Understanding in Healthcare Organisations
- a Prerequisite for Development

BY

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ABSTRACT

This study proposes that a poor understanding of the structures, processes and outcomes of healthcare seriously hampers collaboration between professional groups in care organisations. Three care settings were investigated: follow-up of patients with heart disease, an intensive care unit and elderly care services. The aim was to investigate how people understand structures, processes and outcomes in care organisations. The participants were patients, healthcare professionals, managers and politicians. A qualitative approach was used. Thematic analysis and grounded theory were employed in analysing the data. Despite considerable efforts, no major changes took place over a 7-year period as to how cardiac follow-up services were understood. The system of cardiac follow-up services was found fragmented in its organisation and in the way individuals understood it. The results indicated that care professionals, patients and leaders have dissimilar understandings. The data suggest that care is organised from a professional-centred perspective, rather than from a holistic worldview of the patient’s total context. Leaders in intensive care perceive their organisation as a learning organisation. However, in daily work healthcare tends to function to what can be described as a mass production approach to care. This state of conflict caused confusion and chaos among the leaders. The municipal elderly care services and the county councils’ geriatric organisation had difficulties in co-ordination. Older people were perceived as passive recipients of healthcare, rather than as consumers whose well being and outcome were a reflection of the quality of the service. The study concludes that despite the major changes that have taken place in the Swedish healthcare organisation over the past years, healthcare professionals’ understanding of their work has gone largely unchanged. Their understanding of care structures and processes did not change despite outside pressures. Lack of understanding of what others understand hampers development with the result that care organisations risk stagnation.

Keywords: understanding, elderly care services, healthcare organisation, complex adaptive system, gender, power, care structures, care processes and care outcomes.

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To Hans
PAPERS INCLUDED IN THE THESIS

This thesis is based on the following papers, which are referred to in the text by their Roman numerals:


IV Henriksen, Eva & Rosenqvist, Urban. (2003). Contradictions in Elderly care, a Descriptive Study of Politicians and Managers Understanding of Elderly Care. Health and Social Care in the Community (Accepted)
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Preamble

Being a nurse, a nurse teacher and a mother of three girls (I do have, a son and husband) I am surrounded daily by women existing in a patriarchal structure of the world. Why is it that in care organisations, although clearly in the majority, women are unseen, underpaid and over worked? These are contradictions that constantly confront me in care work. Becoming a researcher has been a long process, and finishing this thesis is only some stumbling steps on the way. The studies I have done have all had the setting of the work I am currently doing and I hope this can serve as an example to others. Do your research where you are. Research does not have to be done in special projects and artificial environments, on the contrary, the stimulating part of my research has been that it has all been done parallel to my daily work.

Two questions I have asked are: What does a good caring environment look like? How can positive working conditions in health and elderly care be developed so that young people, men and women, will want to work there? My interest turned from nursing the individual patient to studying those in charge, i.e. those who have the authority, the power to change and modernise care. Questions I sought answers to were: How do different actors understand their professional roles as leaders and visionaries? How do they understand the consequences of their decisions?

For as long as I have worked in healthcare, political key concepts have been co-ordination, continuity and a holistic worldview of care. One method to study these concepts was to study the organisation for certain key groups. One group was the patients; other groups were, leaders, politicians and care professionals. A positive result of the first study is the assignment of a co-ordinating nurse to guide patients in their cardiac follow-up. Another positive result is that politicians and senior managers, together with leading care professionals, have developed a common vision for elderly care services in the northwestern sector of greater Stockholm County. I hope that these visions (see the individual, see the individual’s resources, see the encounter, and see yourself) will encourage staff to reflect upon their work and organisation so that care in the future, will be more patient-centred and the caring staff members will find it positive and stimulating to develop care wherever they work.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AMI</td>
<td>acute myocardial infarction</td>
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<tr>
<td>CAS</td>
<td>Complex Adaptive System</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>NPM</td>
<td>New Public Management</td>
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<td>NWSC</td>
<td>Northwestern Stockholm County, a part of Greater</td>
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<td></td>
<td>Stockholm County</td>
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<tr>
<td>RHLA</td>
<td>Representatives of the Heart and Lung Association</td>
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<td>ÄNV</td>
<td>Research and Development Unit for Elderly Care</td>
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</tbody>
</table>
Chapter 1

Introduction

This thesis describes understanding of healthcare services from the perspective of some key actors in three care settings. The phenomenon of understanding was investigated with different methods. The results indicate that the participants’ understanding remained stable even in times of major organisational changes. Stability in society is often seen as a good aspect, that offers security and predictability. In complex systems, however, stability is sometimes seen as rigid structures that hamper development efforts.

The first chapter of this thesis is concerned with the concept of understanding, the theoretical framework and aims of this thesis. The second chapter describes central concepts and the settings of each study. The third chapter discusses qualitative methods. The fourth chapter pertains to the participants and methods used in the studies. The fifth chapter is a discussion of Studies I-IV. The sixth chapter discusses the results and the conclusion of the thesis. The seventh and final chapter presents a Swedish summary of the thesis.

Understanding in care organisations

The notion of understanding can be described as the process of discovering the insider’s perspective for a given situation. It is the discovery of the ways in which a culture accomplishes its human ends: why the approach works for a specific culture and under what circumstances an approach works to achieve desired ends (Morse & Field, 1996). In the beginning of the 20th century, understanding the meaning of social actions was described by the German philosopher and historian Wilhelm Dilthey. He proposed a distinction between the natural sciences and the human (mental) sciences.
According to Dilthey, “Nature we explain; psychic life we understand” (Schwandt, 1997).

At the Chicago School of Sociology in 1920, social interactionists asserted that the human self emerges from the process of social interaction with others. According to this view, people act toward things based on the meanings things have for them; furthermore people interpret how they deal with things in the context of their environment (Ritzer, 1992; Vehviläinen-Julkunen, 2000). In social-gerontologic theories “a third generation” of theory development is described. Such theories are multidisciplinary, building on sociology, psychology, history, and pedagogics. The third generation theory focuses on a life perspective on aging which includes gender perspectives (Bengtson, Burgess, Parrott, & Mabry, 2002). Therefore, when studying understanding in care organisations, it is necessary to use a multidisciplinary approach. Our understanding of reality forms the basis for our activities and our behaviour in organisations: as such, different professionals need to collaborate, both in care work, research and in forming organisational structures (Ferlie, 2001). Major efforts to change care organisations have been done during the past decade (Borgert, 1992).

Theoretical Framework

From a theoretical perspective, the concept of understanding needs to borrow theories from different areas and to cut across multiple disciplines, including sociology, pedagogics, gender studies and organisational theories. The theoretical framework for this thesis stems from Bourdieu’s core concepts of habitus, capital and field (Bourdieu, 2002; Broady, 1991). The concepts of culture, power and gender will also be stressed in this thesis (Sherwin, 1992; Smith, 1990). Another framework that I have chosen to include is complexity science (Institute of Medicine [IM], 2001; Lewin, 2001; Zimmerman, Lindberg & Plsek, 2001).

Understanding represents an aspect of what Bourdieu calls the system of dispositions: the capital, the habitus and the field. Bourdieu’s theories of the symbolic and cultural capital were developed when he was studying the educational system in France. In the present thesis I have chosen mainly to apply Broady’s (1991) and Ritzer’s (1992) interpretations of Bourdieu’s theories and texts. Bourdieu asserts that a basic concept of culture is the concept of capital (other concepts for capital are resources or values). These can be symbolic or of a more “real” art, i.e. finances. Important to culture is
symbolic capital, which is different in different groups. It can refer to knowledge, trust, reputation, institutions, prestige, titles, etc. Symbolic capital is usually grounded in a group’s beliefs of what is valuable (Ritzer, 1992).

By *habitus*, Bourdieu denotes a person’s mental or cognitive structures or actions, ways of thinking and perceptions of social constituents (a sort of common lifestyle in a group). Habitus refers to the structures through which people deal with the social world. According to this view we are endowed with a series of internalised schemes through which we perceive, understand, appreciate and evaluate the social world (Broady, 1991; Ritzer, 1992).

The third dimension that Bourdieu describes is the concept of *field*. Bourdieu suggests that a social field exists when a group of people and institutions become operative or take a stand for what they believe is important. People have common goals with ideals or definitions of what is of value. There are many fields in the social world, i.e. religion, art, economy and medicine, all with their own specific logic and all generating in actors a belief about the things that are at stake in a field (Ritzer, 1992, p. 580). Other examples of field are freedom of speech in institutions, the freedom of research and the freedom of academies. Bourdieu defines social field in the following manner:

> A system of relations between positions of special agents and institutions who struggle for a common cause” (Broady, 1991, p. 266).

Because people are historical beings living in different realities, the concept of understanding has many cultural and emotional dimensions. In line with Bourdieu, (2002) a person’s individual history is only a specification of the collective history of his or her group or class. Thus, the world is understood from different life conditions and perspectives (Sohlberg & Sohlberg, 2002). The social context, the school system and higher education all incorporate this system of social dispositions that influence our actions, ways of thinking, values and perceptions. The traditional way of organising institutions can be seen as a result of social norms, traditions and culture.

> ... in each of us, in varying proportions, there is part of yesterday’s man; it is yesterday’s man who inevitably predominates in us, since the present amounts to little compared with the long past in the course of which we were formed and from which we result. Yet we do not sense this man of the past, because he is inveterate in us; he makes up the unconscious part of ourselves (Bourdieu, 2002 p. 79)
Diverse care professional groups and patients have different ways of understanding care organisations and care processes. My hypothesis is that the different ways of understanding care organisations and care work are a major reason for the current gap between what shall be done according to theory and scientific evidence and what is practiced in care organisations. Such a gap is a serious problem because of the large risk that it hinders innovative care work.

Understanding organisations include culture, power and gender

**Culture**

Although the theories of dispositions include aspects of culture, power and gender, I want to particularly stress those aspects and include some additional perspectives. In the different studies of care organisations from an understanding perspective, I have found that culture, power and gender play a large role in the structures, processes and outcomes in care settings. The way a person or group describes culture is often in relation to shared values, beliefs, meaning, understanding and shared sensemaking. Culture can be described as a process of reality construction, allowing people to see and understand particular events, actions, objects, utterances or situations in distinctive ways. In many organisations there may be divergent and competing value systems that create a mosaic of organisation realities, as opposed to a more uniform, corporate culture. Gender, language, ethnicity, religion, socio-economic status, friendship and professional groups can have a decisive impact on the cultural mosaic of an organisation. Diverse professional groups may each have different views of the world and of the nature of their organisation’s business (Morgan, 1997).

The success of an organisation, its capacity to change and its ability to adapt are completely dependent on its people. Leaders play a defining and often pivotal role in shaping the future and career paths of the people they lead. During times of change, it is necessary to have an open communication that builds on a sense of excitement, inclusion and trust. Lack of communication during times of transition and significant change can breed distrust and confusion, where staff members fill the void with rumour and fabrication. Effective leaders have the ability to share their enthusiasm and spirit, which are spread to other members of the organisation (Duncan & Warden, 1999).
Power

Power is a complex social structural phenomenon (Ritzer, 1992). Social and medical sciences develop discourses and institutions that have a significant impact on subjectivity and on the construction of reality. It is not the knowledge itself, but the practices that follow from it that is the exercise of power. In organisations, social order is produced and reproduced according to its members’ unique possibilities and powers to influence. Power is closely related to knowledge (Sebrant, 2000). Management in healthcare is much concerned with new ways of steering and power structures (Lindgren, 1999).

“Dominant groups always need a ‘theodicy’ of their own privilege’ or more precisely, a sociodicy, in other words a theoretical justification of the fact that they are privileged. Competence is nowadays at the heart of that sociodicy” (Bourdieu, 2001, p. 43)

The healthcare sector is characterised by a professional hierarchy and bureaucratic tradition. The medical profession has traditionally had a strong and dominate role with considerable influence on the entire sector (Blomgren, 1999), a dominance that continues today (Diwan, Sachs, & Wahlström, 1997). However, this superior development has been weakened by, for example the introduction of new research programmes and by making university disciplines of other healthcare professions (e.g., nursing, physiotherapy and occupational therapy) (Lindgren, 1992). One purpose for maintaining a hierarchical system in care is that it protects against anxiety in caring, an important factor when a person’s life and death is at stake (Mogensen, 1998).

Hierarchy implies differentiation of policy- and decision-making capacities ascribed to positions in an apparatus of ruling or in organising relations to ruling. Hierarchy is not just internal to an organisation in that relations among professions in the same fields are ordered hierarchically as well (Smith, 1990). Administrative, professional or managerial activities tend to be bound hierarchically to each other. A contradictory aspect is that people most often reproduce traditional power structures though they want change (Lindgren, 1992). The Swedish government stated in 1996 that hierarchies in caring organisations take away energy and focus from caring, and therefore organisations with a less hierarchic structure is a prerequisite for development (SOU, 1996a).

1 By the right of God (rättfärdigande av Gud) (Lubcke, 1988).
Gender

Women are commonly assigned to a lower position in the hierarchy and domains that tend to be dominated by women are commonly lower in the hierarchical structure (Smith, 1990, p. 101). Women in care work constitute more than 80% of the labour force in healthcare worldwide, but men clearly have the leading positions in all key segments of society. In healthcare services, male physicians, male managers and male senior managers and politicians control care policy. Women typically work in middle-positions in care administration, where they usually take the role as mediator. Although such a role is desirable, it has little or no influence on policy (Sherwin, 1992). Elderly care services worldwide also employ mostly women. Women’s caring work is thus of great importance as producers of other people’s health (Oakley, 1993). In the past women with heart diseases have not been as actively followed-up or rehabilitated as men (Hippisley-Cox, Pringle, Crown, Meal, & Wynn, 2001). However, today there is a growing consciousness about gender differences in follow-up services (Hammarström, 1999; Svedlund 2000). Women are the dominating users of both healthcare and elderly care services, indicating that women dominate care in more than one respect (Bird & Rieker, 1999; Lindgren, 1999; Wånell, 2001). From feminist theory, gender is regarded as a social construct, ascribing women certain advantages and disadvantages. In a feminist life perspective, attention is paid to the relation between social, political and economic aspects and women’s life conditions (i.e. the cumulative effect of poverty among older women). Women outnumber men over the age of 60 in Sweden, and an increasing number of older women live alone. In the age group above 80, women make up two thirds of that population (Öberg, 2002).

Understanding complex organisations

Complexity science is not a single theory; rather it is the study of complex systems, the patterns of relationships within them, how they are sustained, how they self-organise and how outcomes emerge. Complexity science is interdisciplinary and an attempt to answer questions about living, adaptable, changeable systems (IM, 2001; Zimmerman, Lindberg & Plsek, 2001). Healthcare organisations, on the other hand, are mechanical systems and complex adaptive systems at the same time. In a mechanical system, we know and are able to predict in detail what each component will do as a response to a given stimulus. In complex systems, however, the components respond to stimuli in different and fundamentally unpredictable ways,
sometimes voluntarily and sometimes involuntarily. Mechanical system thinking works well in many situations when applied to human systems; for instance, it has led to great progress in the field of technical medical care (Plsek, 2001).

In the current management literature on healthcare the organisation is often regarded from the perspective of complexity science. In a complex organisation we can observe that different components of the organisation work and co-ordinate with other components. The different components are described as “microsystems” within a “macrosystem”. The strength in complex organisations depends on how different components co-ordinate to fulfil their task (Plsek, 2001). A large organisation, such as the healthcare system, consists of a number of subsystems, all with different tasks; however, the components of the system are dependent on each other for proper functioning (Boalt-Boethius & Jern, 1998; Greenhalgh & Plsek, 2001). Complex organisations are frequently referred to as complex adaptive systems (CASs).

The term complex implies diversity, meaning that there are a great number of connections among a wide variety of elements in the organisation.

Adaptive suggests the capacity to alter or change, as well as the ability to learn from experience and the history of the organisation. People are described as being adaptive when they have the capacity to adjust effectively to environmental changes and when they can have a significant affect on the environment (Tiedeman, 1996).

A system is a set of connected or interdependent elements, things or units. The “things” in CASs are independent agents. An agent may be a person, a molecule, a species or an organisation (Zimmerman, Lindberg, & Plsek, 2001).

From a mechanistic perspective, processes in CASs are unpredictable and often uncontrollable. Therefore, senior managers and executives can only influence their organisations as to where to go and how to evolve (Lewin, 2001). A few simple rules have been identified by which CASs operate: the source of emergence is the interaction among agents who mutually affect each other; small changes can lead to large effects; emergence is certain, but there is no certainty as to what it will be; and a greater diversity of agents in a system leads to richer emergent patterns (IM, 2001; Lewin, 2001, p. 202). CASs are non-linear systems, which implies that the result can, and often will be, greater than the sum of the inputs (Burns, 2001).
Overall aim of the study

The overall aim of this thesis was to explore how patients, patient representatives, healthcare professionals, senior managers and politicians understand the meaning of structures, processes and outcomes in care organisations and to investigate how their understanding changes over time.

Specific aims of the study

- to study how central concepts in follow-up services are understood among the participating patients, patient representatives, healthcare professionals and senior managers after a major cardiovascular event
- to investigate if and how measures taken by the healthcare staff affected their way of understanding care structures and processes over time
- to study healthcare leaders’ understanding of structures and processes during a period of downsizing and restructuring in an intensive care unit
- to explore how key stakeholders in elderly care services understand elderly care services and how they comprehend the consequences of their understanding.
CHAPTER 2

Concepts and settings

Before proceeding further, it might be useful to define the key concepts used in this paper.

The term care structure denotes the attributes of the settings in which care occurs and to the order (among care providers) in which care is performed, including procedures and positions in the hierarchy. The structure of an organisation ensures that individual differences among its members are held at a reasonable level (Fahlström, 1999). Structure includes the attributes of material resources (facilities, equipment and money), of human resources (the number of personnel and their qualifications) and of organisational structure (the organisation of the medical staff, methods of peer review and methods of reimbursement). The study of structure includes material and social intrumentalities, the number of staff, the mix of staff and the qualifications of staff. It also includes the manner in which staff is organised and governed, i.e. space, equipment and other physical facilities. The assessment of structure is a judgement on whether care is being provided under conditions that are either conducive or inimical to the provision of good care. Demands, control and professional roles are important attributes of structure, as is the history of the organisation, sometimes shown in the mottoes and culture that the organisation embraces (Fahlström, 1999).

Care process denotes what is being done in the act of giving and receiving care. It includes a patient’s activities in seeking care and carrying it out, as well as the healthcare staff’s activities in caring. In short, it refers to how care services are organised, delivered and used (Bowling, 1997).

Care outcome refers to the effects of care on the health status of patients and populations, including improvements in the patients’ knowledge and salutary changes in behaviour and the degree of the patients’ satisfaction with care
Outcomes refer to effectiveness of activities in relation to achievements of the intended goal (Bowling, 1997).

Changes in care structures in Sweden

Health and elderly care in Sweden has undergone numerous structural changes and reorganising programmes during the past decades (Table 1). In organisational studies the focus is on how people behave within organisations. Norms, cultures, power relations and institutions are social constructs that play a major role in how people act. Our understanding of reality forms the basis for our activities and our behaviour in organisations (Ferlie, 2001).

Table 1 shows the major structural changes in the health and elderly care organisations over the past 40 years in the county of Stockholm.

<table>
<thead>
<tr>
<th>Year</th>
<th>Acute Care Model</th>
<th>More focus on chronic diseases and elderly care</th>
<th>Need for elderly care services</th>
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<tbody>
<tr>
<td>1960</td>
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<td>2000</td>
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Table 1. Overview of major structural changes in the health and elderly care organisations over past 40 years in the county of Stockholm

* Storlandstinget = Greater Stockholm County
** NPM = New public Management
*** TQM = Total Quality Management

E. Henriksen 2002
The traditional acute care model is a merger between the medical/physical effective “care and production hierarchy” and the administrative/management economically effective “control and co-ordinating hierarchy” (Gustafsson, 1987). In the 1960s and 1970s, the acute care model and professional hierarchical care structures moved toward more administrative and bureaucratic models. Such models were governed by planned economy, dominated by institutional care and professional-centred perspectives. During this period, there was a major expansion of hospital beds and primary healthcare centres. By the end of the 1980s, the total healthcare sector had reached a standard solution for the entire country. This solution was based on a strong medical professional hierarchy, bureaucracy, specialisation and technical rationality (Blomgren, 1999). In the early 1990s, a major structural change challenged the acute care model. There was a general reduction of budgets in the public sector. Moreover, institutions were closed and the expansion of primary healthcare was halted. By 1995, care production decreased with diminished public resources (Socialstyrelsen, 2000a). In the 1990s, the ideology of care moved toward an ideology that was more market and quality oriented (Sebrant, 2000). The base for the healthcare system was primary healthcare. However, in an evaluation in 2001, only a few counties in the country had achieved primary healthcare as the foundation for medical care services (Socialstyrelsen, 2001a).

The New Public Management

The idea of a new public management (NPM) model aimed at making public organisations conform to a more businesslike approach was introduced in the early 1990s. The phenomenon of NPM includes splitting organisations into purchaser-provider components and profit-centred models originally developed within the framework of market and business corporations (Blomgren, 1999; Garpenby, 1997). The idea of quality assurance, “total quality” and “customer service” movements, which are components of the NPM, was also introduced during this time (Morgan, 1997; Skålén, 2002). The model came to be known as “Stockholmsmodellen” (The Stockholm model), a framework that concentrated on making hospitals independent production units. Additional to this model came two new reform programmes: “Nya Grepp” (New Ways) and “Konkurrensprogrammet” (a programme to encourage competition). In addition to these programmes, a family doctor reform was introduced at the same time in primary healthcare (Blomgren, 1999; Skålén, 2002).
However, the family doctor reform that was implemented in primary healthcare was temporarily blocked, only to be fully implemented by the end of the century. The reason for this temporary action was changes of the political majority in the local government. In the mid 1990s, “Stockholmsmodellen” was modified. By the turn of the century, healthcare units were starting to be sold out and a stronger market-oriented perspective was implemented (Sebrant, 2000). Nevertheless, the healthcare system was still financed through taxes and under the control of either the county councils or the municipalities.

Other reorganising movements in healthcare

Other movements in public healthcare management were “reengineering” and “empowerment”. These movements were aimed at strengthening patients’ position by increasing their access to information about their illnesses. To be effective the movements needed to transform prevailing organisational mind-sets and political patterns, transformations that, for the most part, failed (Morgan, 1997).

“Care-chain” is a metaphor often used when describing a patient’s path through the healthcare system. A critical analysis of the concept of “care-chain” is that “care-chains” are practical from the administrative view and from the perspective of the healthcare professionals. “Care chains” are not designed to make it easy for patients to find their way in the care system (SOU, 1996b). The metaphor “chain” conditions that a patient goes from A to B, to C, etc., i.e. that patients move from one given point to another. The care chain perspective has a professional and administrative view and is called the professional-centred perspective. This perspective has forced care to be fragmented, with care fittings into specialised compartments within the culture of acute care (Carlson, 1990; Östergren & Sahlin-Andersson, 1998; Øvretveit, Mathias, & Thompson, 1997). The professional-centred perspective is still a strong force in most care situations today (Holmström, 2002; SOU, 1996b). In practical care, the metaphor of a network of care providers around the patient would be more appropriate than care chain.

Toward the end of the 20th century patient empowerment movements gained ground, with the significant result that patients’ rights were substantially improved. Care providers were obliged to improve information to patients

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2 Lecture based on the study “Att Hantera Skilda Världar” (in Swedish).
concerning care and alternative treatments. The patients were given a right to comprehensive information and influence over their own care and treatment. In difficult cases patients have the right to seek a second medical opinion. In contrast to earlier regulations when people were not allowed to go outside a certain catchment area for care (i.e. people were bound to a specific hospital or primary healthcare centre), the new system allowed patients the freedom to choose their care provider. Still, Sweden currently has no law to support patients’ rights (Socialstyrelsen, 2001b).

The three domains

Traditionally, the Swedish healthcare system comprises three domains: the political, the administrative and the professional. Although these three domains should work in harmony with one another, in practise the domains are sometimes in disjunction and discord with one another (Kouzes & Mico, 1979). Each domain has its own norms, traditions and control systems. The professional domain has developed increasing autonomy and is thus sometimes in opposition to both the political and administrative domains. The medical profession in particular occupies a strong and highly independent position in relation to the political and administrative domains (Socialstyrelsen, 2001b). Most importantly, the three domains lack a common vision for care, which, according to some people, is a possible reason for the identity crisis in healthcare today (Sandlund, Forsberg, & Wager, 2001). In the past decade, re-organisation toward a more market- and client-oriented healthcare system has put new demands on political and administrative leaders and care professionals, as well as on patients and their families. New perspectives focus on co-ordination between care levels, professionals and patients (whether financed by the county, municipality or privately) and on peoples’ understanding of their attitudes and work processes, both in terms of specific, daily activities and broad general activities.

National changes in the provision of elderly care

In 1992, the Swedish government reached a decision to implement a major organisational reform concerning care of older people in Sweden, namely the Ädel Reform. This reform gave the municipalities the statutory responsibility for their older and disabled citizens, including all elderly patients. In practical terms, it meant that the municipalities were given sole responsibility for all persons over 65 years of age that were judged
sufficiently medically treated and discharged from hospital. The municipality thus became the agent for elderly care services that were once provided in nursing homes and in domiciliary care, including care that was provided in private nursing homes. Through the Ädel Reform, the municipalities became significant producers of care and new professional groups entered the municipal arena, with the exception of the physicians who were still employed by the county councils. For the first time, the municipal social elderly care culture met the county council’s healthcare culture, an encounter that soon led to major difficulties in acculturation.

The Ädel Reform asserts that every municipality has to have a medically responsible nurse and must co-ordinate care interventions with the county council’s healthcare organisation, community organisations and private bodies. Today, social welfare committees or the equivalent head the local authority-run health and nursing care organisations (Socialstyrelsen, 1999). Before the Ädel Reform, bed blockers had been a serious problem for hospitals and acute care (Styrborn & Thorslund, 1993). In 1996, the National Board of Health and Welfare evaluated the Ädel Reform (Socialstyrelsen, 1996). The evaluation revealed that the number of bed blockers in acute hospital care and geriatric clinics had been lowered and waiting times before discharge were shortened. Consequently, the pressure on all parts of the care continuum had increased. Nowadays, it is only those older persons who are severely ill and in most need of help who receive domiciliary care. Fewer people are receiving help from the communities, even though the average input per person assisted has increased (Hellström & Hallberg, 2001).

Settings of the studies

**Studies I and II** investigates changes in follow-up processes in patients after a major cardiovascular event. In 1990, one of several political goals for the healthcare system in the county of Stockholm was to significantly reduce mortality and morbidity in cardiovascular diseases over the next 10 years (Henriksen, Johansson, & Rosenqvist, 1993). This was to be accomplished by intensifying prevention of cardiovascular diseases and secondary prevention (Socialstyrelsen, 1992a;Socialstyrelsen, 1992b). In the Swedish Medical Health Service Act of 1983, prevention was given the same status as medical treatment. In the programme ”Healthcare in the 1990s” emphasis was given to the three dominating risk factors for cardiovascular disease, namely high blood pressure, high blood lipids and smoking (Socialstyrelsen, 1992a). A primary target of the WHO strategy was to reduce mortality that
was due to cardiovascular disease by at least 15%\(^1\). The Swedish National Board of Health and Welfare encouraged local governments to form guidelines and programmes for cardiovascular disease prevention. Special emphasis was to be on secondary prevention, which was given a prominent role in the healthcare organisation.

The northwestern part of the greater Stockholm county council formulated a programme for patients after they had suffered from an acute myocardial infarction (AMI) (NVSO, 1995). In this programme a marked emphasis was given to rehabilitation and information for both patients and their family. After discharge from acute care, all patients were offered a return visit to a nurse-led AMI clinic, which had been started some years earlier. This nurse-led clinic was evaluated in 1993. Positive effects from the evaluation were observed, particularly in male patients and on their psychosocial variables (Undén et al., 1993). After patients had visited the AMI clinic, primary healthcare took responsibility for follow-up processes and further rehabilitation (all rehabilitation of older patients) as well as secondary prevention. If younger and middle-aged patients wished, they could visit special rehabilitation centres that offered programmes for secondary prevention, with special focus on lifestyle changes. These visits were paid for by the National Insurance System (Försäkringskassan) or by the healthcare system, or jointly. In the middle of the 1990s, during the period of the present study, the nurse-led AMI clinic was abruptly closed, with no comprehensive reason given to the nurses running the programme.

**Study III** investigate recent changes within an intensive care unit. The fast development in high-tech medicine has forced intensive care to concentrate its resources to optimise both technical usage and scientific-knowledge. Today, with the advancement of technical-medical field, a larger number of old and frail patients are being operated on or resuscitated with good results. This fact has put new organisational, ethical, medical and nursing demands on healthcare workers. Such demands also include professional development and development of teamwork with multidisciplinary training and collaboration with new professional groups, i.e. the municipal staff in charge of care services for older people (IM, 2001).

**In Study IV**, another major organisational change was investigated within the provision of care services for older people at a local level. In 2000, the National board of Health and Welfare reported that there is a widening gap between needs and resources in the health status of older people

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1 Health for all in Europe by the year 2000.
(Socialstyrelsen, 2000b). It is estimated that 20% of the inhabitants in suburban Stockholm are over 65 years of age and that 50% of their households consist of single dwellers. In the central parts of Stockholm the proportion of inhabitants over 65 years is 30%; of these, 70% are living alone (Wånell, 2001). A major criticism of elderly care services is that older people lack information about the care system and have little or no influence over the care they receive. New national goals for policy on care of older people were inaugurated in 1999, with aims to ensure that older people would be able to lead an active life, play a larger role in society and to have greater influence in their day-to-day life (Socialstyrelsen, 2002a).
CHAPTER 3

Qualitative method

In the present study qualitative methods were used. Qualitative research is often linked to social inquiry, with roots in hermeneutics, phenomenological sociology and the Verstehen tradition. It originally stems from the 19th century German tradition, especially the work of Dilthey, Kant and Weber (Schwandt, 1997). Qualitative research focuses on descriptive data, i.e. an individual’s written or spoken word and observable behaviour. Qualitative inquiry is one feasible means of approaching the empirical world (Taylor & Bogdan, 1984). It can refer to research about peoples’ lives, stories, experiences, behaviour, perceptions and understanding, but it can also concern organisational functioning, social movements or interactional relationships. Data can be obtained in a variety of ways, including interviews, observations, participation, documents, books, videotapes and memos. Qualitative research is used to study individuals, groups or organisations (Morse & Field, 1996).

Qualitative research is inductive, meaning that the researcher develops concepts, insights and understanding from patterns in the data. This approach differs from quantitative research, which, collects data to assess preconceived models, hypothesis or theories. Usually, the researcher examines the data for patterns and relationships and then develops and test hypotheses to generate theory or uses developed theories to explain data (Fridlund & Hildingh, 2000; Morse & Field, 1996). The perspective in qualitative research is holistic in the sense that the settings and people are viewed in the context of their past and present situations.

In qualitative research the researcher often interacts directly with the participants. Thus, the researcher needs to be particularly sensitive to the effects and influences he/she might have on the participants or their processes. A researcher in qualitative studies has to try to suspend, or set
aside, his or her own beliefs, perspectives and predispositions and to understand people from their frame of reference (Taylor & Bogdan, 1984).

A multimethod approach (triangulation)

To understand complex human phenomenon it is necessary to triangulate the results of multiple separate projects using diverse methods (Morse, 2002). Triangulation implies combining different methods or sources of data in a study, or looking at the same phenomenon from different perspectives (Barbour, 1998; Fridlund & Hildingh, 2000; Taylor & Bogdan, 1984). Triangulation can include comparing observational data with interview data, comparing what people say in public with what they say in private, checking consistency of what people say about the same thing over time and comparing people’s perspectives from diverse points of view. Triangulation can be used through multiple analyses or by mixing qualitative and quantitative methods (Morse, 1997; Patton, 1990). Triangulation of conclusions can be used when data must be approached from a variety of perspectives (Eden & Spender, 1998). Investigator triangulation is two or more researchers, often from different disciplines, working jointly using a shared conceptual framework. However, triangulation should be used with caution because there is always a risk of “method quagmire”, i.e. believing that more is better (Sandelowski, 2000). In this study triangulation was used to try to examine the phenomenon of understanding from different perspectives and from diverse actors in a care organisation.

Rigour in qualitative research

Instead of the positivist notions of reliability, objectivity and generalisation, the concepts of credibility, dependability, confirmability, transferability and validity are used in judging and reviewing qualitative research (Barbour, 1998; Guba & Lincoln, 1989).

Credibility entails being thorough in both data collection and analysis. It also implies a subject-oriented approach rather than a researcher-defined approach. Sandelowski defines credibility as follows:

“… such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognise it ... as their own” (Tishelman, 2001).

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Dependability or consistency means that the research process is described such that the reader can easily follow it, and the study is adjusted to new perspectives or material that has emerged from the study. Furthermore, dependability is concerned with the stability of data over time (Guba & Lincoln, 1989).

Confirmability refers to how the results are grounded in the material, i.e. quotes from interviews or narratives are often used for illustrative purposes (Guba & Lincoln, 1989).

Transferability is how the results are communicated to others, i.e. the findings are presented in a way others can readily understand. To enable transferability a thorough description of the context in which a study takes place is important (Hamberg, Johansson, Lindgren, & Westman, 1994).

Validity in qualitative research denotes the extent to which the research findings represent reality (Morse & Field, 1996). Tishelman writes:

“To validate is to question, for example, what subjects report or say, is it false or true? True or false to who? Why do they say what they say? How do they experience, what they experience?”

Validity pertains to the degree to which an instrument measures what is intended to measure (Eden & Spender, 1998). By being close to the people under investigation, the qualitative researcher obtains first-hand knowledge of their social life unfiltered through concepts, operational definitions, and rating scales (Taylor & Bogdan, 1984). To validate the results of the conceptual model and the interviews we presented the results to the participants to discuss if the findings were a reasonable account of their understanding (Mays & Pope, 1995).

How were credibility, dependability, confirmability, transferability and validity in the present studies? Credibility is described in greater depth in the different studies. However, retrospectively, the credibility criterion could have been better met in Study II. The questions sent to the general practitioners and the district nurses should have been coded. If so, it would have been possible to send a reminder to those who did not complete or return the questionnaire. Another criticism of Study II is that an analysis was not done of those patients who did not answer the telephone survey.

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Concerning confirmability, quotes and illustrations were used to depict the results in the different studies. Of course, there is always a risk of researcher bias because the researcher chooses the quotes and illustrations to be presented in the studies. However, to avoid this possibility the results were discussed with other researchers and in seminar groups.

As in all qualitative research, the validity of the different studies is subjective. There are many ways to study changes and group processes. However, I hope that readers from similar environments will recognise the settings and problems and possibly find some thoughts to reflect upon in their own work setting. As far as transferability of the studies is concerned, I leave that to the reader to judge.

A gender perspective was not planned at the beginning of the present study. In retrospect, there should have been an equal number of men and women included in the studies. Moreover, questions focusing on gender-specific follow-up services and processes should have been asked in the telephone survey. Such questions should also have been used in the individual interviews with the patients and with the representatives from the Heart and Lung Association. In addition, questions probing how to lead men and women should have been more explicit and clearly included in the interviews with the leaders, senior managers and politicians. Finally, respondents’ views on how to work with development issues from a gender perspective should have been included.

Observations in qualitative research

In doing research the researcher obviously has more knowledge and expertise about the study than do the participants. Thus, one can say that the research relationship is a hierarchically arranged power relationship, with a hidden power imbalance. In this imbalance the participants are exploited. Therefore, it is important that researchers are aware of the vulnerability of the participants when the latter disclose their activities and meanings, and in some cases, reveal their deepest and most personal secrets (Cormack, 1996).

Using interviews as the data collection method has its limitations, however: for example, words and meanings must be common to both the interviewer and the respondent (Barbour, 1998). As a researcher, we have our own filters, i.e. we take certain things for granted; we are influenced by something or someone; and we have prejudices and blind spots that prevent us from seeing things from different perspectives. It is necessary for
qualitative researchers to be honest, open and acknowledge how we change over time (Chesney, 2001). For persons participating in a qualitative study, their description of reality should be taken at face value.

Other issues are emotions, roles and relationships to the field. When using participant observation as a method, the researcher should preferably be kept in the periphery of the group. Keeping oneself in the periphery is sometimes difficult, however, because most people feel awkward if they do not fit in or belong to a group (Morse, 2001). When conducting qualitative research, the researcher should be aware that people who take part in a study might alter their behaviour, modify their responses or act in an unnatural way when knowing they are being observed. This psychological response is known as the Hawthorne effect and reflects people’s desire to put them in a better light (Cormack, 1996). The Hawthorne effect can also refer to the phenomenon that people change in respects simply as a result of being studied (Bowling, 1997).

Measures taken to avoid some pitfalls

When working in groups, i.e. in the conceptual modelling seminars, a good deal of time was spent defining words, subjects, concepts and phenomenon. It is important that everyone in the group, including the researcher, has a common meaning to the same words and phenomena. This phase takes time and cannot be rushed or quickly produced. To have time set aside when doing conceptual modelling is important. In Study I, the conceptual modelling seminars took a full day’s work. If the researcher is both facilitator and researcher at the same time, there is a risk that the facilitator influences the participants. This possible risk was discussed with a reference group after the conceptual modelling seminars.

In an interview setting it is important that respondents are made to feel comfortable and at ease. The interviews in this thesis were most often done at the respondents’ workplace, i.e. in a setting familiar to them. A presentation of the interviewer was done in advance, both through written information and when making the appointment for the interviews. The respondents were given the interviewer’s telephone number in the event that they had questions later during the study.

Concerning the Hawthorne effect, it is difficult to judge its impact without having knowledge about the respondents in advance, but I believe that the interview situation was such that the respondents felt comfortable and at ease
and hence did not feel the need to act in an unnatural manner. The Hawthorne effect in group settings is difficult to detect. When working in a conceptual modelling seminar, the important thing is that the researcher is conscious of the effect while simultaneously observing the group process.

Ethical considerations

All participants were clearly informed that participation was voluntary. Participants’ names, their place of work or their individual positions is not revealed in the studies. Written information describing the project was sent to all persons invited to participate in the study, including the name and telephone number of the project leader. In addition, they were assured that they could terminate their participation at any time without stating a reason for their decision. The face-to-face interviews were audiotaped after the respondents had given their approval. The telephone interviews with the cardiac patients were not audiotaped. Rather, the interviewer wrote down notes directly after the telephone interview. A possible ethical dilemma is that patients felt obliged to participate in the studies because this allowed them to gain access to resources for follow-up services. The Ethics Committee of Karolinska sjukhuset approved Studies I and II (KS Dnr 94-123 and 97-177, respectively).
CHAPTER 4

Participants and methods

The participants in the studies were selected because of their key positions and their unique knowledge of various aspects of care services. Table 2 shows an overview of the number of participants and the methods used for collecting data and how data was analysed.

Table 2. Overview of participants and methods used in Studies I – IV

<table>
<thead>
<tr>
<th>Study</th>
<th>No of participant</th>
<th>Category</th>
<th>Method</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>38</td>
<td>Patients</td>
<td>Interviews</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RHLA*</td>
<td>Conceptual modelling</td>
<td>Description of central concepts &amp; relationship of described problems 7-year follow-up.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Healthcare professionals</td>
<td>Memos</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Healthcare senior managers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>386</td>
<td>Patients</td>
<td>Questionnaire</td>
<td>Grounded theory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RHLA*</td>
<td>Telephone interviews</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Healthcare professionals</td>
<td>Interviews</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Healthcare senior managers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>6</td>
<td>Healthcare leaders</td>
<td>Interviews</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>IV</td>
<td>20</td>
<td>Healthcare politicians</td>
<td>Interviews</td>
<td>Thematic analysis using a two step transformation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Healthcare senior managers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(* RHLA = representative of the Heart and Lung Association)
A purposeful sample of participants was invited to participate in the studies. Purposeful denotes information-rich participants, i.e. people who have a great deal of knowledge and information at their disposal about the research topic (Patton, 1990). In study II, a considerable number of consecutive and random patients with heart disease were included as well as a purposeful sample of key persons, i.e. senior managers, specialists and representatives from the Heart and Lung Association. These key persons were chosen because they could provide a rich source of information concerning the research topic.

Face-to-face interviews

Semi-structured, open-ended interviews were used in each study. Such a flexible approach allows both the interviewer and the respondents the flexibility to probe for details and/or discuss relevant issues. After the opening question is posed, a series of questions immediately follow querying the respondents’ thoughts and understanding of their organisation, its development, future challenges, goals, visions, care and leadership (Creswell, 1998; Guba & Lincoln, 1989; Kvale, 1997; Olsson & Sörensen, 2001). The interviews lasted between one and two hours.

In studies where a person’s conceptions of a phenomenon are in focus the optimal number of persons to be interviewed has been found to be about 20 (Sandberg, 1994; Stålsby-Lundborg, 1999). In this study, the number of patients is limited because different categories representing divergent perspectives from each group were desired. The intention was not a matter of equal power but to acquire a wide view of the research context.

Telephone interviews

In Study II, 100 consecutive patients with heart disease that had recently been discharged from a cardiac or thoracic clinic were invited to participate. To include 100 patients in the study 120 were contacted. Later, after the telephone interview survey had started, two patients terminated their participation. Thus, 98 patients were telephoned; of these 76 were interviewed once a month for 6 months. The remaining 22 patients were contacted between one and five times during the course of the study. One year later, 69 (70%) of the 76 patients participated in a seventh interview (18 months after discharge). A trained nurse, who was employed by a separate research unit, conducted all the telephone interviews. The nurse never met
notes. The telephone interviews were not audiotaped, which might have been a weakness of the study because nuances, a richer language and the voices of the participants and interviewer voices might have been lost.

**Conceptual modelling**

Conceptual modelling is sometimes referred to as cognitive mapping and can be described as a form of action research. Action research is a way of doing research or inquiry and working on solving problems at the same time. A leading principle in action research is constant monitoring and evaluation (Cormack, 1996). Action research is like a spiral of interlocking cycles of planning, acting, observing and reflecting (Schwandt, 1997).

Conceptual modelling is mostly used when studying a groups’ understanding of an area, phenomenon, problems or actions within an organisation or a group. It can serve as a model to ease understanding and analysis of subconscious mechanisms or structures among people and can clarify goal structures and critical relations between units or actors within an organisation. Further, conceptual modelling is a way of eliciting meaning and promoting understanding as to how people make sense of a given situation (Eden & Spender, 1998). In Study I, conceptual modelling was used with groups. Figure 1 displays an example of a part of a completed conceptual model, concerning cardiovascular care and follow-up processes.

*Figure 1. An example of a section of the conceptual model about cardiovascular care*
Questionnaires

Postal questionnaires were sent to 492 consecutive cardiac patients from other primary care areas that were discharged from hospital. In Study II, only one, an open question, was analysed. The question probed patients’ perceptions, personal experiences and thoughts of the healthcare and follow-up they had received. The same questionnaire was sent to the patients at 1, 6 and 12 months after discharge. Totally, 309 patients answered the questionnaire, and of these, 126 wrote down meaningful answers to the open question. A meaningful answer in this context implies that the respondents were able to write sentences expressing their experiences and perceptions of care and the follow-up services they received. Those who just wrote down single words, such as OK, good, bad, nothing, etc., are not regarded as meaningful and were therefore excluded from analysis.

Three open-ended questions

Three open-ended questions that probed how the respondents viewed follow-up processes after a cardiac event were sent to nine local branches of the Heart and Lung Association in the northwest county area of Greater Stockholm. The three questions were originally developed to probe medical students’ understanding of medical practice and have been tested in our research group in other research projects and settings (Dall’Alba, 1995 & 1998; Holmström, 2002). The three questions are as follows:

1. What do you consider is the essence (or primary aim) in follow-up and secondary prevention after a cardiac event?
2. Can you give an example when you think you have succeeded in performing follow-up and/or secondary prevention?
3. Why do you think what you did was successful?

The three questions, which were answered anonymously, were also sent to all general practitioners and district nurses in the target area. Consequently, we could not send a reminder to those general practitioners or district nurses who did not answer the three questions. Retrospectively, the questions should have been coded so that a reminder could have been sent to persons who did not return the questionnaire, or these persons could have been telephoned or personally interviewed. However, because of the major organisational changes in primary healthcare at the time, it was exceedingly difficult to keep track of workplaces and staff members.
Analysis of data

In Studies I and III thematic analysis was performed. This approach includes identifying, coding and categorising patterns or themes that emerge from the interview, from memos or from respondents’ written responses. First, to obtain a general sense of the respondents’ concepts and understanding of the topic the interviews were read in their entirety. In the next phase the interviews were analysed inductively to discover themes or categories, dimensions and interrelationships (Kvale, 1997; Patton, 1990). In a third phase, meaning units were grouped into larger themes and later narrowed to a few key themes. The key themes were then compared with the entire interview text.

In Study I, the results from the conceptual modelling seminar from 1992 were compared with the results from the seminar in 1999. In addition, the interviews in 1992 were compared with the interviews in 1999.

In Study II, grounded theory was used (Glaser, 1998; Glaser & Strauss, 1967; Strauss & Corbin, 1990; Vehviläinen-Julkunen, 2000). Data collection and data analysis took place simultaneously.

In Study III, thematic analysis was conducted. After the naive reading of the interview transcripts, significant statements or words and descriptions were extracted and organised into files. The files were then grouped and reduced to four themes. As a final step in the analysis the quotes were read again, guided by the question: How does the respondent describe the themes?

In Study IV, significant statements or words and descriptions were extracted and organised into meaning units. Each meaning unit was subsequently transformed into two steps (Kvale, 1997; Sahlberg-Blom, 2001) (Appendix). The themes were later narrowed to five main themes. A number of contradictory statements stood out when comparing results from the interviews with the whole interview text.
CHAPTER 5

Results

Study I. Understanding and practice: a seven-year follow-up study on implementation of a cardiac rehabilitation program.

This study, started in 1992, was an assignment from one of the university hospitals in Stockholm. An earlier evaluation of cardiac follow-up had indicated that follow-up for patients after an acute cardiovascular event lacked structure and continuity. The patients had given critical views on the follow-up processes after discharge (Svärd, 1993 & 1995). It was also found that the healthcare professionals had little knowledge of guidelines for follow-up for patients with heart diseases (Henriksen et al., 1993).

The aim of this study was to investigate how senior managers, healthcare professionals and patients with cardiovascular diseases understood cardiac rehabilitation and follow-up services. Specifically, we wished to study what these groups considered as problems in obtaining cardiac rehabilitation and secondary prevention after an acute cardiac event. Another aim was to determine whether actions that were jointly assessed had affected the participants’ way of working and understanding follow-up services after 7 years.

The results of the study showed an overall picture of a fragmented or patchy organisation. Healthcare professionals and their senior managers saw and understood only a small part of the patients’ problems that was separated from the whole; only the patients saw their whole context. Four key problems areas were identified:

Understanding the quality of cardiac follow-up services. The respondents’ answers revealed an ambiguous and ambivalent structure of follow-up
services and process thinking. Cardiac follow-up processes were unclear to the participants. People at different care levels had varying perspectives.

**Implementation of local clinical guidelines.** A trial to implement local clinical guidelines was carried out. These guidelines were printed on desk pads. In connection with the trial to implement the guidelines, continuous education was provided for staff members. Although a great deal of work was done and a large number of people were involved in trying to implement the local guidelines, it did not fully succeed.

**The patients’ situation in cardiac rehabilitation.** The patients expressed feelings of loneliness and felt that the healthcare staff personnel withdrew their support and help. They reported that they did not receive comprehensive information about care or follow-up processes. Patients wanted information about their own prognosis. Those patients who were sent to cardiac rehabilitation centres in the country went alone, which meant that their family was excluded from participating in the rehabilitation process. Patients over 65 years of age reported that they received no rehabilitation at all. They felt that the healthcare staff largely ignored them. To reduce or eliminate these feelings of isolation and abandonment it was determined that the district nurses carry out routine home visits to all patients with heart disease after discharge from hospital.

**The healthcare professionals and senior managers’ understanding of cardiac follow-up services.** Communication between professionals and different care levels was found to be problematic. Responsibility and leadership roles were ill-defined and a lack of evaluation of health promoting programmes hindered the development of these programmes. According to the senior managers, because health-promoting secondary prevention programmes were not evaluated, such programmes could not be used. This meant that if the programmes were not used they could not be exposed to evaluation and hence the programmes never became adequately developed. The healthcare professionals lacked modern teaching skills for disseminating health promotion programmes. The primary healthcare staff reported that they lacked time, skills and knowledge for providing good follow-up services for patients with cardiovascular diseases. Not all care units were computerised and staff members complained they did not have sufficient time to communicate with other professionals outside their own unit.
Follow-up after 7 years.

In 1999, seven years after the first study, the quality and processes of cardiac follow-up services were still found obscure. After 7 years, the guidelines, printed on desk pads, were practically forgotten by most of the respondents. Now, all primary healthcare centres had computers but the staff members could not find time to locate guidelines or use the computers to locate information. Thus, modern technology did not help in the process of implementing or disseminating the clinical guidelines. The healthcare professionals or senior managers could still not explicitly state who was responsible for setting goals, organising structures and processes for follow-up services. Hence, we found that the participants’ understanding of cardiac follow-up processes had not changed even though the organisation had undergone major changes during these seven years. The home visits by the district nurses had been suddenly terminated without giving the nurses a reason for their termination. Moreover, the nurse-led AMI clinic at the university hospital was closed without stating the reason to the nurses.

Study II. Understanding cardiac follow-up services, a qualitative study of patients, healthcare professionals and managers

The aim of this study was to explore the understanding that patients, patient representatives, healthcare professionals, leaders and managers of follow-up processes and services for patients who suffered an acute cardiovascular event. A multimethod, qualitative approach was used in an effort to obtain a wide range of perspectives from the healthcare arena.

Results from the study identified five core categories of understanding cardiac follow-up: See patients in their total context (the objective perspective), patients should do as healthcare professionals prescribe (the obedient patient), healthcare professionals perform check-ups and control cardiac risk factors (the controllers), healthcare professionals are in charge of care processes (in charge of processes), and the structure and processes of the organisation (in charge of structures).

The study concludes that patients were not seen in the context of their whole life, with a lack of consideration given to their individual needs, experiences, feelings and capabilities. Patients were seen more like objects than individuals taking an active responsibility for their situation. The structure of the organisation of follow-up undermined healthcare workers and patients in their effort to co-ordinate follow-up processes. The different care levels and
professionals were not seen as parts of a CAS. The purchasing organisation had not contracted time so that healthcare professionals could co-ordinate their work between care levels or have time to communicate with each other.

Study III. Clashes between understanding and doing, leaders’ understanding of management in intensive care during a period of reorganisation

Another major organisational change was investigated in Study III, namely when hospitals are closed down and professional groups are dislocated and forced to move to other workplaces. In this study, leaders at an intensive care unit (ICU) in a county hospital are interviewed. The ICU at a smaller county hospital had been closed the previous year (one year before the study was done) and the staff personnel were assigned to another hospital some miles away. In line with reorganisation, all staff members from both hospitals were given notice and everyone had to apply for work at the remaining hospital, including at the ICU. Earlier findings had indicated that during downsizing and restructuring this high-tech medical organisation had developed toward principles of mass production (Lindberg & Rosenqvist, 2002). Individual face-to-face interviews were used focusing on the participants’ understanding of their new professional roles as leaders.

In analysing the interviews themes were sorted based on the question: What was the respondent talking about and how was the content described? The results revealed four themes that described the respondents’ understanding of their roles as leaders. The first theme reflected their understanding of the function of leadership and management. The second concerned their understanding of structures and processes. The third pertained to their understanding of their practical role as a leader. The fourth theme explored the leaders’ understanding of the external world. When viewing the statements of the leaders from the perspective of how the themes were described, four categories were identified: hectic enterprise, disintegration, operational disturbances and development work in contrast to daily work.

The study observed that the leaders perceived their organisation as a learning organisation, but in practice it functioned more like a mass production organisation. The leaders spoke of development work as something that was not part of everyday practical care work and that it was something that disturbed daily work. Thus, development work was seen as an entity that was not integrated in developing intensive care processes as a whole, but
rather as something that interrupted normal routines of daily practical care work.

**Study IV. Contradictions in elderly care, a descriptive study of politicians and managers understanding of elderly care**

The primary aim of this study was to explore how municipal and county council politicians and executive managers in charge of elderly care services understood these services. Another aim was to study the consequences of their understanding in relation to the organisation.

Open-ended interviews were carried out with eight politicians and twelve executive managers. The interviews were analysed using a two-step thematic approach. Five main themes were identified in addition to a number of contradictory statements. The five themes were trust, different cultures, competence and development work, finances and the client and caring. A number of contradictory statements were identified. These contradictions are seen in the light of two large organisations with similar tasks but with different traditions and staff members with different professional backgrounds.

Acculturation between the two major caring organisations (the healthcare and the municipal elderly care organisations) proved to be a serious problem. Collaboration, co-ordination or common assessments were not routine. A discussion of who was to have power over care was highlighted in the study. Further, lack of collaboration between different organisations and levels of care hindered development work. Another problem noted was having two organisations or split organisations within the organisations, i.e. the organisations were divided into a purchaser and provider component within the organisations.

Lack of skilled staff was also a problem. Development was considered a process of preparing for new needs, such as meeting the individual needs of older people. Collaboration between healthcare and municipal elderly care was determined as an important factor for economic reasons. Some participants felt that the healthcare system had a too-large role in affecting health care decisions for older people.

Executive managers from the municipal elderly care services spoke of psychosocial aspects of growing old. However, these managers expressed a fear of “doing wrong”. The last years negative publicity in media had
planted a fear among the executive managers. A fear making the effects of aging look more like a disease than a natural process of life. Because of this fear, nursing homes were at risk of becoming “mini-hospitals.” Executive managers perceived a lack of equity between demands and supplies. Quality in care needed to be improved and older people themselves should be able to influence their own care, illness and daily life. It was made clear, however, that not all older people are in need of caring services. The attitudes of some respondents suggested that older people were regarded more as objects than as autonomous individuals.

The respondents gave a picture of a fragmented and complex organisation that had poorly defined areas of responsibility. The organisation lacked clear visions, goals and leadership. At a follow-up meeting, an attitude of recognition and understanding among the respondents was noted when the results of the interviews were openly discussed. A decision was reached to work together to improve care services for older people in the area. To achieve this goal a special working group was created (Henriksen, Selander, & Rosenqvist, (submitted)).
CHAPTER 6

Discussion

The aim of this thesis was to explore how different actors understand the meaning of structure, process and outcome in their care organisations and to study if their understanding changed over time. Although care organisations have undergone major reorganisations in the past years, including increased pressure from the outside world (i.e. decreased finances, hospital and care unit mergers), the participating professionals’ ways of understanding care processes and structures is still professional-centred and static over time. The results from the different studies largely corroborate this conclusion. Other studies of changes in care organisations have shown that it is difficult to change staff members’ understanding and the way they perform their work (Fahlström, 1999; Melin-Emilsson, 1998). The research was carried out within an empirical and theoretical framework of understanding in care organisations. Several theoretical approaches and methodologies have been combined to facilitate understanding the complexity of care organisations. Care is only one component in a country’s welfare system. In this thesis I have chosen not to include organisations or professionals outside health or elderly care. Another organisation of importance in the perspective of follow-up and rehabilitation is, for example, the National Insurance system.

Most participants in the studies had the knowledge and power to bring about policy changes and to implement agreed upon measures. Figure 2 depicts the various settings of health and elderly care organisations included in this thesis. To illustrate, a woman with heart disease, she would have to move between and within the sub-organisations. Imagine her living in a municipal sheltered home. For good quality care she would most probably have contact with many actors from the different care units (shown as circles in Figure 2).
Some comments on the choice of methods

A plausible question is whether conceptual modelling, interviews and questionnaires are appropriate methods to investigate a person’s understanding in care organisations. Repeated conceptual modelling seminars were performed, as were many interviews and contacts and discussions. The results were discussed with the participants. A repetitive pattern was found which appears to remain fairly stable over time.

A methodological consideration in the current studies is the selection of participants and the number of interviews. Considerations about gender and social class also arose when studying the group processes in the conceptual modelling seminars. The fact that the majority of the specialists, senior managers and general practitioners in Studies I, II & III were men could have had a distinctive effect on the group processes and outcomes. However, the majority of participants in Study IV were women. Gender and class have a significant impact on group processes (Östlin, Sen, & George, 2000; Östlin, Danielsson, Diderichsen, Härenstam, & Lindberg, 1996). In Study I, the male dominance might have had an impact as to why the home visits

\[\text{Figure 2 Henriksen, 2002.}\]
performed by the district nurses, or the nurse-led AMI-clinic at the hospital, were not given proper status and thus abruptly terminated.

A potential weakness in Study I was the limited number of patients. However, the aim was not to have equal power over processes in the conceptual modelling seminar, but to try to understand how care structures and processes are understood and to arrive at constructive ideas to improve quality in follow-up processes. Working with conceptual modelling was for some of the participating healthcare professionals a new approach to revealing and dealing with professional problems.

Researcher bias

I have been both facilitator and participant in the conceptual modelling seminars and follow-up sessions. Thus, I have been an active participant as well as an observer of group processes. This role might have had some influence on group processes. However, I found that by constant communication with the participants, I received a broad view of cardiac follow-up, development work in intensive care and in the provision of care services for older people. Communication is a form of investigation whereby a researcher can come to share the same understanding as the participants (Cormack, 1996). As a researcher and interviewer, however, there is a risk that I became an active co-producer in the interviews and discussions. I tried to counteract this source of a problem through pilot interviews and regular discussions with my research group.

Working with a multimethod approach

There are many ways of understanding tasks, roles, views, phenomena and perspectives in CAS. I have tried to understand a few of these in the present study. The multimethod approach gave a broad picture of different ways of understanding care organisations and care processes. Multimethod approaches have proven valuable when studying other CAS (e.g., modern resource management) (Eden & Ackermann, 1998). The intention of the multimethod approach used here was to capture the multifarious aspects of the problem area from the perspectives of a variety of stakeholders. Joint collaboration among patients and healthcare professionals are necessary in order to develop quality in follow-up processes and care services. A more client-focused perspective that engages and empowers patients and older people might increase the individual’s ability to take control of his/her life
situation. This is a position that envisions patients and older people as managers of their own care and follow-up processes rather than as passive consumers of care.

One aim with using *conceptual modelling* was to establish a forum for democratic dialogue that explored participants’ understanding and perceptions of the meaning of different concepts and their attributes. A further purpose was to try to reach a consensus among participants on how to organise care services. The group process in conceptual modelling is dynamic. In this dynamic process free-flowing opinions from participants are possible in that the pooling of concepts is done anonymously. However, suppression as a group phenomenon needs to be considered in all group processes (Jern, Boalt-Boethius, Hirdman, & Högberg, 1984; Lorentzon, 1988). We might presume that most people are not always as outspoken in groups as they are individually, especially if there are those present from higher levels within the organisation hierarchy. However, to enable people to speak openly working pairs were split into different working groups in the seminars. Nursing perspectives on follow-up processes were not discussed as much as medical aspects. A reason for this might have been the few nurses present but also the difficulties that nurses have making their professional views clear.

Sending *questionnaires* to people always poses concern regarding return rate and possible differences between responders and non-responders. The credibility of participants’ responses in questionnaires is always questionable. For one thing, people in general are often reluctant to write long answers in questionnaires. In Study II, many (126) of the patients did take the necessary time to write meaningful responses. Another consideration is that 70% of the telephoned patients were willing to discuss their situation and follow-up processes on many occasions (1-7 times) and over an extended period (1-18 months). In all, more than 200 patients gave their views on cardiac follow-up services. (Note that the group answers from the representatives from the Heart and Lung association branches are counted as one answer each).

Another criticism might be that only about one third of the general practitioners and half of the district nurses answered the *three questions*. The stressful working conditions, the ongoing changes and the reorganisation in primary healthcare that occurred at that time might partly account for the relatively low response rate. Many general practitioners and district nurses were engaged with other tasks, such as conducting research, participating in continuous education programmes or reorganising schemes for
implementing the family doctor reform or performing administrative duties. The names that were given to the study from the county councils’ administration were names of people who, at the time, were employed in primary healthcare. Substitutes were not included in Study II.

The question of whether we can have confidence in what is said in interviews puts further light on trust as a central concept in care. The interview is a situation in which two actors are dependent on each other (Kvale, 1997). According to Kvale, an interview is created in a circle of conversation, what he calls “circulus fructuosus” Our understanding of the contents of a conversation is based on our pre-understanding of the world. Kvale notes that it is important to get into the circle in a proper manner, meaning that the introduction and opening questions are the key to the whole interview. Credibility is also associated with qualitative aspects of communication, that include open, honest verbal and written communication (Johns, 1996). The challenge in interviewing is to widen our understanding of the world through dialogue (Kvale, 1997, p. 267). Silence in interviews or reluctance to be interviewed, is also ways of expressing a particular view.

When summarising results from the different methods, the ways in which the care organisation and care processes was understood by the participants did not particularly change over time or place. None of the studies contradicts this view. Our overall results indicate stability as the common phenomenon in our data.

Understanding in caring organisations

Social norms, experiences and collective memories direct our actions, thinking and orientation in the world (Bourdieu in Broady, 1991). According to Bourdieu’s theories we are largely shaped by our earlier life experiences. Our actions, thoughts, perceptions and norms are results of encounters with people from different social contexts. We act in the way we perceive and understand our reality. Bourdieu (Bourdieu, 1994) discusses re-contructuring the social room, i.e. the structure that forms society, segregation of classes and professions. In the social room, the concepts of trust and security are important. By trusting others, people sometimes place themselves in a dependent and vulnerable situation. Erikson sees trust as one of the fundamental stages determined early in our childhood (Erikson, 1977). Trust is fragile in the sense that it is easy to destroy but hard to create (Kramer, 1999). Hupcey et al. have assigned five attributes to trust: dependency on another individual to have a need met, choice to take some risk, an
expectation that the trusted individual (an organisation or the representatives of an organisation) will behave in a certain way, limited focus on the area or behaviour related to the need and testing the trustworthiness of an individual. A question raised by these authors is whether it is possible to have a professional-client relationship without trust (Hupcey, Penrod, Morse, & Mitcham, 2001).

In providing care for older people trust and security are central aspects in the provision of care services for older people (Godfrey, 2001). Trust emerged as a central concept in the interviews with the stakeholders from the elderly care services (Study IV). Trust between care levels, care organisations, care professionals, and between care provider and client, is important in order to achieve positive results in healthcare (Hellström, 1999). The politicians in Study IV were concerned with what they perceived as older people’s lack of trust for caring services. In Study I, (in 1992) the specialists did not feel confident that the general practitioners could perform proper follow-up of cardiac patients. In 1999, this lack of confidence had changed. Other studies have found that the manufacture and deployment of trust is an integral part of function in complex systems (Gilbert, 1998). I believe that trust is a vital component in all situations involving care, not only for care outcomes, but also, between caretaker and care provider. There must be a spirit of trust, solidarity and community among care workers, care leaders and policy makers. Trust is perhaps the most crucial element in organisational cultures related to performance. Trust, commitment, and co-operation are clearly interrelated and essential to meeting organisational goals (Johns, 1996).

The professional-centred perspective is strong in care organisations (Blomgren, 1999; Holmström, 2002; Gustafsson, 1987). This perspective means that patients or older people are moved around in the organisations to fit into the professional system. Concepts such as co-ordination and a holistic perspective have been key concepts in care policies for many years (Holm, 1987; Sjöström, 1990; Socialstyrelsen, 2000b; SOU, 1996b). However, what is meant by a holistic care view is not fully clear. Some people suggest that the most important thing is that people go beyond their own one-dimensional perspective by trying to understand what others understand (Sjöström, 1990). From a nursing perspective, Florence Nightingale proposed that a patient’s total context should be included in care. Her conceptual model of nursing included the patient’s total environment and saw the patient as the central figure. To her, caring was embedded within a socio-political and religious context that included the patients’ personal life experiences and philosophical orientation (Fitzpatrick & Whall, 1996). A holistic worldview includes perspectives from biological,
psychological, psychosocial and existential fields, as well as the individual’s own subjective feelings (Fridlund, 1994).

I believe that the traditional “reduce and resolve” approach in health care, as shown in Studies I and II, needs to be replaced by a new conceptual framework that incorporates a dynamic, emergent, creative and intuitive view of the world. Such a complex framework must have the ability to adapt to change, generate new knowledge and continuously improve performance. Complex thinking suggests that leaders in both policy and operations must look beyond individual components and view the system as a whole (IM, 2001). Because follow-up services in cardiac care are complex, goals and resources should be viewed with respect to the whole system.

In Study I, staff from the primary healthcare system complained that because they were not computerised, collaboration between care providers was severely hampered. In 1999, all primary healthcare centres were computerised but collaboration had not improved. From a business reengineering perspective a reason for this inability to collaborate could be that the organisation lacked new structures. What had been done was only manifesting old structures, now with the help of IT, or “paving the cow-paths” (Willoch, 1994).

Some participants in Study IV spoke of older people as passive receivers of care, i.e. as objects rather than independent individuals. This way of seeing people is often referred to as a pathogenic medical world view (Antonovsky, 1991; Dilani, 2001; Hellström, 1994; Sontag, 1981). Simone de Beauvoir (1976) denote older people are often seen as objects from the perspectives of science, history and society. However, she writes, older people are subjects, who have intimate knowledge about their own situation and react upon it. In the future, it is estimated that older people will be more educated and likely assert a greater degree of influence over their own care. This will put new demands on care organisations and staff (Levin & Normann, 2001). Older people who are not aided in time or monitored, are likely to develop a greater need for caring services and support, which would create a circle of decreasing resources and increased needs (Wånell, 2001).

The concepts of culture, power and gender are central in the theories of symbolic capital and in complex organisations. The healthcare system and its allied fields represent an important structural influence in the construction of gender and health (Courtenay, 2000). According to Bourdieu (1994), education is the most important asset to cultural capital in society. To bring about changes in attitudes among staff in elderly care services, continuous
education is a central aspect (Study IV). Practices and discourses are constantly reproduced in society (Montenegro, 2002). The concept of habitus expresses the urge of durable dispositions in people that generate particular practices.

Daily practical experiences of the social world are acts of knowledge. Knowledge is the fundament of which a high tech organisation such as intensive care rests. Therefore, continuous education, reflection and a critical attitude should be viewed as natural attributes of work and leadership in intensive care (Study III). Knowledge needs to be constantly repeated in order to prevent mechanistic thinking (Bourdieu, 1994). Regular staff meetings with time to reflect upon work, knowledge, attitudes and ethical issues should be a natural element in a leader’s role in intensive care and other care organisations.

Hierarchy is not just internal to organisations in that relations among professions in the same field are ordered hierarchically, as are particular local sites of administrative, professional or managerial activities (Smith, 1990). Despite the major changes that have occurred over the past years in the care organisations examined in this thesis, Study I clearly showed that the way healthcare professionals understand care is stable.

To change rigid roles and hierarchical structures certain role models are necessary. One way to act on hierarchical structures is to have good role models or mentors to guide and aid students and those who have recently graduated from their studies when forming their professional roles (Benner, 1993; Benner, Tanner, & Chesla, 1996; Johannisson, 1990; Josefson, 1988; Sherwin, 1992; SOU, 1996a). Another way is to listen to what people in the workforce say and act on it. Today, we can see that lack of dialogue causes people to speak with their feet (Allen, 2000).

It was only during the 1990s that gender consciousness has made its entry into the educational system. Women’s history, lives and perspectives have traditionally been “blind spots” or unseen in the school curriculum (Henriksen, 1990). Many people who today hold leading positions in care organisations have not had gender perspectives as a natural part of their school education and might therefore be “gender blind” (Hjorts, 1984; Jonsson, 1977; Mangs & Martell, 1982; Molloy, 1992). For instance, even today the medical education has a “male norm” curriculum (Blomgren, 1999; Björkelund, 1992; Carlstedt, 1992 Lindgren, 1999; Puranen, 1994; Rehnqvist, 1996; Roberts, 1992; Schei, Botten, & Sundby, 1993; Sherwin, 1992; SOU, 1996a). Theoretical cultures are more rewarded and such
cultures are often male dominated. Practical cultures, such as care, are less awarded and are usually dominated by women (Smith, 1990). Some people distinguish between horizontal and vertical gender segregation. Horizontal segregation describes the concentration of women and men into disproportionately ‘female’ and ‘male’ occupations. Vertical segregation describes the hierarchical division of power and influence within occupations between genders (Ahlgren & Hammarström, 2000; Östlin et al., 2000). I believe that gender issues in care organisations ought to be viewed more critically. In follow-up services after cardiovascular disease women complained about isolation, anxiety and boredom (Study II). Recent figures from the Swedish national register of acute myocardial infarction (AMI) (RIKS-HIA, 2002-03-27) show that the median age for women and men with AMI is 77 years and 72 years, respectively (Socialstyrelsen, 2002b). Although practical care is female dominated, it is not automatically a gender-equal activity. Lack of men in practical care work is just as much a hindrance to development as lack of women in leading positions. I believe it is reasonable to suggest that gender segregated work places have tendencies to stagnate in development.

In Study IV, the question was raised regarding which of the two organisations providing elderly care services should have power and who should lead the services? Should the power be in the hands of the municipalities, the health care authorities, the politicians, the senior managers, the caring staff or the clients? Our studies revealed that acculturation in care organisations is difficult to achieve. In Study IV, resistance to acculturation may represent a power struggle in the sense that the two large care organisations (the county councils healthcare organisation and the municipal elderly care organisation) did not fully trust one another. Representatives from both organisations expressed notions that “the other organisation”, was not performing adequately in providing care services for older people. One way to change perspectives and move from a culture with an authoritarian perspective to one that views both staff members and clients as independent and creative individuals is to work with active guidance (i.e. mentorship) and continuous education. Such assets have been found lacking in elderly care organisations (Berg & Henningson, 2002; Melin-Emilsson, 1998).

A serious problem among older people in suburban areas is loneliness (i.e. lack of meaningful contact with other people) (Andersson, 2002; Holmén, 1994; WHO, 1998a; Wånell, 2001). Loneliness was a problem patients frequently discussed in the telephone interviews. Men with heart disease had often a wife who looked after him, while women with heart disease more
often lived alone (Study II). However, home visits by district nurses to cardiac patients after discharge from hospital were terminated during the study period. The district nurses were not clear as to why the home visits were terminated (Henriksen, Andersson, Undén, & Krakau, 2000). In other studies cardiac patients and their families have been found to be positive towards rehabilitation and follow-up services, even though evaluation studies have shown a lack of participation of elderly patients, especially of older women (Hippisley-Cox et al., 2001; Mosca et al., 1997). Home visits have been shown to have a preventive effect by delaying the onset of disability and dependability as well as improving wellbeing and the quality of life of older people (Clark, 2001; Godfrey, 2001). Especially among elderly women, loneliness is a serious health problem and often a cause for feelings of insecurity (Study IV). De Beauvoir suggested in 1949, that there should be a flexibility of retirement age. Engaged older people, who help others was a way to keep mentally and physically healthy in high age (Beauvoir, 1976). One politician in Study IV, said that society needs some kind of system where “young-old boys” help “older-older boys” (meaning that healthy “younger-“older people should help older-older people).

**Are care organisations adaptable?**

The present studies suggest that it is difficult to change care processes and structures. This problem seems to hold even when staff members themselves have planned the actions and are enthusiastic about implementation in practical everyday care (Study I) (Hutchinson & Baker, 1999). In healthcare there are many persons who have discussed resistance to change, whether it is in caring for patients with chronic conditions such as diabetes (Carlson, 1990; Rosenqvist, 1995; Rosenthal, 1986) or in geriatric care (Smith, 1986). One way to change understanding structures in care organisations could be to view the system as a CAS (Greenhalgh & Plsek, 2001; Richardson et al., 2001; Willoch, 1994). It is difficult to change way of doing things within an organisation, over the past few years some radical projects have therefore been launched outside the care organisation, i.e. a mobile retinal photography service for people with diabetes (Bäcklund, 2000) and, diabetes education for patients organised by the pharmacies (Sarkadi, 2001). Other well known organisations that have had a strong impact on reorganising in traditional manufacturing corporations are, for example IKEA 8 the customer does the work) and IBM (new computers were made “outside” the established factory).
Working towards adaptability denotes working toward a vision (Lewin, 2001). Goals, in contrast to visions, are often referred to as something people put in proposals and plans and hang on the wall, and then go about their daily business more or less forgetting them. For most people, goals are abstract statements of ideals written to secure funding or, meant to inspire, but never to achieve a social purpose. Traditional programme goals versus participant outcomes need to reframe traditional goals and focus on participant outcomes (Patton, 1997). In management research goals have been found to increase levels of production and contribute to a reduction in absenteeism and injuries. However, if goals are to be achieved, they must be fair and reasonable, and most important, subordinates must be able to trust and have confidence in their leaders (Huczynski, 1987).

In my experience, the traditional way to deal with what is “wrong” in care services, is to establish new goals, rules, regulations, guidelines, laws or restrictions. When rules and regulations fail, individuals or groups are blamed and new, even more complex regulations and rules, are enforced (Berg & Henningson, 2002). Such practices are harmful in the context of complex adaptive systems. On the contrary, simple rules have been found to guide people toward complex, innovative system behaviour (Lewin, 2001; Zimmerman et al., 2001). The idea of simple rules is counterintuitive to thinking within a mechanical system (Sjöström, 1990).

At the follow-up session, where the interview results were presented to the politicians and executive managers within elderly care, a special working group was formed (Study IV) with the aim to formulate goals for the elderly care services for the whole target area. The goals were later reformulated as visions (Henriksen et al., (submitted)). In contrast to goals, visions allow an attitude of ready accessibility that characterises innovation and adaptability (Sandberg, 1987).

The present results indicate that the care organisations investigated were broken into small fragments in order to fit into specialised compartments of professional preference. The acute-care perspective in care organisations in general is strong (Carlson, 1990; Holmström, 2002). Patients and older people are often regarded as objects who should ideally behave quietly and with compliance rather than as active participants in control of their own caring processes (Levin & Normann, 2001; Runesson & Eliasson-Lappalainen, 2000).

Complex organisations are contradictory (Study IV): inspiration and energy come from contradictions, and by discussing and reflecting on our acts and
organisations, we can contribute to development (Zimmerman, Lindberg & Plsek, 2001). Complex organisations might appear chaotic and hard to comprehend. However, people in the organisations need to have control over their physical environment, or at least to believe they have control: otherwise, their stress levels and health conditions may be severely affected (Dilani, 2001). I believe this applies to all people, including patients, older people, informal care providers and all healthcare providers.

Implementing radical change in care organisations depends on genuine dialogue. Dialogue in the sense that social processes are involved, whereby people try to understand other people’s arguments, feelings and meaning (Ericson, 2001).

When evaluating the results from the four studies as part of one complex system, the phenomenon of stability was evident. Stability was thus not discussed at the follow-up meetings with the participants in the studies. It may be that stability is a strategy used to protect professional knowledge, collegiality, independence and the organisation against political trends and fickleness. I believe that the only way to tackle static and rigid processes is to jointly discuss and reflect upon, both organising care structures and processes. A common understanding of basic care structures, processes and outcomes among policy makers, leaders, professionals and patients and their family is seen a prerequisite for further development in care organisations.

Implications

To work with staff development

In care work, attributes such as creativity, lust, joy and a perspective on the organisation as CAS is necessary for development. Individual and organisational learning embraces both tacit and explicit dimensions: we learn through feeling and lived experiences as well as through abstract conceptual processes. Knowledge creation is holistic and not just a cognitive approach. I believe that to achieve a change of understanding in care it is important to provide continuous education to all care workers.

Adult education consists of more than merely providing facts and information. It is a perspective that increases understanding and, develops capability and practical abilities (Fraser & Greenhalgh, 2002). In short, this implies that what is needed is not “more of the same school education” (which might have been the case with the continuous education that was
provided the healthcare staff members in Study I), but a pedagogical view that encourages adults to learn. This perspective is called andragogy, the art and science of helping adults learn, as opposed to pedagogy, which is the art and science of teaching children (Knowles, 1980). The intention is to move from a traditional atomistic perspective focusing on knowledge as pieces of facts and information from books and teachers and mediated to someone toward a holistic perspective, where active questioning and seeking of knowledge improve understanding. An andragogic theoretical framework is a holistic approach with the goal of forming a collection of particulars into a whole. Continuous education should aim at helping staff members reflect over their daily experiences in care work.

I believe that a shift in focus from a professional-centred to a client-centred understanding in which the client is put first is a change that places new demands not only on care organisations, its management planners and professionals but also on the clients and their family. Education for capability that focuses on processes and avoids goals with rigid and prescriptive contents is needed.

After Study IV was completed, several goals for elderly care services were formulated. These were later transformed into four visions. This kind of transformation fits well with the ideas of CAS and learning organisations. The four visions are as follows: see the individual, see the individual’s resources, see the encounter, and see yourself. Visions must be formulated such that all staff members working in a healthcare organisation can easily understand them. They should preferably be few in number.

Power and gender perspectives are factors that are relevant in society and thus need to be dealt with in care organisations. I believe that guidance and regular reflection upon work, encounters and life should be natural components in all organisations dealing with the life and welfare of people. Mentors for patients, students, staff members and leaders should also be a natural part of daily work. The Ädel Reform did not encourage regular guidance to staff members and municipal leaders do not have a tradition of mentorship or regular guidance for their staff members (Berg & Henningson, 2002).

Future research should examine how a shift in understanding could be promoted toward an andragogic perspective in the setting of complex adaptive organisations.
My personal reflections: what new knowledge have I acquired from this research journey?

The most important thing I learned is that care organisations are more complicated than I initially thought. I discovered that a person’s way of understanding things is stable and is not subject to change with the passage of time or care setting. To understand includes trying to know and comprehend what others understand. I have made an intriguing and dynamic journey through this work, whereby new questions and intriguing research topics continuously develop. I include this Machiavellian citation because of its relevance here despite it was written nearly 500 years ago.

“There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain of success than to take a lead in the introduction of a new order of things, because the innovation has for enemies all those who have done well under the old conditions and lukewarm defenders in those who may do well under the new”.

Il Principe. Machiavelli (1469 - 1527)

It might be too much to ask that people freely give up power and status. However with genuine collaboration and co-ordination of resources, other attributes to working life might give new forms of reward, such as joy, creativity, less absenteeism and a common understanding of roles and tasks.
Summary

*How did patients, patient representatives, healthcare professionals and senior managers come to understand central concepts in follow-up services after a major cardiovascular event?*

The present study indicated that professional care providers did not have a comprehensive understanding of the structures, processes and outcomes in cardiac rehabilitation services. Common goals and processes for follow-up and rehabilitation services for collaboration between different professionals and care units were vague and imprecise. Healthcare participants had a professional-centred and detailed but patchwork way of understanding follow-up services. They did not see or express benefits of sharing views and information with other professionals or willing to include the patient as a part of the team in planning rehabilitation or follow-up. Consequently, patients were forced to adjust to the healthcare organisation and had to move from care providers and care units to fit into the system.

*Have measures taken by the healthcare staff affected their way of understanding care structures and processes over time?*

Over the 7-year study period, no major changes had taken place regarding, how the participants understood cardiac follow-up and related services. Patients were still perceived as passive recipients of care, as objects with defective parts to be repaired, rather than viewing clients as the experts on their own personal circumstances and wants. There was a wide gap between what was said and what was done. The way of understanding care structures and processes can be described as unchanging, even thought major internal and external changes in the care organisation had taken place during the course of the study period.
Leaders’ understanding of structures and processes during a period of downsizing and restructuring in an intensive care unit.

Although the leaders saw the organisation as a learning organisation, in reality it functioned as organisation dedicated to mass production and standardisation. This misunderstanding clashed with their individual attractor patterns and interfered with efficient and effective leadership.

How key stakeholders in elderly care understand elderly care services and how they comprehend the consequences of their understanding.

The respondents presented a picture of two fragmented and complex organisations with poorly defined areas of responsibility. A lack of common goals and clear leadership resulted in feelings of confusion and distrust among the respondents. Lack of trust could be one reason for them not finding enough qualified staff in elderly care services, and for feelings of insecurity among older people and their family. There was a joint understanding that something needed to be done about the current situation and the near absence of collaboration between the organisations. A working group was therefore formed to draw up common goals in elderly care services.
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CHAPTER 7

Swedish summary

Förståelse i vård och äldreomsorg – en förutsättning för utveckling

Hälsö- och sjukvård och äldreomsorg är verksamheter som i huvudsak bygger på dess arbetskrafts kunskaper, utveckling och förståelse av sitt arbete och sin verksamhet. Stora strukturella och organisatoriska förändringar har genomförts inom dessa verksamheter de senaste decennierna. Trots krav på förändrat arbetssätt och ökad samverkan mellan vårdnivåer och vårdpersonal visar studierna i denna avhandling att vårdpersonal ofta saknar förståelse för vårdorganisationens struktur, dess processer samt för utvecklingsarbete och förändrat arbetssätt.


Det övergripande syftet med avhandlingsarbetet är att studera hur olika aktörer uppfattar betydelsen av struktur, process och resultat i en vårdorganisation ur ett förståelseperspektiv. Min hypotes är att olika förståelseperspektiv av vårdarbete, föränderingsarbete och dess organisation
är en anledning till att det finns ett gap mellan teori och praktik i vården. Ett gap som hindrar samverkan mellan vårdnivåer, förändringsarbete och därmed utveckling av vårdkvalitén.

Teoretisk ram

Kultur, makt och genus är sociala konstruktioner som har betydelse för hur människor förstår sin tillvaro och därmed handlar. Förståelseperspektivet i denna avhandling belyses utifrån Bourdieus teorier om symboliskt och kulturellt kapital, habitus och fält, med tonvikt på begreppen kultur, makt och genus. Förståelse kan beskrivas som en individuell process i ständig utveckling och ofta med en känslomässig bakgrund. Förståelseprocessen kan inte kontrolleras av utomstående men däremot stimuleras och vägledas. Eftersom människan är en historisk varelse som lever i olika verkligheter, förstas omvärlden utifrån olika livsbetingelser och perspektiv.

Med begreppet kapital menar Bourdieu värderingar eller resurser. Symboliskt kapital grundar sig på en grupps uppfattningar av vad som är av betydelse för gruppen t.ex. tillit, rykte, institutioner, prestige, titlar m.m.

Habitus syftar till en persons mentala och förståndsmässiga förmåga, gärningar, tankesätt, värderingar och förståelse av sociala fenomen, t.ex. livsstil.

Med begreppet fält menas en social sfär som får en grupp eller institution att agera eller ta ställning för vad de anser vara viktigt att försvara. Fält kan vara t.ex. religion, konst, ekonomi, medicin m.m.


framförallt inom organisationer som ofta hanterar existentiella frågeställningar. Kvinnor befinner sig oftast i de nedre sfärerna av hierarkierna inom vården. Dock innehåller kvinnor ofta mellanpositioner, där de får rollen som medlare med inget eller lite inflytande. Äldrevård engagerar i huvudsak kvinnor, och kvinnor utgör två tredjedelar av de över 80 år som vårdas inom äldrevården. Således domineras äldrevården av kvinnor både som brukare och producenter.


**Förändringar i vård och äldrevård**


Olika verksamheter som har studerats

*Studie I* studerar förståelse av uppföljning och rehabilitering av kranskärlssjuka patienter inom akutsjukvård och primärvård.

*Studie II*, belyser vårdpersonals och tjänstemäns förståelse av uppföljnings-processer och dess organisation för patienter som vårdats för akut kranskärlssjukdom, samt även förståelse hos patienter och patient representanter.

*Studie III* belyser förståelse av ledarskap och förändringsarbete hos ett antal ledare vid en intensivvårdsavdelning.

*Studie IV* belyser förståelse av innebörd av äldrevård och äldreomsorg hos ett antal politiker och tjänstemän inom äldrevård och äldreomsorg.

Deltagare och metoder

Deltagare i studierna har varit; patienter, vårdpersonal, politiker, tjänstemän och representanter från en patientförening.


Metoder som använts är; deltagande observation och analys av seminarier där deltagarna tillsammans skapat modeller av vårdverksamheten, s.k. konceptuella modeller (begreppsmodeller). Konceptuella modeller kan användas för att studera gruppers förståelse och föreställningar inom ett


Resultat

**Studie I. Förståelse och praktik, en studie av implementering av ett uppföljningsprogram för patienter med kranskärlssjukdom, en sjuårsuppföljning**

Denna studie startade som ett uppdrag av sjukhusledningen på ett av universitetssjukhusen i Stockholm, 1992. Uppdraget var att förbättra vårdkedjan för patienter som vårdats för akut kranskärlssjukdom. Ett antal åtgärder planerades och genomfördes de följande åren, bl. a. gjordes försök att implementera ett gemensamt vårdprogram för akutsjukvården och primärvården, fortbildning erbjöds vårdpersonalen, distriktssköterskorna startade en hembesöksverksamhet för hjärtpatienter, patientföreningen fick del i lokaler för mötesverksamhet och deras medlemmar erbjöds utbildung, m.m. Bristen på datorer i primärvården angavs om en anledning till att vårdpersonal hade svårt att kommunicera med varandra.

Vid sjuåruppfoljningen av detta projekt visade det sig att patienterna inte märkt någon skillnad i bemötande eller uppföljning efter vistelsen på akutsjukhuset. Uppföljning efter akut kranskärlssjukdom var splittrad. Vid det uppföljande seminarier (efter sju år) samt i de intervjuer som gjordes av personal och patienter framkom liknande problematik som för sju år sedan. Vårdpersonalen saknade helhetssyn, de förstod delar av patientens situation.
Vid uppföljningen var alla primärvårdenheter datoriserade men kommunikationen mellan akutvården och primärvården haltade fortfarande.

**Studie II Förståelse av uppföljning efter kranskärlssjukdom, en kvalitativ studie av patienter, vårdpersonal och tjänstemän**

Studien belyser hur vårdpersonal, tjänstemän, patienter och representanter från en patientförening, förstår uppföljning efter akut kranskärlssjukdom. I studien framkom att de olika aktörerna har olika förståelseperspektiv. Resultatet visar att vårdpersonal ofta betraktar patienten som ett objekt, "något" som de tar hand om och som förväntas inta en passiv mottagarroll. De olika deltagarna i studien förstod inte varandras uppgifter och yrkesroller, vilket får konsekvenser för uppföljning av patienter och för samarbete mellan vårdgivare och vårddärare. En fråga som ställdes var huruvida uppföljningen kunde förbättras genom ökad förståelse för varandras roller, samt om patienten kan vara "bärare" av sin egen uppföllningsprocess.

**Studie III Kollision mellan att förstå och att göra; ledares förståelse under en förändringsperiod**

Denna studier undersöker förståelse av förändrings- och utvecklingsarbete hos en grupp chefer vid en intensivvårdsavdelning. Ett år innan studien hade sjukhuset slagits samman med ett mindre sjukhus. All personal, inklusive cheferna hade fått söka tjänst på det sjukhus som var kvar. Studien har utgått från de intervjuade chefernas förståelse av sina ledarroller och deras syn på förändringsarbete.

Studie IV Motsättningar inom äldrevård, en beskrivning av hur politiker och tjänstemän förstår äldrevård och äldreomsorg


Diskussion och slutsats

Resultaten av studierna visar att förståelse för uppföljning av kranskärlssjuka patienter med avseende på vårdprocesser och vården organisation inte förändrats under de sju åren. Den centrala teoretiska kärfrågan i Bourdieus habitusteori ger uttryck för att människan formas av sitt hittills upplevda liv.

politiker eller tjänstemän uppfattas inte alltid som tydliga styrdokument eller handlingsplaner av vårdpersonalen.


Att arbeta med utveckling och förändringsarbete vid en högt specialiserad och tekniskt avancerad enhet som en intensivvårdsavdelning, bör vara en naturlig del av verksamheten. Trots detta anser de svarande cheferna att utvecklingsarbete stör det dagliga vårdarbetet på intensivvårdsavdelningen.

Exempel på otydliga strukturer finns också inom äldrevården och äldreomsorgen i samverkan, eller i brist på samverkan. I analysen av intervjuerna med de ledande tjänstemännen och politikerna blev ett antal motsatsförhållanden tydliga. En positiv vilja bland deltagarna att gemensamt försöka lösa problemen visade sig dock.


Deltagarna i studien från äldrevården uttryckte en vilja att åtgärda de framstagna problemen. En arbetsgrupp bildades för att formulera gemensamma mål. Målen omvandlades senare till fyra visioner. Dessa är; se individen, se individens resurser, se mötet och se dig själv. Perspektivet är
att äldre personer är självständiga, aktiva individer som själva kan besluta om sin egen vård.

En fråga man kan ställa är om förståelseperspektivet har belysts korrekt med hjälp av de metoder som använts i studierna? Upprepade seminarier och uppföljningsträffar gjordes och intervjuresultaten diskuterades öppet med samtliga inblandade deltagare. För att försöka fånga olika perspektiv av förståelse har olika datainsamlings- och analysmetoder använts. Trots ett yttre tryck på förändring av vård och äldrevård och trots att de undersökta personerna och verksamheterna är olika, så verkar det som om vårdpersonalens förståelse av vården inte förändras över tid. Stabilitet kan vara ett sätt att skydda professionell kunskap, kollegialitet, självständighet och verksamheter mot politiska trender och politisk inblandning. Min hypotes är att för att kunna påverka stabila och ibland rigida vårdstrukturer och vårdprocesser måste alla parter gemensamt förstå och reflektera över hur vården är organiserad, hur vårdprocesser formas och utförs och över vårdresultaten. En gemensam förståelse för vårdstrukturer och vårdprocesser bland politiker, tjänstemän, vårdpersonal, patienter, och anhöriga är en förutsättning för utveckling.

Att gå vidare


Jag har valt att avsluta med detta citat av Machiavelli. Trots att det är mer än 500 år sen den skrevs är den fortfarande aktuell:

*Det finns inget så svårt att ta itu med, inget så vanskligt att leda, inget så riskfyllt som att söka införa en ny tingens ordning. De som förändrar får nämligen till motståndare alla dem som lyckats väl i de gamla spåren och endast ljumma försvare i dem som kan tänkas fungera i det nya.*

Il Principe Machiavelli 1469-1527
Det kanske är för mycket att begära att personer med makt och inflytande ska riskera sina positioner för mer oprovade och osäkra organisationsformer. Men kanske det kan löna sig i form av nya vinningar t.ex. som ökad arbetsglädje, kreativitet, mindre frånvaro bland vårdanställda, samt en ökad förståelse för varandras roller, uppgifter och verksamheter, en förutsättning för utvecklingsarbete.

Sammanfattning

_Hur förstår patienter, patientrepresentanter, vårdpersonal och ledande tjänsteman centrala begrepp för uppföljning efter akut kranshärtssjukdom?_


_Har åtgärder som vårdpersonalen själva beslutat om påverkat deras förståelse för strukturer och processer för uppföljning av hjärtpatienter?_

Vid uppföljning efter sju år, hade inga större förändringar med avseende på hur deltagarna förstår uppföljning efter akut kranshärtssjukdom inträffat. Patienten ses fortfarande som en passiv mottagare av vård och uppföljning, som ett objekt med defekta organ och inte som en medarbetare i uppföljningsprocessen. Ett gap finns mellan vad som var sägs och vad som görs. Hur deltagarna i studien förstår vården och vårdprocesserna är oförändrat trots att stora interna och externa förändringar genomförts i vården under projektetid.
Ledares förståelse av strukturer och processer under en period av nedskärning och omorganisering på en intensivvårdsavdelning.


Hur nyckelpersoner inom äldrevård och äldreomsorg förstår sin verksamhet och hur de förstår konsekvenser av sin förståelse.

References


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Washington D.C: National Academy Press


Plsek, P. (2001). *Redesigning health care with insights from the science complex adaptive systems*. In; *Crossing the Quality Chasm, A new health system for the 21st Century*. Washington D.C. Institute of Medicine, National Academy Press, USA.


Svedlund, M. (2000). Women with acute myocardial infarction: Meaning of lived experiences, narrated by patients, partners and nurses (Thesis)., Umeå University, Umeå.


Appendix

Example of how the interviews were analysed (P= politician; M= manager; the number next to the letters P and M indicated the respondent’s number)

<table>
<thead>
<tr>
<th>Original text</th>
<th>Transformation 1</th>
<th>Transformation 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Trust</strong></td>
<td>IP describes feelings of insecurity among older people. Older people lack trusts in elderly care organisations. This feeling could be reduced using alarm systems and providing new houses and nursing homes.</td>
<td>Trust, Contact that is more human, New housing and better technical solutions.</td>
</tr>
</tbody>
</table>
nursing homes creates a great deal of insecurity in spouses and families. They can’t understand why their mother or father can’t get into a nursing home at the time they want it. P1

We can note that the family of the older person feels secure with traditional care. It’s a matter of different generations. M11

An older person must know what is going to happen. To be able to trust the system so that when they need help they know it will be provided. P5

IP wants to go back to traditional care. IP asserts that older people’s siblings need security.

IP speaks of older peoples’ need for trust in the organisation and system

Trust in traditional care.

IP notes that all older people cannot get help.

2. Different cultures

We must see to it that co-ordination is written into our agreements so that healthcare professionals are paid to collaborate with us. M6

The border between elderly care and health care has become problematic. We must do something here. M7

If we stimulate medical care or caring only for sick people, people become ill. M20

IP describes care discrepancies between the two organisations (healthcare and elderly care) based on confusion and incomplete agreements.

IP describes problems with collaboration between healthcare and elderly care.

Medical care gets too much attention.

No collaboration. Healthcare professionals do it their way.

IP feel little responsibility for collaboration. IP feels no mandate or authority to deal with problems.

Power discussion.
We get signals that elderly care organisations want to narrow their responsibilities, arguing that elderly care services are the responsibility of hospitals. At the same time, however, they claim that medical care has too much influence and does far too much already. Elderly care organisations can do much more. M2

We constantly disagree on whose responsibility it is—the municipality’s or the healthcare organisation’s. P2

Sometimes the municipal authorities do not accept the medical staff’s diagnosis. I am distressed about that. I think they (the elderly care providers) have to accept and trust decisions from medical staff and act accordingly. P17

IP argues that too much work is “left” to the medical care organisation.

IP proposes they have a power struggle.

IP says they have a power struggle.

“The other” organisation could do more. Power discussion.

Older people have no power.

Power discussion.

3. Competence and development work

We have to be the best employer in the entire region. That’s what all newly graduated students and all those seeking work must know about us. P15

IP describes difficulties in finding young people willing to work in elderly care.

IP fails to see his own responsibility in making work stimulating and interesting.
We need a person who is something between a doctor and a nurse. Someone who can make home visits on the spare of the moment and who has the mandate to decide what measures to take. P15

The essence of caring for older persons is to have a competent staff: they must have good qualities, competency and a high ethical standard. They must show integrity and respect in all aspects when dealing with older people. M4

IP wants some person with authority to solve problems for him. IP describes how she wants the staff to behave.

IP does not account for older persons or their family’s point of view.

IP does not see her own responsibility to achieve these goals. IP does not see herself as a role model.

4. Finances
We must have common assessments. We can’t afford to do the wrong thing. As soon as we do the wrong thing, it becomes very costly. P15

We must be competitive and pay good salaries, and see to it that our staff are proud of working in elderly care. M4

Despite all the money we spend on healthcare, we can’t say it is optimal for our elderly citizens. M3

It says in our agreements and policies, which are signed, that we must collaborate.

IP points out that lack of co-ordination costs money and that it is expensive when things are done incorrectly. Mistakes occur when people don’t collaborate.

IP reports that he doesn’t know where the money goes.

IP posits that care professionals do not follow policy and earlier agreements.

Lack of co-ordination is expensive. Sees old people as objects.

IP has the authority to do something about this but does his part.

IP does not see his responsibility. Professional-centred care.

Who has power?
All is well and fine, but when it comes down to the bottom line, it’s all about money. M14

<table>
<thead>
<tr>
<th>5. The client and caring</th>
</tr>
</thead>
</table>

*IP* refers to when she worked in geriatric care. She sees that today’s older people are often very ill.

IP refers to when she worked in geriatric care. She sees that today’s older people are often very ill.

*Old persons must be well cared for and believe they can have a significant influence on their care.* P5

IP alleges that older people must feel they can influence their care.

IP alleges that older people must feel they can influence their care.

The essence is to provide active care for older people; that is, we must focus on the patients. I sometimes think we don’t really do that. M16

IP says that the focus is not on the older person’s wishes.

IP says that the focus is not on the older person’s wishes.

In the beginning, when we started to buy elderly care, it was all a matter of price. Now, we want quality at a fixed price on a given object. Now we want customer choice. We want to focus on the customer, the older person. We now compete with quality of care- not the price of care. You take power from the staff and give it to the older person, the customer. P1

IP wants to remove power from the care professionals and give power to older people.

IP wants to remove power from the care professionals and give power to older people.

IP’s personal experiences. Not as a leader.

IP’s personal experiences. Not as a leader.

Older people must have influence over their care. Who has power?

Older people must have influence over their care. Who has power?

Care is professional-centred.

Care is professional-centred.

Who is to have power over care?
**Up-date list and corrections**

Paper II. Henriksen, E. & Rosenqvist, U. Understanding cardiac follow-up services, a qualitative study of patients, healthcare professionals and managers. Accepted for publication in European Journal of Cardiovascular Nursing, 2003 (minor revision has been done in the paper).

P. 24. Last line is missing, should read: The nurse never met the patients. Directly after the interviews she wrote down notes.

P. 33. 2nd paragraph, last line, (submitted) should be: (Accepted for publication in Health Policy, 2003).

P. 43. 2nd paragraph, line 9: the reference (Richardson et al. 2001) should be (IM, 2001).

P. 43. 2nd last line, after IKEA, the 8 should be a parenthesis (.).

P. 44. 3rd paragraph, 5th line (Henriksen et.al., submitted) should be (Henriksen et al., in press).

S. 59. 2:a stycket, 5:e raden, ofat skall vara ofia. Samma stycke, 8:e raden, fä ska vara så.

S. 61. 1-a stycket i sammanfattningen, näst sista raden, uppföljningen ska vara uppföljning.

S. 61 4e raden nerifrån, ordet var, ska bort.

**References**

P. 67. 4th reference: Henriksen, E., Selander, G. & Rosenqvist, U. Can we bridge the gap between goals and practice through a common vision? A study of politicians and managers’ understanding of the provision of elderly care services. (Accepted for publication in *Health Policy*, 2003).

P. 67. Institute of Medicine, the name Chssin should be Chassin, M. and Lawrence should be Lawrence, D.M.


P. 69, last reference. Missing full stop after Sage.

P. 73. Zimmerman, B. Lindberg, C. & Plsek, not Plesk

**Paper II.** P. 4. Table II: the group, Heart failure is missing:

The table should read:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>n = 309</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myocardial infarction</td>
<td>144</td>
<td>107</td>
<td>37</td>
</tr>
<tr>
<td>Angina</td>
<td>112</td>
<td>68</td>
<td>44</td>
</tr>
<tr>
<td>Heart failure</td>
<td>40</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td>By-pass surgery</td>
<td>78</td>
<td>54</td>
<td>24</td>
</tr>
<tr>
<td>Diabetes</td>
<td>23</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>29</td>
<td>16</td>
<td>13</td>
</tr>
</tbody>
</table>