS departments*So, the hospital of the future will be more directed towards DCS? Yes, that’s right. And when is that future arriving? In other countries, it’s already here.* Head Nurse, existing DCS | Inspiration from other organisations | Trends and demands in organisational field |
| Private hospitals are more efficient*I believe that when public hospitals have visited private providers, and heard how good they are at getting a lot of patient through, the public ones say: «wow, there’s a lot of money to be made here for us”. Or saved.* Senior Consultant, existing DCS department. |
| A trend towards shielding planned activity from acute care*There’s been this trend that they want to shield what is planned activities, you know?* Project manager. |
| Managers travel to study other hospitals*All these directors, they travel to around to see other places.* Project manager.  |
| Patient demands*Most patients think it’s wonderful not to have to stay in the hospital – they get to go home.* Project manager. | Societal demands |
| Owner and hospital board demands*Evident in project documents.* | Clear signals from top management | Business-like logic arguments |
| Director of surgical division determined to deliver on demands*It has to succeed. And the result targets set are incredibly tough, and the number of patients treated has to be delivered. And it has to increase.* Director of surgical division. |
| Increased capacity, efficiency, volume of DCS activities*We had to do something, because the capacity was too low*. Director of surgical division. *It’s a wish to use resources more efficiently than what is currently happening in the hospital, that’s part of the point.* Project manager. | Efficiency and economic goals |
| Reduce waiting times*Efficiency is not just something that is supposed to make money for the hospital. It’s also in order to provide treatment to patients without them having to wait so long.* Project manager.  |
| Retrieve patients who are currently going elsewhere*We have a lot of patients who are travelling out of the county in order to receive DCS treatment.* Director of surgical division. |
| Reduce overnight stays in the hospital*That way, it’s possible to save a lot of overnight stays in hospital which is – at least in our case, probably in a lot of other places to – overburdened by patients just lying and lying there, taking up a lot of space and resources.* Senior Consultant, existing DCS department. |
| Shield elective services*So, it’s in order to shield that activity, get through more procedures, get it to be more efficient, yes - streamline the treatment pathways.* Project Manager. |
| Organising professionals around the patient*We should organise our staff according to the services they are to provide to our population.* Director of surgical division. | Increased patient centeredness |
| Focusing on patient needs*Here, the patients will get smart solutions, efficient solutions and feel like they are taken well care of, get a top quality treatment service.* Project manager. |
| Clear lines of leadership and communication*They (staff in existing DCS) want a clearer line of communication. Because that’s partly what they are struggling with today, they have three or four managers and no one can point to who’s in charge there.* Project manager. | Professionals will be working as one, unified team |
| Avoiding separate groupings*We are going to work together in other professional groups. New disciplines are coming in, and we have a new building, we are going to think in a way where it’s not like those people eat their lunch over here, those people are over there and those people are over there. We are going to be an “us”.* Project Manager. |
| Increased collaboration and multidisciplinary teamwork*We’ve come a long way, because we have managed to create a unit that includes all professional groups except the physicians. If it had been any other hospital at our size, you would meet one manager for the surgical nurses, one manager for the registered nurses, one manager for the nurse anaesthesiologists, one manager for cleaning, and one manager for secretarial staff. If you asked them «who’s in charge of the DCS?» all five would say “it’s me”, you know? So even if it seems like this is a small step, it’s actually a giant leap.* Director of surgical division |
| Less strict task division among separate professional groups*(…) having a common manager in order to establish a new center with new ways of working and efficiency and cooperation and great solutions for the patients – it’s an advantage to be organised in the same department. Pulling the weight together, having everyone as part of the same team.* Project manager. |

**TABLE 2.** Arguments in favour of the new department: first order concepts, second order themes and aggregate dimensions.

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| Arguments against the implementation of a new, external DCS department with a multidisciplinary organisation model |
| First order concepts | **Second order themes** | **Aggregate dimensions** |
| DCS work is not diverse*And up here at central operations, they get more innovative and diverse work. There’s also a bit more blood and a bit more action.*  Senior Consultant, existing DCS department.  | DCS work not attractive | Professional logic arguments |
| DCS work is not exciting*(Some will say that in the new DCS there will be) too few challenges, not enough excitement, not enough action, not enough pressure.* Nurse anesthesiologist. |
| DCS work tasks are demanding*Anaesthesia is an art. Doing it just right. Up here at central operations, you can “bang” medication into most patients. And then they lie there. And after, it doesn’t matter if they’re a little groggy, out in the post-op department. They can come back slowly. Whereas down there (the new DCS department), you have to control it so that they (snaps finger) are awake after the surgery is over.* Senior Consultant, existing DCS department. |
| A small and less diverse working environment*What’s very exciting about working in a hospital (…) is the enormous diversity, you encounter it on your way to the cafeteria. You’ll lose that part of the job. Meeting people that you haven’t seen in a very long time and all that. So, you’ll lose some of that.* Project manager. | Resistance against external location |
| Risks to patient safety*Discussed repeatedly in project meetings.* |
| Identity and a sense of belonging to “mother departments”*It’s about a threat to identity. And that’s dangerous, in the sense that such a strong feeling of identity is also an important value and a foundational pillar in the health service.* Director of surgical division. | Resistance against the multidisciplinary organising model |
| Traditionally each discipline controls its own staff resource*The anaesthesia staff is spread all over the hospital. They are not tied to surgical work exclusively. In order for that whole puzzle to work, it would be good to keep them as one group. Because that means less strain. People are very happy with working in different places.* Nurse Anaesthesiologist Manager. |
| Scepticism towards being managed by other disciplines*(They said) “We cannot be managed by a surgical nurse”. And they actually cannot. It’s as simple as that. And it has nothing to do with… we like surgical nurses, and we work closely with them, but we have a different profession.”* Anaesthesiology Department Head Nurse. |
| Fear of reduced competency building*And I think there is an honest fear that their professional competency will be reduced. That their opportunity to do structured competency building, and always secure that they can perform their services in the best possible way, that it will weaken. I think that’s a real fear.* Director of surgical division.  |

**TABLE 3.** Arguments against the new department: first order concepts, second order themes and aggregate dimensions.

1. Approval number 33311. [↑](#footnote-ref-1)