Culture in the queue

Physicians' perceptions of waiting times in healthcare; causes, and culture

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Abstract

The issue of waiting times in healthcare is an increasingly demanding challenge for policymakers and managers globally. Addressing the matter is key for sustained levels of healthcare provided in modern societies with demographic challenges, such as increased and aging populations. Many factors have been suggested to contribute: financial restraints, such as different financing/reward systems in healthcare insurance; or structural issues within healthcare management. In the Swedish publicly financed healthcare system this issue is usually intertwined with the fluctuations in municipal politics.

This study explores physicians' perceptions of healthcare waiting times, their causes and cultural aspects through semi-structured interviews with 13 physicians across different specialities in Sweden, analyzing the qualitative data through thematic analysis. Our results indicate that most physicians consider the concept of healthcare waiting times to be multifaceted and complex, requiring a narrower definition. The study shows that many physicians consider some waiting times to be useful, and others negative, depending on whether the waiting time fulfills a purpose in the healthcare system and benefits the patient.

Physicians from similar work backgrounds, particularly between public and private healthcare, tend to stress similar contributing factors to negative waiting times. Some physicians perceive organizational culture as an obstacle to implementing disruptive solutions aimed at decreasing waiting times. Our data also suggest that it is nowadays easier to end up in a waiting line than before, questioning whether all increased healthcare waiting times are inherently negative, or whether some waiting times have arisen from expanding the set of demanded services considered as *needs* by the healthcare system.

Analysing the results through the Three Perspectives Cultural analysis framework, reveals that respondents with similar backgrounds share similar perspectives, to fit with the Integration perspective, while also connecting to the Differentiation and Fragmentation aspects. Through Institutional Logics Theory, it appears logical that physicians working in organizations operating in similar frames share similar views, particularly regarding the private-vs-public debate in healthcare politics.

Studying different healthcare professions' attitudes, perceptions and thoughts on waiting times is specifically relevant for managers and policymakers aiming to decrease waiting times. The complex set of values, opinions, and beliefs among the employees at hand is important to consider when making decisions in such a pursuit.

Keywords:

Healthcare waiting times, organizational culture, public healthcare, private healthcare, cultural rigidity

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1. Introduction

1.1 Background

The demographic trend of increased life expectancy exerts upwards pressure on healthcare systems (Kallestrup-Lamb et al., 2024). Nordic welfare states have a health spending per capita above the OECD average (OECD, 2023), suggesting a long-term challenge in light of this development. Another report shows that particularly people in Nordic countries, except for Iceland, cite waiting times as the main reason for their unmet care needs (OECD, 2020). The same report also reveals that tackling waiting times is an important policy priority in many OECD countries: Denmark, Norway and Sweden listing it as high priority; Finland and Iceland classifying it as a medium-high priority. This question thus provides a major challenge for policymakers and healthcare professionals worldwide.

Growing global pressure on healthcare systems has resulted both in longer waiting times and in divergent emphasis on different types of waiting time, with monitoring particularly focused on elective surgery and emergency department queues (McIntyre & Chow, 2020). Consequently, how waiting time is defined and prioritized affects outcomes significantly. This is where culture could play a role.

For instance, the emergency department (ED) at a hospital carries responsibility for urgent patients with healthcare needs that cannot wait. The culture of triage personnel and other medical staff at an ED might affect the length of stay (LOS) for an individual patient, as the patient's visit starts with assessment of complaints, moving on to investigation, diagnostics, and potential treatment and/or admission.

Organizational culture can encompass multiple aspects, including flow efficiencies and management practices. Psychological safety (Newman et al., 2017) is another relevant factor in assessing the culture of healthcare teams. The culture is also influenced by external factors, for instance how a municipality's healthcare system is built, i.e how it "sorts" different categories of patients to different parts/chains of healthcare. A primary care provider (PCP) might in general take most of the "non-urgent" patients, whereas a major hospital ED might be built for receiving the "urgent" ones. Defining "urgency" in this case is a challenge, as many patients end up in a gray-zone, medically. If patients perceived as "non-urgent" show up at the ED, the staff will in the long run feel like they end up treating patients they were not trained to (Khorram‐Manesh et al., 2019).

Furthermore, internal conflicts between different EDs at a hospital might create competition, for instance between a surgical ED and a medical one. Although the structural configurations are managerial decisions, they impact staff working conditions, culture, and ultimately healthcare performance.

The healthcare system is vast and complex, with multiple actors and varying motives formed by the remuneration system. Understanding the interplay of organizational aspects at the strategic level (underlying logics), management level (power structures), and operational level (day-to-day practices) is thus needed to come up with effective approaches to this tenacious challenge.

1.2 Problem Area and Knowledge Gap

While financial, technical and operational solutions to reduce waiting times have been proposed (Ebbevi et al., 2021; Söderlund, 2023), the cultural dimensions of waiting time management is less researched. While there is extensive research on the technical aspects of waiting time and on organizational culture separately, their potential intersection has been less explored.

The relationship between organizational culture and operational practices has been widely researched. Building upon this research and concepts presented, and applying them to a healthcare context in general and to waiting times in specific, can provide for novel insights of the phenomenon. This thesis aims to contribute to the academic discourse by studying physicians' perspectives on the role of organizational culture in managing waiting times.

1.3 Research Question

This study does not seek to provide a solution to waiting times, but rather to shed a light on different perceptions and on the work being done to manage them. This study examines:

How do physicians perceive the role of organizational culture in managing patient waiting times?

1.4 Scope

The study focuses on physicians in Swedish healthcare organizations, and their perceptions of organizational culture and waiting times, and perceived potential causes. It does not focus on the viewpoints of eg. other healthcare professionals or patients. The study narrows its scope to mainly the organizational management aspects of this matter and tries not to diverge too much into the medical side of the subject.

2. Literature Review

2.1 Waiting times as policy priority

Healthcare waiting times is a high policy priority in many OECD countries, especially in those with a national health system (Siciliani et al., 2023). Sweden has for example introduced maximum waiting-time guarantees for patients, as a way of trying to increase both efficiency and access to healthcare. But these kinds of guarantees also have financial implications, as meeting the maximum waiting-time objective requires significant funding and resources. A policy of trying to solely increase supply is not enough if the objective is reducing waiting times, as demand is also variable and risks offsetting the investments. This category of financial incentives is not unusual, and we can find Pay for Performance (P4P) programs across many healthcare systems around the world (Eijkenaar, 2012). The general idea with them is to reward providers who meet predefined benchmarks.

A related and highly contentious question then arises on who the healthcare provider should be: Should it remain a public matter or are private providers a necessary complement? Sweden for example has leaned towards the latter option (Anell, 2015), with increased freedom of choice for patients and privatizations. Although access to healthcare improved accompanied by a growth in care providers, disparities within the system also increased as a consequence of the reforms: private providers mainly concentrating on urban areas, and people with above-median incomes benefiting more than the rest (Anell, 2015).

2.2 Alternative explanations

But is increased financing the solution to waiting times, or are there perhaps additional explanations to why queues arise? Healthcare organizations are rather hierarchical by nature, as they are built around different professions with varying status and authority (Essex et al., 2023). Hierarchy is thus embedded in the organizational culture. These hierarchical structures impact the communication and decision making, which could for example hinder staff members from speaking up. They might contribute to inefficiencies by causing among other things delays in service delivery.

The topic of waiting times in health care is widely researched and has recently been compiled into a literature review (Söderlund, 2023). However, the vast majority of the

articles focused on policy and management issues, with none of them covering waiting times for general practitioner visits. In the article “Waiting time as an indicator for health services under strain” (McIntyre & Chow, 2020), the main focus is the resource distribution and different funding models. A lot of focus is also laid on technical aspects, such as open access scheduling, when wanting to reduce wait times (Ansell et al., 2017). Another article “Challenges to ensuring valid and useful waiting time monitoring” (Ebbevi et al., 2021) discusses barriers to accurate waiting time reporting, and attributes this to inadequate data systems. Again, technical and structurals aspects are the focus, although the article does also discuss to some extent the impact of soft factors such as resistance to change in the form of “extensive willful manipulation of data”.

This resistance to change is made more explicit and further researched in “Ignoring and collective passivity in relation to information systems” (Ebbevi et al., 2024), in which the failure to use digital tools designed to monitor and reduce waiting times is examined. Terms such as “collective passivity” and “strategic ignorance” are introduced, and overall this study takes a step beyond purely technical explanations by revealing how cultural factors can also contribute to these healthcare outcomes.

2.3 Culture steps in

In recent years, some research (Armstrong et al., 2019; Khorram‐Manesh et al., 2019) regarding organizational culture and its effect on decision-making has begun focusing on this effect particularly in hospital emergency departments (ED’s). In an ED, the effect on decision-making is closely connected to other healthcare performance variables, such as length of stay (LOS), affecting morbidity and mortality, which among others are used as organizational KPIs in hospitals.

Affected clinical performance seems to increase uncertainty, which in turn further has a negative impact on performance, potentially creating some form of vicious circle. Furthermore, the authors refer to a type of patient with abnormally high ED visiting frequency, and usually relatively “non-urgent” complaints, labeled double-frequent user (DFU). According to the article, DFUs have significantly higher LOS at the ED. Finding solutions to decrease DFU ED visiting frequency without compromising on patient safety could be key to solving stress-related cultural issues in the ED working environment. The study conducted semi-structured interviews with ED medical staff, where many interviewees mentioned the effect DFU’s had on staff motivation and

culture. One interviewee argued that DFUs decreased the motivation and culture among ED staff, since they do not constitute the kind of patients they are medically trained to treat. DFU's were often seen as patients ED staff competed in "getting rid of".

Khorram‐Manesh et al., 2019 cite four different dimensions of uncertainty, namely:

Dimensions	**Defintion**
Personal/routines/culture (PRC)	"being afraid of criticism, reprimand, and gossip or feelings of guilt and intrinsic and extrinsic demands to do everything correctly"
Medical	Uncertainty relating to diagnostics etc.
Practical	Such as ED overcrowding, resource allocation challenges
Patient-centered	Psychosocial/existential factors affecting healthcare personnel's impression about some patients)

Table 1: *Table created by the authors, based on the Dimensions of uncertainty (Khorram‐Manesh et al., 2019)*

Although the three latter dimensions were reported by the study participants as mainly affecting DFU LOS, the PRC dimension was to a greater extent emphasized as being important during the subsequent interviews with some of the respondents. Further investigating this cultural effect on ED performance might contribute to increased patient safety, both for DFU's and non-DFU's.

In another article (Armstrong et al., 2019), the authors aimed to identify the dominant culture at Belfast Royal Victoria Hospital ED, using a combination of the two cultural management models Organizational Culture Assessment Instrument (OCAI) and Rich Pictures (a soft systems methodology for workplace culture assessment).

The OCAI identifies dominant culture in a workplace as the following:

Culture	**Description**
Market	Customer focus and fierce competition
Clan	Collaboration, inclusion, and participation
Hierarchy	Strong control and capable processes
Adhocracy	Stimulating innovation and new resources

Table 2: *Dominant organizational cultures (Armstrong et al., 2019)*

It also identifies the respondents' proposed direction for cultural change, if the workplace should, for instance, adopt a more adhocratic culture. Although adhocracy might be an example of a way of organizing in the structural perspective (Mintzberg & McHugh, 1985), it is clear from the article that structural configurations may also be impacting workplace culture.

3. Theoretical Framework

In order to contextualise the research question and provide a foundation for interpreting the findings, this section introduces theoretical frameworks that have informed the understanding of organisational culture.

In the book *Organisational Culture: Mapping the Terrain* (Martin, 2001), professor Joanne Martin expands upon her Three Perspective Model of organizational culture, which includes the Integration Perspective, Differentiation Perspective and Fragmentation Perspective. The first, Integration Perspective, emphasizes a cohesive and unified organizational culture and could be described as the managerial view. Strong culture is connected with improved performance. Differentiation Perspective, on the other hand, acknowledges that organizations are constituted by several subcultures, with each having their own particular characteristic. The third one, Fragmentation Perspective takes a more fluid approach: a strong well-defined culture doesn't always exist.

Applying the Differentiation Perspective, which involves identifying distinct subcultures within a hospital or healthcare system, could provide valuable insights for the study. These subcultures may have conflicting priorities, potentially leading to delays.

Related to differing goals and priorities we have the institutional logics theory, which is further refined in the book *The institutional logics perspective: a new approach to culture, structure, and process* (Thornton et al., 2012). In summary, the perspective of institutional logics examines how overarching belief systems and practices influence organizational culture. Applying this into our health care context, we have different providers with differing funding mechanisms. For example, private and public clinics can be seen as operating under distinct logics: a market logic that drives them to prioritize efficiency and patient satisfaction, and a state logic with a broader mission and a focus on equity.

Another useful tool can be the psychological safety theory, which analyzes how the fear of interpersonal risks can lead to stress and miscommunication. This could harm the overall operations. A team that on the other hand fosters open communication, and where members don't have to constantly fear negative consequences if they make a mistake, will in turn have positive work outcomes. This aspect of organizational culture could potentially be a contributing factor affecting waiting times. Psychological safety

is also related to power distance; it could be described as an inverse relationship: hierarchical barriers in a high-power distance environment can make employees feel unsafe to speak up, and vice versa. This is especially interesting since health care organizations often tend to be quite hierarchical organizations, where one's ranking in the organization plays an important role (Essex et al., 2023).

Different research regarding psychological safety has been compiled into a systematic review of literature (Newman et al., 2017), which has been widely cited, and which provides a useful theoretical ground for this research project as well. The contemporary form of the concept of Psychological Safety was introduced by the Harvard scholar Amy Edmonson (Edmondson, 1999). Edmonson shifted the focus from individual to teams, and described psychological safety in terms of a "shared belief" within a group. Since then, extensive research has been conducted about the topic. Combining this with the aforementioned Three Perspective Model will help in mapping out whether there are differences within or across these subcultures in regard to e.g. trust and cooperation.

4. Methodology

4.1 Research paradigm

This study adopts an interpretivist research philosophy, with a qualitative semi-structured interview approach. This is since the aim of the study is to understand organizational culture's influence on waiting times, which is a highly subjective matter that requires examining the lived experiences of the physicians. Rather than searching for an axiom, we seek to understand how physicians interpret and encounter the influence of cultural aspects on waiting time management, within their context.

4.2 Research design

The qualitative approach focuses on semi-structured interviews with 13 physicians, working in different parts of the healthcare system and with some variation in their specialities. This mode of semi-structured interviewing was chosen, since it creates an opportunity for the interviewee to spontaneously mention aspects of the challenge in question that the interviewers will not necessarily expect beforehand. With this in mind, the study approach is explorative, since the topic of culture in healthcare can be multifaceted and complex. Thus the study aims to be as "open" as possible and not limit itself to one or a few variables expected to cause the challenge.

4.3 Data collection

4.3.1 Participants

Thirteen physicians with working experience in Sweden were selected, representing professionals from various career stages, 8 men and 5 women, and with participants from both private and public sector. This was to enable diverse perspectives on the matter. Nurses or other healthcare professionals were not interviewed. This sampling approach thus provides a physician-focused mapping of insights on the manifestation of cultural influences across different healthcare contexts and hierarchical levels.

4.3.2 Interview design

The semi-structured interviews were recorded and notes were taken by the author(s) of key takeaways and important concepts mentioned. All interviews were conducted in

Swedish, see Appendix 1-2 for the original and the English, translated questionnaire. Thus the answers are translations, but based on multiple listenings of both recordings and re-reading the written notes taken during the interviews. The interviews were carried out either in person at a location convenient to the interviewee, or through online video calling services. All interviews except two, due to technical and practical difficulties, were recorded for later analysis and partial transcription. The recordings were kept in a folder on a cloud service offered by the school, and listened to multiple times by the authors in order to successively sort out fitting and relevant quotes for thematic analysis.

The initial interviews were conducted in a calibratory manner, in order to know what type of questions yielded the most valuable data for the theme of waiting times, depending on what role each respective interviewee had. The questionnaire (*appendix 1*) tries to incorporate the different aspects raised by the theoretical frameworks used in this thesis, and has been calibrated after initial informal consultations with some of the respondents. The exact research question as well as our scope, became more clear in sync with our increased understanding of the issue. The authors attempted to interpret the collected qualitative data in relation to existing, up-to-date theory based on established and contemporary culture management models, as well as psychological safety theory. This study hopefully sheds new light on potential solutions that have previously been neglected, while clarifying the view on healthcare organization's culture management issues.

4.3.2 Theoretical framework integration

Discussing the connection between workplace culture in relation to waiting times, positions the Three Perspective Model and Institutional Logic Perspective within the scope of our study. Connecting the literature review proposed issue of PRC dimension of uncertainty (Khorram‐Manesh et al., 2019) to contemporary theory on psychological safety (Newman et al., 2017) and the hierarchical nature of healthcare organizations, can provide insights in whether social/cultural uncertainty might result from a psychologically unsafe working environment. The Edmonson methodology (Edmondson, 1999) to assess psychological safety (PS) in a working environment was mentioned to the respondents, in some cases to clarify what was meant by PS.

But in general, the interviews did not involve presenting respondents with specific theories and asking them to either confirm or refute them as an explanation. The study draws on three complementary frameworks that have informed our research without

constraining it. These frameworks serve as sensitizing concepts, a sort of starting point for data collection and analysis rather than rigid pre-determined explanations, allowing for alternative themes to arise from the participants.

4.3.3 Transcription of interviews

Transcribing and translating of selected quotes from the interviewees were carried out carefully, in order to try to preserve the message conveyed as accurately and objectively as possible. When used, commas, dots and other separation signs are used to try to as accurately as possible convey the oral message during the interview. However, no predefined model was used to exactly define which breaks, breaths, "hums" or the like, should be transcribed as which exact separation sign.

Some important aspects to consider when reading the quotes:

- The sign "[...]" indicates that words are excluded between the quote before the sign and following it.
- When words are put in square brackets: "[example words here]", it signifies that the authors have put the additional words there to make sense of the quote, by providing a context around what was discussed at that moment during the interview. The purpose of this was to bridge the implied meanings conveyed in talking language in the interview session, to the written language for the reader to interpret. Thus, the words in square brackets were not explicitly stated by the interviewee at that exact moment in the quote.
- Some key terms in Swedish might be important to know that they work as synonyms. Many respondents included the term "Region" in their answer, which can be roughly translated as "municipality". In the Swedish publicly financed healthcare system, the 21 municipalities are separate entities organizing/financing their own respective healthcare systems. Likewise, the words "doctor", "physician", and "medical doctor" are used interchangeably.

4.3.4 Study participants

In Appendix 3, all participants in the study are stated. The "Main medical field" column mentions the specialty in which the doctor in question last worked in, has specialized/specializes (in case of ongoing residency) in, researches in, or was most relevant and most often mentioned and implied as relevant during the interview by them. Thus, some might be doing their residency in the stated field, and some might have a background in one or more specialties apart from the one stated. The purpose in

choosing one, is mainly for the reader to get a transparency and opportunity to compare one respondent's quotes, stated thoughts and opinions to their nearest medical background, since patterns might appear.

Similarly, gender and union representativity are stated in Appendix 3 to provide an opportunity for the reader to compare and see if any patterns are discernable in those regards. When a participant is stated as a union representative, it does not mean that the participant is only a member of The Swedish Medical Association, but rather that the person has some kind of higher engagement in a specific role in the union, for instance work environment representative at their workplace, or other roles. All columns only mention information known to the authors.

4.4 Data Analysis

Our analytical approach followed the thematic analysis framework. This was deemed appropriate due to the large amounts of qualitative yet open ended data. The purpose of the thematic analysis is identifying themes and patterns across datasets (Saunders, 2019). The interview recordings and notes underwent a thorough thematic analysis, in line with the six-phase framework by Braun and Clarke (Braun & Clarke, 2006)**.**

Phase	Description of the process
1. Familiarizing yourself with your data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis

Table 3: *Phases of thematic analysis (Braun & Clarke, 2006)*

Empirical data was thus collected from the interviews, and analyzed using the thematic analysis approach. Through this process, patterns were identified to categorize the transcribed excerpts and interview notes into first first-order themes. Thereafter, a comprehensive analysis of the entire dataset and re-evaluation of the chosen themes lead to the categorisation of the core concepts into second-order themes.

4.5 Ethical considerations

The research topic being healthcare, and with the interviewees possibly discussing topics that can be sensitive in nature, the interviewees have been anonymised and no transcription software has been used for processing the data. Prior to being interviewed, all participants consented to being recorded and were informed that the data would be deleted when the thesis is completed. The participants were asked to sign a form agreeing to the data collection, all in accordance with the General Data Protection Regulation (GDPR) and SSE policy.

5. Empirical Results

5.1. What is waiting time?

When asked what waiting times in healthcare was to them, the respondents provided differing, yet sometimes overlapping views:

"To me, waiting time is time that does not create value for the patient." - Doctor I

"If you are widely engaged in your patients as a caregiver, waiting times become unbelievably disturbing." - Doctor G

"In my work, [...] waiting times for me [...] is when I can not assess a patient whether they need a higher level of healthcare or not. [...] If I have a lot to do, there will be more assessment I will need to do, regarding the morbidity for these patients. And then it becomes sort of a small queue." - Doctor J

"The waiting time will be very varying dependent on what type of problem we talk about. Highly urgent, the waiting times are quite okay. Half urgent, they are also quite okay. The unsustainable waiting times are in the planned surgeries." - Doctor L

In general, no absolute answer was obtained from the respondents on whether waiting times are positive or negative. Rather, most respondents seemed to find the concept of waiting times complex and multi-faceted. Albeit implying a medical risk to varying degrees, many respondents admitted that there is an aspect of usefulness to waiting times. Especially when it comes to patients deemed to be non-urgent at an ED.

"Waiting times for a patient who doesn't need to be admitted in the ED is not completely negative." - Doctor A

"Waiting times are positive and dangerous. What's good with waiting times is that they can be the price, since we pay very little to go to the doctor. [...] The price we pay is instead the waiting time, which decides how urgent I am for this problem. [...] That which is most negative with waiting times is that there is a medical risk." - Doctor E

"If waiting times become really low at the emergency department, it will just fill upp more with patients. [...] Since the need for that is infinite. [...] One must understand that supply will never meet demand at an emergency department. That equation does not exist. [...]" - Doctor A

"Waiting times are,[...] from an organization's perspective, both necessary and a disadvantage. Since we work in prioritized operations, [...] In an ED, you prioritize mainly around assumed level of emergency. [...] With relatively high accuracy you can say that this patients is in higher need of healthcare than the other. [...] It can be unfair waiting times,[...]" - Doctor H

When asked whether they agreed with the opinion that it is not completely negative that a patient labeled "non-urgent" has to wait for a long time at the ED, Doctor E agreed:

"I agree with that. If you seek care at the ED to get help like that, to show your birth mark that you barely find again [...] the ED would not work. [...] Most people wouldn't try to seek at the ED for that, but there are some people who do that" - Doctor E

However, not all respondents agreed. Doctor D countered this notion, by mentioning that there is a value of seeking care even if the patient doesn't turn out to be in need of immediate medical attention.

5.2. Why do patients have to wait?

Regarding potential causes of waiting times in healthcare, some respondents admitted that there are multiple causes in combination.

"It is multifactorial. One can say that we have an increased need of healthcare, with an increased share of elderly people. The share [of the population] more than 80 years old will almost increase by 50% during a 10-year period. And it is after 80 that the big needs for healthcare arise. [...] at the same time as we have a lack of staff, lack of resources, lack of beds. That equation does not hold" - Doctor I

"[It] depends on several different things. Partially, it depends on how much capacity we have in the organization, and partially it depends on how we use and plan the capacity we have in the organization, and partially it depends on how urgent it really is to do things. For some things, it can be really good to have some waiting time. [...]it is not really the meaning, but it is not always 100% negative." - Doctor L

When asked who bears the responsibility for waiting times, Doctor C said:

"Well, actually everyone. The organization, since one has produced less healthcare than was demanded, but then also partially the patients, since there is a group of patients seeking healthcare unnecessarily. However, they themselves don't percieve it to be the

case. And that is a pedagogical challenge, to reach them. But the whole system bears responsibility." - Doctor C

Doctor L emphasized early on in her interview that the responsibility for waiting times is becoming less and less a matter for doctors:

"It is important to include when you discuss this, that sadly, we have less and less impact on how one actively works with it. We can have opinions and thoughts on it, but even the ones of us working as administrative managers have a quite small impact on what it becomes in reality. One needs to be aware of that, we are not the ones who decide" - Doctor L

A novel perspective to the concept of waiting times was mentioned by Doctor E, namely that it is today easier to "end up" in a waiting line, than before:

"A waiting time only arises if you seek medical care. Otherwise, no waiting time arises. [...] The foundation of waiting times is also the citizens' demands and expectations. When it comes to, for example, waiting times to orthopedics, they have pushed a lot what they operate. When I studied medicine [...] Nowadays it's like: 'oh, you have pains [...] you don't like to eat Alvedon all the time, [...] lets operate'. [...] We have moved, slowly, the threshold to who we think should be in line [...] It is easier to end up in a waiting line today" - Doctor E

Regarding DFU LOS, Doctor F mentioned that the clinical assessment ability is affected in cases of known DFU's showing up at an ED.

"It is a thing with DFU's at the ED. [...] If a person has been 200 times at the ED, and it has never been any [medical] danger, of course it will eventually color your assessment." - Doctor F

Doctor A emphasized the importance of recognizing the inevitable bias regarding certain categories of patients, be it DFU's or other, that can arise in ED's.

"Of course we can help each other out in counteracting bias, [...] what's important to note is that one is always biased." - Doctor A

The issue of DFU LOS could also be connected to a recurring notion mentioned among the respondents with a hospital medical background; namely that the outflow of patients at the wards was a stronger explanatory factor to queues from the ED to the wards, than the inflow of ED patients in need of admission.

5.3 Public vs private healthcare differences

The respondents were subsequently asked whether they thought waiting times were treated differently in public vs private healthcare organizations. Many shared the notion that there are cultural differences between private and public, but emphasized that this culture is formed by the remuneration system. The recurring notion of "cherrypicking" was explained by the incentives of the system rather than blaming the individual caregiver:

"Everything depends on 'how many patients do you as a doctor have to take responsibility of?'. [...] One puts blame on private actors [...] but all this stems from the remuneration system that the Region has created" - Doctor G

Doctor L, working in a public organization, mentioned the following about private caregivers:

"They have another incentive than we have. We have an incentive to take care of the general healthcare. They have an incentive where it is included that it should pay off. [...] It is a little bit so that they relieve the public healthcare [...] You can't just say that they don't create value, [...] but there needs to be a control that makes sure that they add value." - Doctor L

Doctor C countered this:

"Those prejudices usually come from colleagues who have never worked in a private organization. They have no anchoring to reality [...] whereas everyone, who have worked for private employers have worked publicly, earlier [...] " - Doctor C

In contrast, the non-profit-seeking public caregivers were described as having a more lax view of waiting times in relation to their peers in the private sector.

"I think that you have higher tolerance for waiting times in public healthcare." - Doctor E

This was however attributed by many to the more restricted role of the private actors, and to the earlier mentioned notion of "cherry picking" patients:

"I haven't worked in private healthcare, but my prejudices are positive prejudices: that there are private units that are better at organizing themselves in order to decrease waiting times. But above all, it is easy to decrease the waiting times if you work with a selected mission. There has been a few of those. [...] You have a one-size-fits-all for

these patients. And then it becomes really easy to scale up, since then the complexity decreases - you don't have to adapt to the individual patient as much." - Doctor F

"It's incredibly complicated, not least with these private units run entirely by tax funds. [...] Of course, they are profit-seeking. They make business, and they will follow the rules to their best; not by doing anything bad for any patient. [...] But it says itself: they are supposed to make money. It is different for us in the Region" - Doctor A

When Doctor A was asked whether she perceived it as that the Regions were taking more complicated patients, she seemed to agree strongly.

"If I perceive it like that? That's just the first name. It's 'daily, daily'. [...] They [the private caregivers] never take the complicated cases, and they also very seldom take it when there is a complication. [...] Sick patients come to the Region [...] But they [private] are fast and good at what they are doing" - Doctor A

The notion that publicly run healthcare facilities get to treat more complicated patients, whereas the private units treat more homogeneous, easy-to-treat cases, was persistent throughout the sample. However, differing opinions were expressed as to whether that was seen as a good or a bad thing. Doctor C, a private-practicing ophthalmologist, referring to cataract surgeries (according to him the most common surgery in any country worldwide), said the following:

"75% of them are done in private healthcare, and in those regions where they have agreements with private caregivers, there are almost no waiting times at all, since they operate the need that exists. 75% is done privately, [...] the surgeries done by the public healthcare, they cost two and a half time as much" - Doctor C

From the sample, there seems to be a recurring pattern throughout healthcare that sub-specialized, fast-track healthcare units exist that seem to work more efficiently, with a narrower mission. Doctor F, a psychiatrist working in public psychiatry, developed this further, how fast-tracks are also in some cases used in public healthcare. The unit he refers to in the following quote is a psychiatric, publicly run unit specialized on a very specific psychiatric disease.

"Even in the publicly run healthcare, there are organizations where: 'this condition, we treat at that unit'. And those facilities, which are that narrow, they generally work better. I've actually worked at one such facility myself [...] It is actually a unit that manages complicated cases. Lifelong treatment times, lots of medication. But given that

it is such a narrow group that you work with,[...] you become like an expert in that field. [...] We have short waiting times, and it goes very well for the patients" - Doctor F

5.4 Power relations, hierarchies, and decision-making

When it comes to healthcare management, managerial communication regarding organizational goals seems to differ from the incentive-emphasizing communication often used in private companies in other industries.

"I perceive the management culture of healthcare a lot like, it is not so much that the manager says: 'I have decided it is going to be like this, follow me', but it is more like: 'the politicians have said, therefore we now have to', that it's more like: 'we sit in the same boat, I haven't come up with this, but now we must do like this'. That's rather how I perceive the communication, as a coworker. [...] Yes, there is a whip, there is a threat: 'you must do this, you must do that'. but it is often quite vague what the consequence is if you refuse to do it. There are often no consequences. [...] There is no profit in doing a better job, and no loss in doing a worse job. " - Doctor F

Also, many respondents reported that in the last decades, fewer and fewer healthcare managers are doctors, and that this implies a lack of leadership that can make decisions fully understanding the medical consequences. Spending a lot of time and effort making the managers understand the medical issue (for instance by writing incident reports) has implications on the workplace culture:

"Now, one has a much more pending culture, [...] Most of our problems in healthcare are very well known to them [the managers]. We write and write, and nothing happens. [...] A silent culture might be a part of [...] I say and say one thing and then finally I'm like: 'I don't have the energy to say this anymore' and then we no longer write. And that is a problem, a culture problem, I'd say. [...] 15 years ago, this wasn't an issue in the same way. Now it is an issue." - Doctor J

As for psychological safety in the workplace, some respondents mentioned the patient safety gains that come from a more psychologically safe culture, albeit many still emphasized the significance of some sort of hierarchy:

"We have a hierarchical system in healthcare - between the professions, which is quite strong. And we are not always aware about it. [...] for instance, assistant nurses are usually the ones closest to the patient. By including them more, we can understand more [...]. So there is some power distance in that, and there also has to be an environment

where the assistant nurse [...] says: 'wait, this is how I think' [...] it must be okay, and that person must get cred for it. [...] or the medical student or whoever is there and has come up with a good idea." - Doctor A

However, Doctor L suggested that within Swedish healthcare, internationally compared, working culture in general is fairly non-hierarchical:

"I think in Sweden generally, we have a very open environment, us who work on the floor. [...] Then, how it works upwards is very different for [...] different hospitals. But then if you compare to the rest of Europe, we have an extremely non-hierarchical organization. [...] You just need to travel over to Denmark, and it becomes much more hierarchical. Or Finland, compared to Sweden. People who come from other countries and start working with us, they become shocked: 'how can, the assistant nurse told the doctor [something]?' [...] but in Sweden, a medical student could say: 'why don't you do it like this?' [...] In Sweden that is completely okay." - Doctor L

5.5 Inter-unit collaboration

When asked whether workplace culture can affect the cooperation between healthcare units, many answers were obtained, pertaining to different aspects of the issue.

Doctor A mentioned the transfer of patients between units, especially when trying to get a spot for a patient at another unit:

"There are some very dysfunctional units, [...] where you call one time, and if you get an answer that you are not satisfied with, you call when you know that they have switched staff. You call again, get another answer. And that is a sign of a bad culture, where it even matters who is working - what answer you get" - Doctor A

Another participant chose to emphasize how individual healthcare units' levels of independence affect the units' obedience to the central management, for instance in the Region.

"The healthcare system resembles a lot Germany prior to The First World War, that is to say, it consists of a number of small principalities, which in first hand look after themselves and their own best, and those are the clinics. Then there is a central management of this [...] it has very little power, rather, since these units are very independent" - Doctor G

Improved collaboration between primary care providers and hospitals was suggested by Doctor I to aid in mitigating unnecessary healthcare.

"*For example, if you have a good cooperation with the primary care system, making that the primary care system doesn't send in the patient to the hospital as soon as they don't quite know what to do or have a lack of time. If we have a good cooperation there, we can strongly decrease the inflow to the hospitals, which would increase the accessibility instantly, almost.*" - *Doctor I*

5.6 Healthcare system improvement moving forward

A rather pessimistic workplace culture and ethics prognosis was presented by Doctor J, in a hypothetical scenario where doctors feel so far from having influence over the system and culture that healthcare professions in general decrease in popularity.

"You can imagine, what happens if healthcare becomes so unattractive that the [...] grade admission scores decrease and become very low for medical school and nursing school. Then you might get individuals who [...] don't have this approach that we think one should have in healthcare, where one has an ethical compass that is working, that one questions things, and so on. Which makes so that we can keep up a high quality where the patients are so well taken care of. Then we might get a healthcare [...] where people are even more quiet, don't care a lot about, are unengaged in, these questions, eventually. That could evolve into a societal issue. We get a healthcare where competence isn't what's important, but that there is some guy there who does something, performing something, more of a process thinking. [...] As you realize, healthcare is controlled by processes, but really not. It is the engagement that controls." - Doctor J

Thus, preserving and nurturing this intrinsic motivation and engagement from the staff is key for a sustained, trusted, healthcare system amidst the waiting time challenge.

Most respondents elaborated in some way or another that changes need to be made in order to develop the healthcare system from the current state. Some respondents mentioned the importance in healthcare making necessary structural, technological and cultural changes so as to meet the waiting time challenge with more efficient tools than today.

"Unless we fundamentally can change how we work and get smarter tools and support in different ways, the waiting times will be severely worsened. Many people in healthcare think: 'if we only get more resources we will solve the problem'. [...] the

resources are not there, it becomes too expensive for society, and it might lead to us not changing the ways in which we work, that we don't make the necessary changes required in order for us to become more efficient." - Doctor I

Doctor G, who had worked for a long time as a primary care manager, especially emphasized innovative technological solutions, and how healthcare works at a service level lagging behind other contemporary industries:

"A strongly contributing factor to queues and waiting times in healthcare is that we work in the same way we have done for 100 years, that is to say that if a patient comes to me in primary care, and I feel that this patient needs to see an orthopedic specialist, I write a letter to them. Nowadays electronically, but anyhow. And then this is managed in a number of different ways, and it leads to it taking almost always the whole healthcare guarantee, three months, until this human gets to meet the orthopedician. A service level that I don't think would be accepted anywhere else in society today. It is fantastically catastrophically abysmal. And especially if this meeting doesn't lead to anything, and the patient has just been put in a waiting mode." - Doctor G

When talking about hinders to making a change in this regard, he mentioned a rigid culture as a major factor, especially in lowering the change ambitions among new generations of doctors, and thereby hindering necessary change:

"Culture is very strong [...] they [Doctors with less experience] will be grinded into the old culture, unless we manage to find management ways in which we can gather them and say: 'okay, these are the future specialists in ten years and the managers in 15-20 years - you must provide them conditions to create a fully new culture'. Otherwise we can go on like this for years" - Doctor G

Lastly, a concrete suggestion to cultural change was mentioned. When elaborating on different situations in healthcare where culture is critical, doctor A mentioned the morning handover-meetings at wards. During these meetings, test results or symptoms might be stated as too certain by the night staff handing over, unless there is an established culture where it is accepted to mention uncertainties and ask for reassessments.

"How does the staff coming in the morning, brisk, interact with the night staff, when talking about what that person has done? [...] Naturally, it has a great significance whether I in the morning tell my colleagues: 'well, this patient was admitted at 4 AM and I did this, I did that and I am uncertain about this, please check it'. Or, if I [...]: 'Oh I don't remember I don't really know how it was, I didn't have time to read I was tired

[...] but probably it was nothing important'. If I report in that way, it naturally has an effect on what happens next. And how my colleagues receive it when I tell that, has a lot of influence on: what will I say the next time?" - Doctor A

By establishing such a culture, she mentioned that the risk of patient harm could be lowered, when overtaking staff is encouraged to look at the previous statements done by healthcare staff with a critical eye.

6. Analysis

Through the lens of the three perspective model of organizational culture (Martin, 2001), each perspective can yield valuable insights.

6.1. Integration and shared beliefs

Firstly, Integration perspective rhymes well with what our data suggest, namely that groups of similar level in the hierarchy will tend to have shared values and beliefs. In our data, this was especially evident pertaining to what a respondent thought to be most important to solving the challenge of waiting times, and what the main obstacles were to making this change. For instance, Doctor G, who had a managerial background within primary care, alleged that a rigid culture among his and other's employees was a major obstacle for necessary technological change. His perspective could thus be seen as similar to that of other doctors in managerial roles.

6.2 Differentiation: subcultural variations

Secondly, the differentiation perspective would imply that subcultures, such as public healthcare employees on the one hand, and private healthcare employees on the other, have similar views on a topic (consensus) within each respective subculture. Our data suggest this, since many respondents from the public healthcare sector tended to emphasize the complexity in healthcare waiting times. From the respondents in the private healthcare industry, the complexity wasn't portrayed to be equally strong in waiting times, which could stem from the fact that private healthcare organizations have a narrower mission, and thereby more efficient flow of patients. This could then have implications on the practitioners' perceptions on the level of complexity to the challenge of waiting times. If you work for an efficient, narrow-mission, sub-specialized private caregiver, you might not perceive the challenge as complex as you would if you worked in e.g. a public hospital, where the diversity of patient cases is much more noticeable and you perceive the average patient to be more complicated.

This discrepancy in perceptions and beliefs between private working and publicly employed doctors can be more clearly understood in the light of *Institutional Logics* (IL) theory (Thornton et al., 2012). The IL theory would suggest that different logics prevail among employees in organizations with fundamental differences. In the case of healthcare, it would seem like a natural distinction to make between the public and the

private organizations, since they do seem to have fundamental differences, for instance according to Doctor L, when mentioning the difference in incentives. The overarching beliefs in a private healthcare organization will penetrate the organization at many levels, so that most of their employees will learn to appreciate the positive aspects of private healthcare to society and the production of healthcare, implying more of a *market logic*.

Similarly, an overarching belief in public healthcare seems to be, at least among doctors (given our sample), that of a state logic: emphasizing the goal of an equal healthcare system for all citizens, which then naturally comes with a patient diversity in terms of morbidity. This logic shone through clearly in our sample data: physicians employed in public organizations tended to emphasize the fact that not all patients could be put in algorithms as if the healthcare system would be a factory, and equivalently, physicians with a private healthcare background would emphasize the societal winnings from their more streamlined production, with narrower missions.

6.3 Cultural complexity and ambiguity

In the Three Perspectives model, the Fragmentation perspective suggests that a consistent and unified culture is unlikely to persist across an organisation (Martin, 2001). The fragmentation perspective would then emphasize that, within the healthcare organizations, one can never be certain enough that the culture is coherent and similar. There will always be tensions, in our case potentially between different professional groups or departments. The emphasis on system complexity shared among public sector physicians suggests a greater degree of cultural fragmentation in beliefs among healthcare staff employed in public organizations.

6.4 Power, hierarchy, and rigidity of culture

Using IL theory, one can interpret different hierarchical and power aspects of healthcare management in the public versus private sector. Regarding Doctor F's quote (see 5.4), the pressure on staff to perform in public healthcare is usually combined with the message of "the politicians" wanting something, which motivates the goal for performance. Although most private healthcare organizations are also partially financed publicly, it could seem logical that their management communicates performance goals differently, with more focus on profit, given their different purpose as profit-seeking entities. However, more doctors from the private sector should have been interviewed in order to establish this further, if that is the case.

The attempts from healthcare management to decrease healthcare waiting times seem, from our data, to range from structural changes in remuneration systems to technological implementations. Some of them seem to require the employees to embrace the new ways of working. This is apparently especially hard to achieve given the cultural rigidness mentioned by Doctor G, among other respondents. A cultural reluctance to technological innovations implementation seems to be a recurring pattern.

Lastly, it seems to be the case that a more psychologically safe working environment (Edmondson, 1999) (Newman et al., 2017), might aid in increasing efficiency and treatment outcomes, which might decrease waiting times. One such change could regard the ways in which staff communicate, e.g during hand-over meetings at wards. Although psychological safety was in the suggested theoretical framework and constituted a part of our questionnaire, most respondents tended to focus on the other questions on aspects of waiting times.

7. Discussion

7.1 Research question - encore

How do physicians perceive the role of organisational culture in managing patient waiting times?

We can conclude that physicians perceive this role differently. Some respondents explicitly mentioned culture having a part in the waiting time issue, whereas others found the potential connection a bit vague, although many of them still mentioned many factors indirectly contributing, when asked to elaborate on the topic of culture in healthcare.

7.2 Contributions to existing literature

This study contributes to existing research in three key ways. First, it shows how cultural elements manifest differently across the three perspectives (Martin, 2001) in the management of waiting time in health care organizations, e.g. physicians from similar backgrounds tending to share views on waiting times while distinct perspectives emerge between private and public healthcare settings. While previous studies have focused on the resource distribution (McIntyre & Chow, 2020), or the technical (Ansell et al., 2017; Ebbevi et al., 2021) aspects of waiting time, this research sheds light on the cultural dynamics and how they can constrain operational practices.

Second, this study contributes to the literature on institutional logics, by discussing the different approaches of public versus private healthcare providers, and how they seem to represent distinct subcultures with differing approaches on waiting time management. This study aligns with some previous research on dominant cultures in a healthcare organisation (Armstrong et al., 2019), namely with the identification of a market focus in parts of the system. But it additionally investigates what impact that culture has on outcomes such as waiting time.

Third, this study builds on prior research highlighting that, in interview, participants identified culture as a significant factor in delays in managing known complex patients (Khorram‐Manesh et al., 2019). This study extends this approach to explore its applicability across all patient groups and different parts of the healthcare system, broadening the focus to encompass the comprehensive concept of waiting times. In conclusion, this research bridges the gap between the distinctly but widely researched fields of organisational culture and waiting times in healthcare.

7.3 Implications for practice

Addressing waiting times in healthcare organisations can be approached from three key perspectives: the complexity of the organisational system, practical strategies for improvement, and fostering a psychologically safe culture.

Understanding different healthcare professions' attitudes, perceptions and thoughts on waiting times is specifically relevant for managers and policymakers seeking to alleviate waiting times in healthcare, as an organizational goal. When implementing change projects, our study and others might aid in nuancing the complex set of values, opinions, and cultures among the employees at hand. With a nuanced perspective, implementing change projects aimed at mitigating the issue of healthcare waiting times might become easier for managers and policymakers, assuming that the insights gained from our and similar studies are included in the equation. Hopefully, it might also produce synergies among the staff affected by the implementation, e.g. when they feel more included and their needs and beliefs catered to in the process.

Practically, some concrete insights can be found from the sample data. In hospital management, the outflow of patients from wards seems to be more important for controlling the queues from the ED to the wards, than the outflow. Thus, instead of trying to make the ED staff more restrictive regarding admissions, an alternative strategy could be to solve the ward bed issue, since these processes are interdependent. That is, focusing the management efforts on improved outflow from wards, without compromising on patient safety. In this, an increased bed count might be crucial, so that patients are not sent home earlier than medically motivated. In this regard, financial constraints come into the picture, making healthcare management a complex challenge.

Also, fostering a psychologically safe culture in the workplace will contribute to increased patient safety and might also have implications on waiting times. Dysfunctional healthcare units, trapped in cycles of high employee turnover and psychologically unsafe work cultures, might be able to mitigate this by implementing psychological safety training for their staff. Thereby, communication with other units might become smoother, which in turn could improve patient flow overall in the healthcare system.

In summary, managers for healthcare units might thus focus change projects at reforming the organizational culture among employees to a more psychologically safe

environment. And in addition, implement hand-over meetings in the case of wards, with a culture encouraging honesty about mistakes and demands for reassessments.

In the long run, as a manager in private healthcare, it is important to consider the clinic's reputation when it comes to the observed notion of "cherry picking". It might thus make sense to communicate the clinic's operations and role in the healthcare system more clearly, making public relations decisions keeping the "cherry picking" reputation in mind.

7.4 Limitations

Firstly, the sample and its size in itself is a limitation. Though the data is rich, it lacks the perspectives of other health care professionals. This entails a more narrow range of perspectives, but is in line with the scope of the study. Secondly, it is namely the self-perceptions of physicians that is being studied, how they think they think, and not the participant's actual behaviour. Thirdly,when conducting the semi-structured interviews with the participant doctors and discussing culture, the authors identified a recurring pattern in that many interviewees tended to start discussing the culture of non-employees, e.g. the culture among patient groups: when different patient groups deemed it reasonable to seek medical care, and why. However, although potentially relevant to the complex issue of healthcare waiting times, the authors decided to not include this input data into the academic reasoning, in order to keep the study's scope and not attempt to explain too many variables.

7.5 Sources of error/biases

While a clear difference of opinion emerged between private and public practitioners regarding the role of private healthcare in reducing waiting times, our sample was skewed so that only one of 13 participants actively worked private-practicing at the time of the interview. This skewness could be partially explained by the authors' challenge in finding a diverse enough, representative sample of doctors available for interviews. However, the respondents weren't asked as to whether they had at any time worked in private healthcare, so many of the doctors not currently working privately could potentially have done it before.

Furthermore, the fact that 10 out of 13 interviewees were explicitly known to the authors for having an active engagement in The Swedish Medical Association, could suggest that many opinions and beliefs are colored by their union engagement. This could imply a bias towards union opinions, affecting the responses in the sample data.

7.6 Implications for further research

Our study comes with several implications for further research in the topic of waiting times and organizational culture in healthcare. These implications are dispersed among different topics, since our study itself took a rather broad perspective, and could have tried to focus even more narrowly on one specific relationship.

Concretely, a similar study could have asked for more details regarding each respondent's professional background, so as to nuance the sorting into private and public work background. It is likely that many doctors might have worked some time during their career privately, and some time publicly, and their perspective could then not be placed in private or public as a binary variable.

Since waiting times turned out to be concepts hard to pinpoint as one distinct issue, it could definitely increase the academic stringency if future studies untangled the complex set of waiting queues for different treatments and/or services in healthcare. With a clearer definition of what a healthcare waiting line is, what it implies for patients of different categories, and a clear mapping of interdependent processes in the healthcare value chain, researchers could more confidently conclude causations between studied variables, which would then cater for even stronger recommendations and practical implications in the clinical reality.

In summary, more research is needed in order to establish, rule out, or partially establish a connection between culture and healthcare waiting times. Also, the type of waiting time to assess needs to be decided and elaborated on in the preparations for similar studies in order to clarify what type of waiting times are to be studied. In addition, if the aim is to assess whether different beliefs exist between healthcare employees in private vs public healthcare, it would make intuitive sense to seek a 50/50 percentage ratio between respondents with private and public work background, respectively.

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9. Appendix

9.1 Appendix 1: Questionnaire in Swedish

Del 1: Bakgrund

1. Kan du berätta om din yrkesbakgrund och vilken roll du har idag?

Del 2: Väntetider

2. Vad betyder “väntetider” för dig i ditt arbete?

3. Varför tror du att väntetider uppstår i vården?

4. Tror du att väntetider hanteras olika inom privata, jämfört med offentlig vård? Vad kan det bero på?

5. Hur påverkar samarbetet mellan olika vårdenheter hanteringen av väntetider, patientöverföringar i synnerhet?

6. Upplever du att vissa typer av patienter prioriteras över andra för att korta väntetiderna?

7. Hur varierar kostnaden för väntetider inom olika vårdenheter, eller mellan den offentliga och privata sektorn? Vilka typer av konsekvenser kan det bli?

8. Hur påverkar den organisatoriska kulturen hanteringen av väntetider?

9. Vad upplever du som främsta orsakerna till att patienter får vänta längre än förväntat?

10. Hur disciplinerar cheferna på din arbetsplats arbetet kring att minska väntetider?

Del 3: Väntetider

11. Låt oss betrakta vårdköer som en ”artefakt”, ett synligt och konkret fenomen som speglar den underliggande vårdkulturen. Hur ser du på det i din organisation?

12. Tror du att förbättrad arbetskultur och samarbete mellan olika vårdenheter skulle kunna minska väntetider? Isåfall hur?

13. Betraktar du väntetider som ett resultat av maktfördelning inom vården, mellan olika roller? Hur kan detta påverka patientflödet?

14. Tror du att vissa avdelningar eller roller har mer inflytande över att förkorta väntetider än andra? Vilka då? Eller varför inte?

Del 4: Avslutande frågor

15. Vad ser du som de mest effektiva sätten att minska väntetider?

16. Finns det något du vill tillägga om väntetider, eller något annat som du tycker är viktigt att diskutera?

9.2 Appendix 2: Questionnaire translated to English

Part 1: Background

1. Can you tell us about your professional background and what role you have today?

Part 2: Waiting times

2. What do “waiting times” mean to you in your work?

3. Why do you think waiting times arise in healthcare?

4. Do you think waiting times are managed differently in private healthcare, compared to public? Why is that so?

5. How does the cooperation between different healthcare units affect the management of waiting times, patient handovers in particular?

6. Do you perceive that certain types of patients are prioritized over others in order to shorten the waiting times?

7. How does the cost of waiting times vary within different healthcare units, or between the public and the private sector? What types of consequences can it be?

8. How does the organizational culture affect the management of waiting times.

9. What do you perceive as the main reasons to paitents having to wait longer than expected?

10. How do the managers at your workplace discipline the work around decreasing waiting times?

Part 3: Waiting times

11. Let us consider waiting queues as an “artefact”, a visual and concrete phenomenon mirroring the underlying healthcare culture. How do consider that in your organization?

12. Do you think improved working culture and cooperation between different healthcare units could decrease waiting times? In that case, how?

13. Do you consider waiting times a result of power distribution in healthcare, between different roles? How can this affect the patient flow?

14. Do you think certain departments or roles have more influence in shortening waiting times than others? Which ones? Or why not?

Part 4: Final questions

15. What do you see as the most effective ways to decrease waiting times?

16. Is there anything you would like to add regarding waiting times, or something else that you think is important to discuss?

9.3 Appendix 3: Table of study participants and relevant characteristics

Interviewee	Main medical field	Gender	Union representative
A	Anaesthesiology	Female	No
B	Emergency Medicine	Male	No
C	Ophthalmology	Male	Yes
D	Emergency Medicine	Female	No
E	General practice	Female	Yes
F	Psychiatry	Male	Yes
G	General practice	Male	Yes
H	Emergency medicine	Male	Yes
I	Orthopedics	Male	Yes
J	Internal Medicine	Male	Yes
K	Gynaecology	Female	Yes
L	Otorhinolaryngology	Female	Yes
M	Surgery	Male	Yes

Appendix 3 - table of study participants, anonymized.