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Bachelor Thesis in Management

"IT'S A BIT NAÏVE TO BELIEVE THAT BEING A DOCTOR IS A MEDICAL PROFESSION"

Exploring medical doctors' responses to competing institutional logics

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Abstract

In this thesis, clinical doctor's experiences and responses to competing logics are studied. This is done to build an understanding of the implications NPM has from a bottom-up perspective. Eleven doctors participate in this qualitative study. To comprehend how doctors respond to competing logics, theory covering institutional logics and individual responses to competing logics is applied. The findings indicate that doctors firmly adhere to their profession logic but that the identification with other logics relating to NPM varies. Depending on the identifications doctors have with competing logics, they respond differently. This thesis increases the understanding of how doctors perceive and respond to current management policies, which has implications for how to structure management systems in complex organisations.

Key Words: NPM, Institutional logics, Healthcare, Institutional complexity

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1. INTRODUCTION

1.1. Background

> *"...any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity." ("The doctor's dilemma, Shaw, 1909)*

Considering the stress that covid has put on Swedish healthcare, Nobel laureate Shaw's century-old words about healthcare management may be surprisingly relevant. But let us not start in 2021, nor 1909, but 1987. For then, the Swedish change in the role of being a doctor began. The political left wanted to democratise the services of the welfare state. The right-wing wanted to limit governmental spending. Management by objectives (MBO) came to be the solution where both parts of the political spectrum could agree. Governance by law was through MBO replaced by contracts and state supervision through price lists and fines.

The aim was efficiency. In the 80s, Government finances were miserable. Swedes were getting fed up with queuing for building permits, kindergarten, the Swedish Alcohol Retailing Monopoly, stamps and finally, the doctor. And how could you tell whether an orthopaedic surgeon was efficient or not? Judicious tools for measuring efficiency were lacking. But there were tools at the marketplace. There, commodities for the right price, content customers and robust companies matched. In this light, the practice of imitating market conditions was seen as a customer-friendly and clear-sighted solution to the problem. New public management (NPM) thus become part of the governance of the Swedish welfare. (Zaremba 2013, SOU 2018).

To solve the problem of inefficiency, professional discretion has significantly been replaced by bureaucratic control, with a shift in power from professionals to management (Jonnergård, Funck & Wolmesjö, 2008). While this change encompasses professions as diverse as civil servants, teachers, police officers and medical doctors, it is the latter that this thesis focuses on. This focus is meaningful since doctors historically have been the profession with the most substantial level of professional discretion (Brante, 2015). Perhaps consequently, NPM policies have had doctors react. The doctors' appeal of 2013 had 9000 professionals requesting attention to the problems they associate with NPM, spurring intense debate in media (Läkartidningen, 2013). In 2020 and 2021, the topic of how to manage healthcare well is still active. (Boman & Eriksson 2020 & The Swedish Society of Medicine, 2021) As of April 2021, healthcare is simultaneously the most critical issue for Swedish voters (Novus, 2021).

Management (by objectives) and NPM do not only do what they aim to do, but also what they actually do. As doctors, being individual agents of themselves, get put to handle the conditions prescribed to them.

By interviewing clinically active doctors, we deepen the understanding of how they perceive working under NPM and how they cope with it.

1.2. Purpose and research gap

There are difficulties in designing management systems for health care that do not lead to unintended or severe consequences. Misleading and demotivating systems can require specific focus and close encounters with those affected to be understood since the systems are not fully visible and known mostly at an aggregate level. On the clinical level, errors are commonly seen as separate or individual, as opposed to being viewed in their structural context. Doctors may also not be keen to talk about the experiences and actions they are not proud of when it is not in line with their ideals and professional ambition (Brewer & Walker 2013; Frey et al. 2013).

Several studies have been conducted on strategic responses to institutional logics by organisations (e.g. Oliver, 1991; Meyer & Rowan, 1977; Greenwood, Díaz, Li, & Lorente, 2010; Pache & Santos, 2010). However, on an individual level, response to institutional logics is not as well studied (Pache & Santos 2013).

Given the NPM system in place today, what indeed are its consequences? A Swedish 2015 literature overview found a poor understanding of the relationship between financial incitements and how it is perceived and acted upon by healthcare professionals. (Forum for health policy, 2015). This thesis aims to improve upon that poor understanding.

As hinted at above, doctor profession *logic* entails a superior level of discretion of performing medically. The tension between that logic and the NPM logics of the market and bureaucracy will be explored using the work of Freidson (2001). Thus, the effects of the bureaucracy and market forces of NPM can be unpacked in a proven framework, giving a setting for doctors' experiences. Freidson's ideal logic types are, however, deliberately static. They are frames of reference through which dynamics can be understood.

Keep in mind that doctors are in no way mere recipients of impending top-down logics of the bureaucracy and market. We will explore doctors' bottom-up avenues for responding. Pache and Santos (2013) widely cited work on individual responses to the competing logics will therefore be used.

1.3. Research question

> *How are doctors experiencing the competing logics that have been introduced through NPM, and what are their responses?*

1.4. Primary focus and delimitation

Rooted in that interplay of the logics, coping mechanisms will be explored. The coping used by doctors in Swedish health care units, including both inpatient and outpatient care. This wide array of doctors is meant to increase the interesting variation. Thus, allowing for seeing a diversity of situational responses. Therefore,

the study is deliberately not limited to specific regional differences, specialisations, or differences between doctors of different seniority within the profession. However, given the interest of studying the doctors working clinically, we have excluded physicians in manager roles. The doctors studied are moreover all working under NPM conditions. The motive behind this delimitation is that NPM is a national management policy. Thus, limiting to a single county or specialisation would rather answer to that context than that of NPM. Uninteresting variation is thus kept at bay.

1.5. Disposition

Six parts make up this thesis. Firstly, the critical concepts of NPM and DRG are described in the literature review. After that, the chosen theories of institutional logics and strategic responses are presented and assessed. Thirdly, study design and execution are explained. The fourth part presents empirics from 11 interviews that have been conducted. Finally, the findings are analysed and then discussed.

2. LITERATURE REVIEW

This thesis aims to deepen the understanding of how the nuances of NPM affects the doctor's work life and their corresponding responses. Therefore, New Public Management, with its Diagnosis Related Groups (DRG) and its potential for complicating the doctor's role, is presented.

2.1. The New Public Management concept

As described in the introduction, management by objectives (MBO) became part of the Swedish state government in 1987. Coined by Drucker in 1954, MBO means quantitative measurements that are followed up on. The idea is to improve performance by clearly defined goals.

Applying MBO in state governance, New Public Management (NPM) has been developed. State governance is to be organised and structured in mimicry of the private sector. The market is believed to be the most efficient coordinator of the world (Agevall, 2005). Furthermore, one of the NPM devices to be efficient and cut costs is through implementing top-down management directives (Hyndman & Lapsley 2016)

Christopher Hood is one of the leading theorists behind NPM. Hood presented an early definition of what the key elements of NPM are:

1. Increased authority and the influence for managers and coordinators.
2. Measure the results with the ambition of having clear measurements.
3. Focus on the results, not the processes.
4. Decentralise and breakup organisations into several smaller divisions.
5. Introduce competition within the public sector.
6. Governance and management with the private sector as a model.
7. The ambition to decrease the costs (Hoods, 1991).

The exact definition of NPM is disputed. Eriksen made the definition used in this thesis. He described that NPM

> *"(...) means that the top level and the control function is amplified while you underscore the importance of quantitative result indicators and targets for efficiency. The resources should be utilised with better efficiency, and there should be new incentives to motivate and discipline the employees. Meanwhile, there is a great emphasis in decentralisation and delegation which shall be used as an instrument to improve the services which the public sector can offer" (Eriksen, 1997, s. 105).*

One of the earliest implementations of NPM in Sweden was the development of a reimbursement system to increase efficiency. With diagnosis related groups (DRG), patients are grouped into groups of cost-wise similar patients. With DRG, the diagnosis a patient gets is a central basis for the subsequent compensation for the healthcare provided (Bejerot & Hasselbladh 2013).

2.2. New Public Management complications

Studies show that doctors respond to financial incentives as expected by providing more services of the kind that is profitable for the clinic, including services that may be of no value or even harmful (Hemenway et al. 1990, Rodwin, 1993). Moreover, the DRG based compensation for treatment may not cover the costs for certain patients (Andrén-Sandberg, 1994). In their critique of NPM referenced in the background section, these are the perceived system design flaws referred to (Läkartidningen, 2013 & Boman & Eriksson, 2020). Moreover, it has been shown that work-life satisfaction has a causal relationship with overall life satisfaction (Judge et al. 1993)

3. THEORETICAL FRAMEWORK

Presented here are the leading theory lenses for exploring the research question. Profession theory (Freidson, 2001) helps the understanding of conflicts between profession, bureaucracy, and market logics. Pache & Santos (2013) offers a typology for (a doctor's) coping with institutional pressures.

3.1. Institutional Logics

The research question is placed within institutional logics, a field that originates from theory and analysis of how institutions shape their world view based on ideas and values (Thornton & Ocasio, 2008). Organisations receive pressure from the outside world and form solutions to corresponding problems. Institutional logics refers to these various forms of pressure. (Falk & Sandevall, 2015).

Institutional logics are defined as material and symbolic organisational principles that are essential in an organisations' purpose. Individuals within an organisation manage, develop, and act according to these underlying logics (Friedland & Alford 1991). Thornton and Ocasio (2008) comply with the idea of considering institutional logics as drivers of action and agree with Meyer & Rowan in that they are also sources of legitimacy and provide a sense of order.

Meyer & Rowan (1977) describe how organisational structures arise as reflections of institutional rules, giving them legitimacy. These rules, which can be seen as myths, are incorporated by organisations offering them legitimacy and an increased chance of survival (Meyer & Rowan, 1977). Also, Friedland and Alford (1991) argue that these institutional rules (logics) indicate the appropriate way of acting, giving legitimacy to organisations following these indications.

On the contrary, DiMaggio & Powell (1983) claims that other types of organisations influence organisations. This sociological phenomenon of isomorphism can be seen in NPM as it lets the public sector mimic the private sector (SOU, 2018).

Based on the idea of institutional logics presented by Friedland & Alford (1991), where society is defined as an institutional arena, researchers have presented multiple logics used in various organisations. In this arena, logics co-exist and sometimes contradict each other, leaving organisations and individuals subject to forces in different directions. This also implicates that there are several sources to rational behaviour within this interinstitutional arena (Friedland & Alford, 1991). Furthermore, given this parallel existence of logics, knowledge or facts are neither neutral nor constant. Organisational terms such as efficiency and rationality are influenced, defined, and evaluated in the light of the logics (Friedland & Alford, 1991).

This study is based on this idea of logics as co-existing and potentially interfering with each other.

Freidson (2001) argues that the professional logic contends with the logics of *bureaucracy* and *market*. The *bureaucratic* logic is based on the rational-legal model presented by Weber (1947). Its logic strongly relates to NPM in its focus on thorough regulations and administration (Meyer & Hammerschmidt 2006). The *market* logic originates from Adam Smith's (1976) model about the free market (Freidson, 2001). Other studies have presented different logics that influence individuals due to being a part of society (Thornton et al., 2012). This includes the logics of family and religion. However, this thesis will be limited to the logics presented by Freidson (2001), which are elaborated on below.

Scott et al. (2000) argue that health care organisations previously have been dominated by the doctors' profession logic. However, the profession logic within health care has become less significant and is now equally prominent as the other existing logics.

Profession logic

Profession theory was developed to describe the profession as certain attributes within an occupational group. This theory, however, now also covers how professions organise and control their occupations (Goodrick & Reay, 2010). Similar to an organisation, professions are also exposed to pressures (DiMaggio &

Powell 1983). The professional logic constitutes an institutional logic and exists within people in an organisation (Muzio, Brock & Suddaby, 2013).

The full expression of the profession logic would have its members have the complete discretion to decide the qualifications required to perform the work, how the work is controlled and evaluated afterwards. This would contrast to having work directed by the consumers or managers (Freidson, 2001). Freidson argues that professional logic is the only institutional logic that can organise occupations where specialist knowledge is needed. He argues that this is due to the complex expertise required due to the time and effort required to properly comprehend the matter. Friedman furthermore describes five pillars that define a suitable ground for when an occupation shall be managed according to the profession logic:

- knowledge that brings status
- unique access to the profession
- protected labour market
- knowledge and education governed by the profession
- certain ideology that drives the profession (Freidson, 2001).

However, Freidson notes that the *full* expression of the profession logic has never nor never will happen. Nevertheless, he argues that the profession logic ought to be sufficiently strong to organise the specialist occupations (Freidson, 2001) correctly.

The doctor profession

The doctor profession, which is being studied in this thesis, is a classical profession (Brante, 2015). This classical profession is strongly connected to academia and is built upon specific ways of performing. The role of being a doctor is built on authority which also comes with high status (Brante, 2015). To be a member of the Swedish doctor profession, one must complete a fundamental education of five and a half years, followed by a general internship. Subsequently, there is the opportunity to continue within a specialisation.

Doctors form a significant part of society. Therefore, it is important to examine how the profession is being affected by the existing management systems. This thesis is doing so by exploring how NPM affects doctors and how doctors respond to NPM.

Logics that compete with the profession logic under NPM

Since the 1990s, patients have gradually gotten more significant opportunities to choose their health care provider. This development reached a crucial point in 2010 when it became mandatory for counties to offer freedom of choice for clients and freedom of establishment for private actors (Anell et al.12). With that, the market and bureaucracy logic increased its contention with the profession logic (Freidson, 2001).

While the market is essentially a quasi-market in the sense that policymakers and not the market itself set prices, the effects are still significant. Changing the price lists effectively changes the conditions for work. The patient is also given an important role, as he or she chooses from whom to consume care (Anell et al., 2012).

Similarly, hospitals are compensated partly per basis on the diagnoses they give patients. Each diagnosis produced is effectively a service "sold" to the county. As noted in the DRG chapter above, the service sold is not necessarily making up for the cost of caring for said patient.

Freidson (2001) describes the bureaucracy logics with reference to the Weber (1947) definition of bureaucracy. With NPM, through increased regulation and administration, the control of detail increases, moving work closer to Weber's archetypical image (Meyer & Hammerschmid 2006):

> *" Precision, speed, unambiguity, knowledge of files, continuity, discretion, unity, strict subordination, reduction of friction and of material and personal costs - these are raised to the optimum point in the strictly bureaucratic administration." (Weber, 1947)*

Analytical framework

The effect on the profession will be analysed based on Freidson's framework.

Logics Parameters	**Bureaucracy logic**	**Market logic**	**Profession logic**
Who is in command	The manager	The patient	Colleagues in the profession
What organises work	The organisational view on efficiency	Market demand	The professionals themselves
Good performance	Output following the organisation's regulations	As demanded by the marketplace	Work following professional judgment

Table 1. An analytical framework for the thesis. Freidson's (2001) parameters for the logics of the bureaucracy, market, and profession.

3.2. Coping with competing institutional logics

Doctors' individual responses to the competing logics will be analysed using the framework presented by Pache and Santos (2013), which covers coping mechanisms used by individuals facing competing institutional pressures. Based upon the extent with which the individual enacts the knowledge of two conflicting logics, one of these five responses can be predicted:

- The most conforming response is *compliance*. It indicates that an individual performs a complete adaptation of an institutional logic in terms of values, norms, and practices.
- *Defiance* is considered the opposite and refers to when individuals explicitly reject whatever a given logics tries to impose.

- *Ignorance* occurs when an individual does not react to the pressures of a given logic. Unlike defiance, this refers to rejection due to lacking awareness of the pressures rather than the active rejection of it.
- *Compartmentalisation* occurs when an individual chose to adhere to a logic at a given time and another logic at another time, depending on the context. This enables individuals to adapt to the situation and be compliant depending on what is expected in each situation.
- *Combination* is much like compartmentalisation but instead refers to when an individual is trying to comply with multiple logics simultaneously. This can frequently be difficult, given that different logics may contradict each other.

The enactment of knowledge is categorised into three levels of identifications which range from *novice* (lacking adherence) to *identified* (high adherence), with *familiar* as the in-between level where the individual shows intermediate identification with the logic. For example, the novice individual has limited knowledge about the logic at stake. Or the novice is so guided by another logic that the individual is unable to enact other perspectives.

Pache & Santos (2013) further presents *roles* depending on one's identification with the competing logics. The roles also rely on the hybridity of the context, meaning the relative strengths of the logics. The context of health care is considered to be high in hybridity (Scott et al., 2000). Hence, the roles presented in this study are in a high hybridity context.

To identify with a logic is to enact its knowledge to the extent that the individual is emotionally and ideologically dedicated to the logic. Thus, the logic is effectively part of who the person is (Pache 2013). DiMaggio & Powell (1983) argues that the member within an organisation identify with a logic depending on to what extent the individual has been embedded in the logic during the education and its work-life experiences.

Logic A\B	**Novice**	**Familiar**	**Identified**
Novice	Ingenuous member *Ignore A and B*	Disengaged coalition member *Comply with A and ignore B*	Challenger *Comply with A and defy B*
Familiar	Disengaged coalition member *Ignore A and comply with B*	Intermediary *Compartmentalise A and B*	Advocate *Compartmentalise A and B*
Identified	Challenger *Defy A and comply with B*	Advocate *Compartmentalise A and B*	Hybridiser *Combine A and B*

Table 2 The framework used for identifying responses to conflicting logics, based upon Pache & Santos (2013)

Aspects influencing individual coping strategies

It has been shown in several studies that individuals respond differently despite a homogeneous context (e.g., Meyer & Hammerschmid). Almandoz (2012) argues that the responses will depend on individuals' social embeddedness in different institutional logics. Pache and Santos (2013), as noted, suggest that individual's enacted knowledge about logics will impact how they respond to it. Furthermore, it is argued that the power of each logic will affect where the individual will find itself. In contexts where competing logics have similar strengths, individuals tend to act more actively (Pache & Santos, 2013).

3.3. Theory discussion

One of the limitations brought up by Pache & Santos (2013) is that the model presents a simplified view of institutional logics and that it is limited to two competing logics. Despite this, they argue that the model holds for contexts where there is more than two logics. Also, Thornton et al. (2012) stresses that analysis of institutional logics must be done regarding the research context and the most salient logics. Given the focus of this thesis, the competing logics that doctors experience, the focus will be the doctors' perspective. Hence, when analysing doctors' responses to competing logics using the framework presented by Pache & Santos (2013), the market and the bureaucracy logic will be considered a joint logic relating to NPM, competing with doctors' profession logic.

4. METHOD

This chapter lays out the reasons why the study was carried out the way it was. Using a qualitative research method and an abductive approach, the aim was to go beyond what could be understood through, for example, questionaries in a positivist paradigm.

4.1. An abductive and qualitative study

This study is based on an abductive approach. The development of theory and the collection of empirics thus occur in parallel, enabling continuous search for more sophisticated use and deepening understanding of the empirics (Bryman & Bell, 2018). Furthermore, given that the focus of the study is to understand the experience and agency of doctors, the study is qualitative. Therefore, it has been conducted with semi-structured interviews emphasising the topics that the interviewee gravitated towards. That is, posing open, curious questions, allowing the interviewees to share his or her sense-making freely.

Given that the interviewees are not bound to strict questions, they were able to bring up their most essential topics more efficiently, which rigid interview questions might not have covered otherwise. In addition, open questions were used

to give more depth to the answers, increasing the ability to truly understand the doctors. (Bryman & Bell, 2018).

4.2. A study based on constructivism and interpretivism

This study is conducted from a constructivist ontological perspective. Therefore, the perception of the world of both the interviewees and the authors of this thesis is thought of as social constructions. In line with the constructivist point of view, cultures and institutions are considered to form the reality of the individual through interactions between people, rather than the idea that the reality exists regardless of human interaction (Bryman & Bell, 2018). The reason for this constructivist position is that doctors' perceived relation with health care organisations and logics are not absolute truths but social constructions perceived by humans**.** Given that this study focuses on this interaction from the doctors' perspective, a constructivist ontological position is adequate.

To better understand the consequences of the top-down nature of NPM, a bottom-up, individual approach is relevant. As shown at the end of the literature review, incentive systems under NPM can entice doctors to prescribe medically insignificant or even harmful services, directly contrasting the profession logic of consistently doing what is medically judged to be the best for the patient. To allow doctors to be open about what they might regret doing, an emphatical and understanding interpretivist approach is called for. Accordingly, the proclamations of the interviewees are interpreted through the minds of the writers. Choosing this approach is reasonable given the aim of the research to understand behaviour in a social context (Bryman & Bell, 2018).

4.3. A Cross-sectional research design

A cross-sectional research design was used for this study, and accordingly, it contains multiple cases rather than a particular case. The interviewees work in different regions and within different specialisations. It is considered a strength in qualitative studies not to be biased towards contextual or other particular aspects. This is highly relevant for this study since it also aims at understanding NPM, which is not limited to one specific context in healthcare. Given the aim of this study, 11 interviews were considered to contribute with greater insight than what a survey or public data would have provided. An alternative would have been to conduct a one-case study instead. However, it is the NPM picture at large that is aimed for. NPM and the conflicting institutional logics it involves is not exclusive to a single specialisation or region; it is a national policy.

4.4. Interviewed individuals

Eleven individuals are included in this study, all of whom work clinically. Many interviewees studied at medical school together with the thesis author Jansson. They are now licensed physicians in postgraduate training to become specialists. Because of the sampling method, there is a respondent variation in terms of gender,

region, position, and specialisation. However, as expected, age and seniority were consistently low throughout the interviews with the interviewees from med school. However, the interviewees referred to by previous subjects were chosen on the purpose of seniority and specific specialisations of interest. An overview of participating respondents and further information about them is disclosed in appendix B.

Thirty-five doctors were contacted, of whom 20 responded, which then led to 11 interviews. Some interviewees were found via the previous interviewees (snowballing).

While 15 interviews were aimed, a recurring theme in contacts with potential respondents was fatigue from covid-stressed workplaces. Doctors expressed an urge to contribute but also hinted at being close to burnout. One acquaintance said that she barely had time to wash her clothes. In these cases, with the ethical principle of avoiding harm to participants in mind (Diener and Crandall (1978), cited in Bryman & Bell (2018), we encouraged them to recover rather than to participate in the study. Naturally, this decision limits empirics. As it was decided to bring data collection to a close, however, the signs of saturation were clear.

The initial selection was not based on any specific parameters. Instead, previous classmates were contacted, knowing that there would be variation in gender, region, position, and specialisation. However, as expected, age and seniority were consistently low throughout the interviews with the interviewees from medical school. However, the interviewees referred to by previous subjects were chosen to have a different position or seniority. An overview of participating respondents and further information about them is disclosed in appendix B.

4.5. Reflexive considerations

One of the authors of this thesis, Jansson, has studied to become a medical doctor at the Karolinska Institute. In contact with doctors and various doctors' associations, he gained knowledge about and interest in the challenge of managing healthcare. This milieu fostered an urge to gain an in-depth understanding of the issue that this thesis explored. This is in line with the bottom-up, individual level of analysis of the thesis.

4.6. The credibility of the thesis

The research aimed at heeding the call from the quality criteria presented by Bryman & Bell (2018): reliability, replication, and validity.

Reliability and replication

The specific settings of a study cannot be frozen. The very same empirics can therefore not be reproduced (LeCompte and Guetz, 1982). For replicating (qualitative) ethnographic research, LeCompte and Guetz (1982) accordingly suggest that the same social role ought to be taken by researchers aiming to replicate a study. For this thesis to be replicated, semi-structured interviews would

again need to be set up. The researchers similarly build trust with the interviewees to freely elaborate on their work-life, including aspects they may not be proud of. While we have seen signs of saturation in our empirics, the small sample could be an outlier, making the study challenging to replicate.

Regarding internal reliability, the authors have been careful to do coding of the interview texts separately. This is especially relevant since one has a medical background and interest in the field, which the other has not.

Validity

LeCompte and Guetz (1982) distinguish between internal and external validity.

Regarding *internal validity*, is there a proper match between the researchers' observations and the theoretical ideas developed? Ideally, extended participation in the work-life of doctors had allowed for addressing this concern (LeCompte and Guetz, 1982). But, unfortunately, about a dozen interviews are nowhere near participating at clinics. Given the frame of his medical school training and thus partial alignment with the profession logic, the author Jansson could, however, come closer to understanding the "lived" work-life experience of the interviewed doctors. This permits a higher level of correspondence between observations and the concepts developed in the thesis. At the same time, the non-medical background of the other author, Quick, served to avoid the risk of having the thesis promote the profession logic itself.

External validity poses an issue for qualitative researchers. The often-small samples make it difficult to generalise findings into other social settings (LeCompte and Guetz 1982). Therefore, the aim of this thesis is not a definite answer about the state of Swedish healthcare. Instead, the objective is to present a picture of experiences and coping, with which the right questions can be asked in future research.

5. EMPIRICS

This chapter begins by depicting the experiences of being a doctor. Then, the identified sample space of doctors' agency is presented and elaborated upon.

5.1. Experiencing the competing logics of NPM

Interviews depict a deep urge to provide sound care for patients. This was also the reason most interviewees became doctors. They wanted to do something meaningful and help people. However, for several respondents, this aim is at odds with the conditions of the work environment:

> *"It is a bit naïve to believe that being a doctor is a medical profession. At least when it comes to being a general practitioner. There are elements of [medicine], but the job is very much politically controlled, and as a doctor one tries to make the job to be about some kind of medicine or science or evidence, but it is obvious that the political agenda in a country affects everyday work a huge lot, especially for general practitioners. Also, for doctors in other fields, I'd think." (Sara)*

There is, however, a broad spectrum of perspectives on one's work life. George is at the other end of the scope of (dis)satisfaction:

> *I have the discretion to do what is medically relevant…. We have a well-functioning clinic, and I also believe that the hospital is functioning well under this management. (George)*

Market logic at the workplace

The patient as a customer

An example of the market logics in action comes through the need to make patient records understandable for the customers, the patients:

> *I used to be able to write the patient records for them to specify medical assessments and treatments. With the patients' right to access the records, however, I must simplify the language. Otherwise, the patients will not understand the records. But understandable records for the layperson means that the function of the record as a professional collaboration tool gets diluted. (Kajsa)*

Sara showed her frustration about seeing the patient as a 'customer' and the implications that that paradigm has. Swapping your present doctor for another one can be done in minutes at the county's healthcare website. Sara described how the patient chooses a doctor whose clinic will receive funds for having the patient listed. The doctor decides what tests to run (e.g., blood work or costly magnetic resonance imaging) according to their medical knowledge. If the patient is not content with the tests chosen, he can choose another doctor. Several doctors empathise that the implicit incentive for doctors to comply with patient requests undermines the legitimacy and authority of the doctor. Sara further describes her role as being the patient's "order station":

> *Why would one place a person with a 15-year education to play that role? If there comes a patient to someone of you that are not doctors and says, "I want a magnetic resonance imaging on my knee", to refer that patient, that is not difficult. One can just do it! The difficult part is to assess whether magnetic resonance imaging is needed or not. (Sara)*

Sara also described how she sometimes refers patients per their wishes while saying that she does not find doing so necessary. Having later realised that the referral was unnecessary, the patients may better trust the doctor's judgment. The need to build trust is recurring among primary care respondents:

> *Sometimes, the reason for ordering tests would not be medical but about managing the worry of the patient. But with trust and through being pedagogical, I can meet the patient halfway. (Emma)*

The county as a customer

Due to the decentralised structure of Swedish health care, some doctors described how counties could be seen as customers as well, given that health care is regional, not national. Counties are generally unwilling to pay hospitals in other counties for care. Therefore, except for acute needs of treatment, patients outside of their home county are referred home for treatment:

> *It feels frustrating sometimes to explain to the patient that she must be sent to her home hospital instead of treating her. If medically absolutely necessary, we give the treatment despite not getting paid [by the home county]. If not, we send the patient off and hope for the best. (Johanna)*

Bureaucracy logic at the workplace

The experience of top-down management.

When asked about their ability to influence their schedules, all doctors stated that their influence is limited and that they can neither choose how to prioritise. While being generally content with her work situation, Johanna dislikes how administrative policies nudges her:

> *I choose to not think about it [economic aspects], but I have never been good at that. It has not been my strong side to comprehend economic models and why you would do it in one way or another. I don't think that they are bad, but they have a rigidity that bothers me, given that it is about working with people. People do not work like that, always following a script. And deviations always cost. I do not like that. It feels mean. As if one would have acted out of laziness or being evil if deviations would cost. (Johanna)*

As noted at the onset of this chapter, there is a spectrum of experiences. Johan shows more dissatisfaction:

> *Unfortunately, the clinic is very much controlled from the top. And that affects <u>everything</u> [uttered with emphasis] (Johan)*

> *It is very much top-down all the time. […] No one asks people working clinically if it is reasonable [new policies]. It does not feel cost-efficient or efficient at all. A lot looks good on paper but only creates more administration or a new policy, but it has no clinical impact. (Kajsa)*

Frustration can also come in management policy critique:

> *Recently it was announced that 150 bureaucrats were laid off. But our clinic and other clinics are still working. What was that administrative personnel doing? (Johan)*

The topic of personnel policies is recurring:

> *There is currently a lack of [medical] personnel in Swedish health care. More and more people are laid off, and you are not allowed to hire […] three people could leave, there is no replacement, and it does not become less to do, rather more, and the ones left are supposed to manage it. This hopeless feeling of being insufficient makes people quit. […] We had three specialists within haematology. Two of them retired, and since there was no replacement, the one left took a leave of absence because it became too much to handle. (Kajsa)*

> *With too few [medical] personnel working, there is this vicious circle. Experienced doctors quit, making the situation even worse. (Johan)*

The impact of listing patients

Primary care clinics are primarily compensated for their number of listed patients. Some primary care doctors stress that the number of listed patients necessary for making primary care unit ends meet is too many. 2500 patients can make the workload over encumbering:

> *We are competing with [app based] net doctors. They get easily manageable patients, and we get the more severe cases, while compensation is the same. I cannot but get upset. (Brad)*

Olivia, a more senior primary care specialist, is however generally content with her work environment

I can handle my present number of patients. … The private clinic where I am now working has managed to limit our patient uptake somewhat to not have a too big share of the most care-demanding patients. (Olivia)

The impact of earnings through DRG points

Productivity is measured through the DRG system. The number points of earned can be relevant for the salary:

I personally think that medical needs rather than financial aspects should govern the care. […] during wage negotiations, I was compared with my colleagues on how many clients I saw [money generated] and the cost of the tests I took on patients. (Emma)

Several doctors shared their confusion about using DRG:

A patient with hypertension and PTSD due to war memories comes to me to test her blood pressure. Meanwhile, because I am her doctor, I know that she has PTSD, and she might even add that she currently has more nightmares than usual and sleeps poorly. Have we then discussed her PTSD, can I add it as an [income-generating through DRG] sub-diagnosis, or not? In that case, I believe I should since it is a part of her clinical picture and likely affects her hypertension. We have not received clear instructions in cases like this and therefore do not know how to act. (Sara)

These respondents perceive a grayscale where the act of medical assessments and considering the clinic's finances intertwine.

Fredrik explained that he felt that it was necessary to learn how to efficiently set reimbursement codes in cases of several diagnoses to avoid having the clinic receive less reimbursement than it is entitled to. However, he also explained that he did not wish to learn about the specific sums matching with them. Fredrik thought it could affect his choices, and he stresses that the medical need is more important than the economic. If he knew how what sum each diagnosis generated, he might subconsciously consider that. Despite doing this, he felt that he still could find himself reasoning in terms of costs due to other reasons.

"The department head can say that we have high costs for test-taking and that we need to consider if all tests are necessary. We should, of course, do this, but when he says that, I feel questioned and insecure if I do take unnecessary tests." (Fredrik)

5.2. Coping strategies

So how do doctors handle the various situations prescribed to them? Corresponding to the spectrum of experiences, a range of coping strategies can be seen.

Acting to 'protect' one's professional logic

Kajsa and Sara shared that it was an issue when non-doctors are managers (or healthcare board members) and therefore lacks knowledge about the operations on the floor. Kajsa shared that once the healthcare board had decided that their town hospital would close. She and her colleagues refused to comply:

One day we had had it. Having an in-town hospital is a matter of life-and-death in some emergencies. So, we gathered public support. Eventually, 10 000 citizens had signed our protest in our town of 40 000. Then, the healthcare board bent. (Kajsa)

Insubordination, again with crucial peer support, can also be less apparent towards the healthcare board. However, this expression was nevertheless heartfelt:

I could have been more aware of it [economy and management guidelines]. But regardless of how much I know, and I believe this is common among doctors, I think people are rebellious and say, "Screw the rules". I do what is best for the patient. And if something costs 100 crowns more than something else, we don't give a damn" (Kajsa)

Multiple doctors used prescribing medicines as an example of when they defy the set-out structures. This involved renewing medicines or certificates even though it is supposed to require a new evaluation. However, if the patient is chronically ill or too old or weak to move to the hospital, they see no point in not just renewing it right away.

When a patient has a chronic psychosis, I cannot see an ethical conflict here […]. She will not change; she is still going to need mobility services, and to then require a visit serves no purpose. (Johanna)

The interviews suggest a robust ethical motivation among doctors. Some of the responses to being unable to provide the care you want were to either quit or move to another care unit. It was also brought up that this creates even more stress for the ones left.

" I will start working only a few days a week, and during day-time, because there are more resources then […] I have also made an application for other care units where they have more resources. I'm stuck in this, and I have realised that I'm not able to change this myself." (Johan)

Making a trade-off

Another take on the situation is, however, to distance oneself from the identity.

One mustn't care too much. (Hannah)

Hannah, an experienced primary care doctor, described how her work-life had to work for her long-term health. Some patients ideally would need far more medical attention than what is possible in the timeslot provided. However, if she would spread herself too thin, she would eventually not provide care at all.

Sara, being interviewed on a Friday evening, described how she still had 40 test results not gone over. Among these test results, a patient of hers might have an aggressive and time-sensitive form of cancer. While not being formally obliged to act on this potential call for action on a Friday evening, she professionally feels a moral obligation to do so:

No matter how much time one has, you still need to live with some ethical stress. I cannot sit here and worry about the x-ray pictures I did not have time to look at – I cannot live like that. And if the patient has cancer today, they most likely have it on Monday too [stated with sarcastic humour]. (Sara)

Sara's way of handling this pattern of continuously not being able to do good is to work only 80% of full time. So that she better can handle test results in her spare time. She has also previously moved to a county managed clinic because, according to her, work is now less stressful. She described that it is crucial to find a suitable unit since they differ in terms of stress.

Sometimes it feels like one must choose between one's health and that of the patient. (Sara)

Adopting to demands

At the end of the interview, Sara removed her wig. She has worked for about six years in primary care. She did also share that her health conditions may explain the recent loss of her hair. Psychological stress is, however, a known cause of hair loss (Davidhizar, 2001). While causality between work environment and hair loss cannot be inferred in this particular case, the withering health of this relatively young doctor is noteworthy. Health implications were described by Johan as well:

> *I am about to quit work [at the emergency ward]. Attempting to take on ever more work has taken a toll on me that I can no longer sustain. (Johan)*

On the other hand, Johanna, being a resident practitioner, described how she lacked options.

> *I do not have very much put against it; if I don't want the job, then… ok. Nothing will cease working without me (Johanna)*

Finding balance

While some sets of data points are dramatic, normality is also found in the data. That is clinics that are working reasonably well, with primarily content doctors, which Olivia and George describe themselves as. Fredrik did not share an equally positive view. However, he was able to manage the competing logics well.

> *I felt like I need to take responsibility for my own work-life balance […] and dare to say no to bad work conditions. […] My opinion is that a requirement for being a good doctor is to feel good yourself. I know that I have colleagues who always say "yes" and are very agreeable, which affects their health and wellbeing, and I can see that it also negatively affects their performance. (Fredrik)*

Another strategy mentioned by several doctors is to become a manager and thereby make management more adjusted to their profession. However, Kajsa and Johan described that the incentives for doing so are insufficient given that most doctors prefer to work clinically and given that the wage does not differ much. Fanny, however, did want to become a manager. She was about to start working as a chief physician and had several ideas for improving the unit that were also appreciated by top management. Fanny was overall happy with how her clinic is managed; however, she did have several ideas for improving structures and solving the issues she finds with the current policies at the clinic.

6. ANALYSIS

This chapter begins by analysing the experiences of being a doctor. Then, the doctors are analysed according to the framework of Pache & Santos (2013).

The interviewees mostly adhere to the profession logic. This affects their way of responding to the competing logics in their everyday work. The adherence with the profession logic is voiced via their emphasis on doctors as the most suitable personnel for managing health care. This is in line with the conventionally significant extent to which doctors regulate themselves, with their advantage in

terms of expertise (Freidson 2001). However, paradoxically there was only one respondent who desired to move to a manager position. The rest emphasised that they prefer working clinically rather than becoming a manager. Furthermore, the quality of the care is the highest priority among the interview subjects, despite having worked for many years under competing logics. This corresponds with previous research, suggesting that individuals stay adherent to the logic one is embedded in during its education (DiMaggio & Powell, 1983).

To keep patients, primary care doctors in the empirics must keep the patients somewhat content, even though it means partly straying from what makes medical sense regarding their expertise. This is partly a consequence of the NPM market logic where patients are customers who get to put demands on the caregiver. But it is also related to the NPM bureaucracy logic, given that the care units are very aware of the compensation scheme and ultimately need to meet economic demands. The units are financed by having patients listed and setting diagnoses. The doctors, therefore, have an incentive to handle the patients cautiously rather than just presenting them with the appropriate treatment.

Primary care doctors work at units where the organisation is structured and governed for bureaucratic efficiency and patient demand. Patient demand is expressed through the choice of primary care unit as well as through insisting on what tests the doctor ought to order. The reimbursement systems and contracts entice the doctors to prioritise the will of the market and the bureaucratic requests. Work hours are highly scripted, following the bureaucracy logic.

The individual within the primary care profession has overall limited possibilities to influence how the job is organised. Moreover, the "patient market" (market logic) organises the doctors' daily working life, emphasising their availability. The profession logic still exists and is formally final regarding the doctor's medical decisions. However, the integrity of several medical doctors is put into question, as depicted in the title of this thesis. In these cases, a tug-of-war in-between the logics partly seems to be 'won' by the market and bureaucracy logics. Moreover, primary care work lacks the collegial comradery found at hospitals.

Empirics show that some doctors are heavily undermined in their pursuit of working based on the profession logic. It is in these cases clear that the doctor profession is the recipient of significant institutional pressure through NPM and DRG. For some doctors, this pressure is over encumbering; for some, it is not.

Hospitals, in the empirics, show a different picture. Some respondents report severe issues with a type of bureaucratic management that fails to cater to the doctors' needs to perform well. Other respondents describe a team spirit that allows them to endure the institutional pressure better. Furthermore, some hospital clinicians are not significantly affected by NPM in the first place. These respondents generally get to focus on medical work, with a team surrounding them supporting just that. Nevertheless, as shown in the empirics and the table below, hospital

doctors are also part of the game of institutional tug-of-war, albeit with different conditions.

Logics Parameters	Bureaucracy logics	Market logics	Profession logics
Who is in command	The clinic administrator	Primary care: the patient Hospital care: policymakers through price-lists for diagnoses	The doctor
What organises work	What is (financially/medically) best for the clinic. The compensation scheme with the county	Primary care: The patients demand quickly accessible care. The doctor is an "order station". Hospital care: the current DRG compensation scheme.	The doctor and her colleagues, governed by the status-rewarding knowledge in their occupational group.
Good performance	As deemed by the compensation scheme. Keep up with the budget.	Primary care: What makes patients content so that they stay listed at the unit. Accessibility following the compensation scheme. Hospital care: medical measures that can be executed swiftly while being well paid for.	To provide patient care according to medical competence.

6.1. Intermediaries

Johanna and Hannah are the only interviewees that fit in the role of intermediary, which indicates that they compartmentalise the professional and the competing logics. This can be seen in their emphasis on the importance of managing according to the expertise, but meanwhile feeling suppressed by the policies set up under the influence of NPM. However, they adhere much to the guidelines and respond according to what is suggested by the competing logics, unlike the doctors positioned as challengers. They also act according to different logics in different contexts, as indicated by Pache & Santos (2013).

6.2. Advocates

Unlike the intermediaries, Emma, Brad and Fredrik show strong identification to the profession logic. They are still compartmentalising the logics, but they show a greater identification with the profession. This is shown as they are also acting according to the competing logics while still highlighting its flaws and, on such occasions, also leaning towards solutions suggested by the profession logic. This is apparent as Fredrik and Emma choose to cope with the policies but deliberately not let themselves manage them. This corresponds to Pache & Santos (2013), who

suggests that advocates while compartmentalising with competing logics, acts to maintain the integrity of the logic it identifies with.

6.3. Challengers

Three respondents, Sara, Kajsa and Johan, can be referred to as challengers with Pache & Santos (2013) framework. They all have an identity firmly rooted in the profession logic to the extent that they cannot see their context from the perspectives of other logics. Their identification with the profession leads to compliance with it and defiance of competing logics. However, while they are all acting in the role of challengers, the expression thereof differs. Sara prioritises the profession logic by working part-time to do some medical work in her spare time. It also seems that she and Johan are sacrificing their health in their pursuit to always adhere to the profession logic.

As suggested by Pache & Santos (2013), these challengers consider conflicting logics as problematic and therefore reject them favouring the identification with the profession. Kajsa also defies the market and bureaucracy logic, albeit with different conditions. She was part of what can be seen as a mutiny against the healthcare board, succeeding in making what she finds medically relevant prevail. Finally, Johan expresses deep discontent with top-down management and quits his job to salvage his professional identity instead.

6.4. Hybridisers

Three of the doctors (Olivia, Fanny and George) indicated identification with the profession logic as well as the market and bureaucracy logic and is therefore considered to by hybridisers (Pache & Santos 2013). They show commitment to all logics and combine them rather than choose between them as advocates and intermediaries do. Pache & Santos (2013) suggested that hybridisers are sometimes required to compromise to create new institutional arrangements. This could be seen with Fanny, given that she plans to give up working clinically. However, this does not appear to be necessary for George and Olivia. Perhaps that explains how they can combine the logics rather than any other responses to the conflicting logics. Unlike the challengers, Olivia, Fanny and George are content with their workplaces. It is hard to tell if identifying with the competing logics results in satisfaction or vice versa.

Logic BM \ P	**Novice**	**Familiar**	**Identified**
Novice	Role: Ingenuous member *Ignore A and B*	Role: Disengaged coalition member *Comply with A and ignore B*	Role: Challenger **Sara, Kajsa and Johan** *Comply with A and defy B*

Familiar	Role: Disengaged coalition member *Ignore A and comply with B*	Role: Intermediary **Johanna and Hannah** *Compartmentalise A and B*	Role: Advocate **Emma, Brad and Fredrik** *Compartmentalise A and B*
Identified	Role: Challenger *Defy A and comply with B*	Role: Advocate *Compartmentalise A and B*	Role: Hybridiser **Olivia, Fanny and George** *Combine A and B*

Profession (P) and Bureaucratic-Market (BP)

6.5. Conclusion

Concluding the view of the experience of being a doctor, and noting that doctors tend to be ambitious and status & autonomy expecting individuals. The aggregate work-life for some doctors studied leads them to fit in well, in combining logics. For others, what metaphorically might be seen as a pressure cooker appears. With consequences in terms of personal health or defiance.

7. DISCUSSION

7.1. Answer to research question

With the purpose to increase the understanding of how NPM, and the top-down management that comes with it, is seen from a bottom-up perspective, we conducted a qualitative study on doctors. Empirical data from 11 clinically working doctors have been analysed using theories about institutional logics and individuals' responses to such to answer the research question:

How are doctors experiencing the competing logics that have been introduced through NPM, and what are their strategic responses?

Based on the analysis in the previous section, the conclusion is that the experience and the responses occurring varies widely among doctors. Most doctors identify themselves strongly with the professional logic, while the identification with the competing logics varies. Depending on their identification with the logics competing with profession logic, their responses range from dramatic strategic responses to what appears to be a lack of responses. This happens in line with their roles. Furthermore, these findings correspond with what is suggested by Pache and Santos (2013).

7.2. Discussion and practical implications

As discussed in the theoretical framework, the academic literature of responses to competing institutional logics has focused on the perspective of the organisations rather than the individuals. This study brings insights into how doctors in Sweden are influenced by institutional complexity. The findings suggest that some doctors

with solid identification with the profession, which most appear to have, find it hard to cope with the type of management influenced by NPM, while others do not. This is due to how they identify themselves with the respective logics of market, bureaucracy and profession.

Referring back to the introduction, it can also be noted that an attempt to solve one management problem may create a new one. The aim with management by objectives and New Public Management was to solve the problem of inefficiency. Having doctors experience an ongoing battle with management or with themselves in terms of health issues may be a new inefficiency caused by the attempt to solve the inefficiency of the '80s.

7.3. Limitations with the study

There are a few limitations to this study. As it is conducted in a constructivist and interpretivist approach, the empirics are dependent on how well the authors can present the empirics analyse it without bias. One issue faced is that of capturing the depth and variety of the interviews in a limited text. Furthermore, the interviewees' ability to be nuanced in their reflections is also affected by the interviewees' ability to be nuanced in their reflections, which can be expected to be complicated. Moreover, the adaptation of the theoretical frameworks, being those of Friedland and Pache & Santos, impose limitations given that they simplify a complex context. One such example is the assumption made about high hybridity within health care. However, the interviews suggest that the level of hybridity varies for doctors working within different specialisations.

Additionally, concerning the large population, the sample size is small. Despite seeing a saturation in the findings in the later interviews, it is difficult to cover the number of different specialisations and regions needed to reach the analogy of statistical significance for a qualitative study.

Finally, the study is limited because it is difficult to determine if an experience is due to NPM or other factors affecting the doctors. For example, empirics is likely to be affected by the ongoing pandemic. Furthermore, some dictums may also relate to a general budget deficit, rather than consequences as of NPM.

7.4. Suggestions for further research

During the collection and presentation of the empirics, we have seen reasons to conduct further research on the topic but with more minor simplifications regarding the complexity of the context. Given the scope of the thesis, we considered it necessary to reduce the theoretical models to more general guidelines and the empirics to be dependent on a predetermined number of logics. Other logics could also affect the responses of individuals, e.g., social logics such as the family logic (Thornton et al., 2012). For future research, we see the need to take more of the healthcare system's complexity into account.

That way, one could better explain how individuals respond to the institutional complexity, which is a critical ground for understanding how to structure and implement management systems in complex organisations. This enables management systems to be better aligned with strong profession identities, rather than cause the metaphorical pressure cooker to either cause rebellion or health issues.

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9. APPENDIX A: INTERVIEW GUIDE

9.1. Formalities

We want to begin by emphasising that your participation in this interview is naturally entirely voluntary. Your participation is going to be anonymised. You can withdraw from participating at any time, without explaining why you would do so. How does this sound to you?

We would like to make a recording of the interview. This recording would be deleted as soon as the work with the thesis is finished. Or earlier if you would ask us to, according to the GDPR form you signed. Do you accept that we record the interview?

9.2. Background and the role of being a doctor

What was the reason you chose to become a doctor?

For how long have you been a doctor?

What do you enjoy the most, about being a doctor?

When do you get to use your competence the most?

9.3. Daily work

What can a normal day look like for you?

How do you prioritise your time?

Had you wanted to prioritise your time differently?

What is a good work environment for you?

To what extent do you cooperate with your colleagues in your daily work?

9.4. The place of work and organisation

What does productivity mean for a doctor?

How is it decided what to prioritise?

How does one get a doctor to stay at a place of work?

What does quality mean for a doctor?

What causes new patients to list themselves at the clinic and what causes them to un-list themselves? (Primary care)

How does one make a patient content? (Primary care)

What do you know about New Public Management?

How aware are you of the compensation scheme?

Is there anything you would want to add?

10. APPENDIX B: INFORMATION ABOUT INTERVIEWS

No	Name (coded)	Role	Date
1	Johan	Emergency ward	26/2
2	Sara	Primary care	28/2
3	Johanna	Orthopedics	9/4
4	Kajsa	Internal medicine	13/4
5	Fredrik	Psychiatry	15/4
6	George	Cardiology	16/4
7	Emma	Primary care	5/5
8	Brad	Psychiatry	28/4
9	Fanny	Psychiatry	24/4
10	Olivia	Primary care	3/5
11	Hannah	Primary care	10/4