ID 035: Incremental Practice Interventions based on Advanced Academic Work Life Concepts

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Abstract
This paper examines the psychosocial work environment in the hospital sector from a learning perspective. The paper is based on case studies in the Danish hospital system, characterized by professionalism, centralized management and constant organizational change. In all cases, the psychosocial burdens are primarily related to the managerial structure the hospital system is subject to. Employees experience that the psychosocial strain is related to external conditions to the workplace and as a result of decisions taken far away. As such it is difficult to eliminate the causes locally. Managers and employees in the individual departments must learn to cope with the stress imposed. Learning-related concepts are found to be suitable for analysing how they actually do cope locally. However, these concepts not only pave the way for an analysis. They also open for reflection, interpretations and learning at the work site as a result of the incremental practice intervention. This might have a positive effect in reducing psychosocial stress. The paper focuses on one of the cases – a specialized hospital section with approx. 400 employees. It is investigated how learning-related activities, studied through three concepts – jobcrafting, temporality and relational coordination – contribute to the improvement of the psychosocial work environment.

Introduction
The need for improving the psychosocial work environment in Danish hospitals has been acknowledged for quite some time. Employers and unions have therefore initiated a number of initiatives to improve the psychosocial work environment at hospitals. We have been involved in one of these activities. This involvement is the foundation of this paper.

Hospitals in Denmark are governed by five regional authorities that in general are responsible for managing hospitals. The association of regions, Danish Regions, represents the five regions. The Negotiation Community, an association of trade unions representing (among others) employees at hospitals, has given priority to the psychosocial work environment as well. In 2015 Danish Regions and the Negotiation Community confirmed a joint agreement to promote Expert Advice and Inspiration for a Better Psychosocial Work. The initiative, which had 135,000 euros of funding, was a result of the collective agreement made in 2015. Managers and trade union representatives manage the fund collaboratively.

As researchers in Working Life Studies at Roskilde University, we were invited to contribute with expert advice and guidance related to organizational development and psychosocial work environment and professional development. Our activities should be differentiated from and complementary to what internal consultants at the hospitals provide. By means of research-based activities, they should contribute to improvement of the psychosocial work environment and improve the qualities of the services of the hospitals.

We developed a framework of three interconnected research-based concepts as a strong foundation for interpretation, analysis and expert advice to the hospitals. The framework is based on preliminary knowledge
about contemporary strengths and challenges within the work environment at hospitals and are all learning-oriented concepts:

- **Jobcrafting**, saying that an important part of organizational development is the jobcrafting everyone perform as part of her job (Wrzesniewski & Dutton 2001; Berg, Dutton & Wrzesniewski 2007)
- **Temporality** inspired by Lefebvre’s concept of Rhythm analyses (2012), saying that the daily rhythms of the work organization are crucial for social support and learning opportunities (Hvid 2010; Hvid, Lund & Pejtersen 2008)
- **Relational coordination**, inspired by Gittell (2009), saying that shared goals, timing of work, shared knowledge and mutual respect among professions, are crucial for performance and wellbeing

We invited hospital units to be analysed based on the suggested framework, thus at the same time inviting them to explore, reflect and learn about their own work environment. The analysis provided us with insight into working conditions, and gave local managers and employees a new perspective on their daily work practices. The aim was to pave the way for incremental changes in order to increase organizational resilience (Hagedorn-Rasmussen et al. 2016; Sutcliffe & Vogus 2003), enhance the ability to learn, adapt work organization to environmental change and mobilize coping strategies and resistance related to work strain. Our methodological approach was to conduct focus group interviews providing data for analysis. Subsequently we facilitated workshops where we presented the framework as well as findings. Dialogues among participants focusing on possible (incremental) changes were facilitated following the presentations.

Our ambition was to create a two-way knowledge-production: from academia to practice by means of dialogical and reflective practices; and from practice to academia in order to gain practical knowledge, thus developing the coherence of the conceptual framework.

In this paper we focus on one of the cases. We inquire how jobcrafting, temporality and relational coordination as a learning-oriented framework may contribute to understanding and improving the psychosocial work environment.

**Case presentation**

Until now, we have been involved in five hospital units: a hospital ward for children, a major district psychiatric ward, a medical department of a hospital, an emergency department, and a specialized unit. In order to reduce the complexity of the analysis, we focus on the specialized unit, and only involve the other cases occasionally. The specialized unit is organized around two closely related medical specialties. It is a relatively large unit with about 400 employees. Most are involved in the treatment of outpatients, but there is also a bed section in the unit. Many specialized functions have been developed, among doctors, nurses, secretaries and other staff. Interdisciplinary cooperation is well developed in the unit, but the unit has experienced intense organizational turbulence: During seven years, ten major organizational changes have been implemented. A large number of smaller departments have gradually been merged into a large entity.

Financial management has been tightened. The hospital is funded exclusively by public funds distributed by regional authorities, but management has gradually become increasingly market-oriented. Thus, increasingly detailed "pricing" of all patient-related activities, ranging from a short phone call to a comprehensive operation, has occurred. Following this, financial management has also demanded an increasing standardization of all activities in the unit.
For a number of years, the unit has been developed by inter-professional collaboration (IPLS) combined with a lean-inspired approach. However, the unit recently has been subject to a new comprehensive IT system that will form the framework of all activities in the unit. The system has been introduced to all hospitals in two Danish regions, but has evolved into a contemporary publicly-known IT scandal: employees perceive the system as illogical, complicating simple workflows, and placing obstacles in the way of interdisciplinary collaboration. Productivity has fallen due to the IT system, and many feel that the system has increased the workload dramatically.

Method
In the specialized unit, as in most of the other cases we have been involved in, focus group interviews and workshops were conducted. However, the specialized unit was so large that these activities could not be implemented throughout the unit. Therefore, three departments were selected in which interviews and workshops were conducted during the summer and autumn 2017. In each department, we conducted four focus group interviews each of 1 hour and 45 minutes, including:

- local employee representatives (shop stewards and safety representatives)
- the local management team
- two focus groups including 5–7 staff members – interdisciplinary composed

Instead of regular questions, we developed ‘statement cards’. Statement cards translates the foundational framework in a language related to everyday work practices. For instance “The opportunity for planning my daily work is good”, “Coordinating daily tasks is challenged by the way we cooperate among professional groups”, and “We are frequently disturbed while doing tasks that require full attention”. In the interviews, a participant read a statement card aloud, and reflected upon the statement. A dialogue continued around the statement. This process facilitates a dynamic exploration of the work practices and the work environment. Subsequently the interviews were transcribed and coded according to the three main concepts, though with an openness to other issues. A separate analysis was made for each of the three departments.

At each of the departments a seminar was arranged. The analysis was presented for both staff and managers. The foundational framework was presented together with our findings. The participants were invited to discuss whether the analysis was valid and what could be done to improve the psychosocial work environment. The intention was that by inviting employees into this analysis of their own working conditions, opportunities for incremental improvements in working conditions would appear.

After the dialogue was completed in the three departments, there was a thorough discussion of the activities and results with the central management of the unit and the key employee representatives. At this early point, it is difficult to assess whether the activity gave rise to concrete improvements in the psychosocial work environment as intended. However, we can observe that a number of suggestions for improvements have been made. In addition, we can refer to an evaluation, conducted as a small survey among the participants. Here, more than 95% of participants in the workshops indicate that the activity had given new perspectives on activities related to the improvement of the psychosocial work environment and that the activity had increased the motivation to work with the improvement of the psychosocial work environment.

Results
The strain come from the outside and above the top
In all cases, employees and local managers express that the most serious strains come from outside. This also applies to the specialized unit: “We’ve experienced many mergers and changes the latter years which have been
imposed on us... without any prior involvement. Also the new IT platform. It’s like kicking somebody who is already down.” Local management is considered to be well functioning. Co-operation between professions works well, and internal co-operation within the professions also works well (with the exception of a professional group in a single department). In all the departments there was a great pride in the work that was done. Most of the staff in the specialized unit work in an ambulatory, which provides a framework for work that may be conducive to the psychosocial work environment: only dayshifts, and relatively predictable working days. There is thus a schedule for the arrival of the patients and a specific number of minutes has been set for each patient. A number of special functions have been developed that help create professional engagement and clarity about the division of labour.

The most important stressors are related to experienced uncertainty, change that challenges sensemaking and thus the foundational meaning of work, and lastly a lack of recognition.

Uncertainty. There are apparently only negative experiences with the organizational changes so far implemented. Staff have been fired. Features have been moved. Organizational changes have occasionally created conflicts internally and between professional groups. The distance to top management has increased. It is expressed that there is considerable uncertainty about what are central management’s strategic considerations. “What do they want with us?” Over and over again, more information and better contact with centralized management are sought. Uncertainty is quite present, because it is the general assumption that new cuts and organizational changes are approaching. During the period we were there, staff reductions were announced among the secretaries.

Meaningless work was seen as a major strain. The effort to standardize work tasks to fit them into management and finance systems was criticized because it did not benefit the patients. In particular, the new IT system that had been introduced had multiplied the amount of meaningless work. Doctors found it meaningless that they, as highly paid specialists, should do secretarial work – write journals, order samples, send references, etc. Another stressful circumstance is the documentation requirements the system asks for. A large part of the documentation is not for the sake of the individual patient, but to give input to management systems. The system is experienced as very time consuming. There are errors due to the system’s functionality, and doctors need to check if blood samples and references actually run through the system as expected. The experience of improperly functioning systems is confirmed by the fact that the productivity of the department that first introduced the system 1½ years ago is still lagging behind compared to the time before the system – despite the fact that doctors work more intensively than they did before. It is now more difficult for doctors to accomplish their tasks within normal working hours. An additional stressful factor in relation to the new IT system lies in the fact that the system creates a sharp division of labour between the various professions in the departments. This counteracts many years of efforts to create interprofessional cooperation: “Even though we have been imposed new work processes, we continuously work to resolve it. It’s not only producing conflicts and quarrels as I have heard from other hospitals implementing the IT platform. [...] People went home crying and feeling terrible.”

Lack of recognition. There is a widespread perception that those who make the decisions do not recognize or acknowledge the efforts of employees. Those who decide are both top management in the unit, hospital management and the region. One example is the lack of recognition of the staff’s handling of the new IT system. When staff complain about problems with the new IT system, it is interpreted by management as an expression
of conservatism and lack of commitment. Gradually, however, it was recognized by central management that there was something seriously wrong with the IT system. However, employees still experience that top management do not fully recognize the endeavours they put into making things work despite the IT system. The general perception is that the externally imposed strains are completely outside the control of individuals, the workplace, the local leadership and the unions. The criticism of the stressful changes in the organization, financial management systems and IT system is great. However, there is no unilateral demand for removing the strains since they are recognized as part of the necessary changes. Employees ask for more and better information about when and how the strains are coming.

It is widely accepted that the hospital is a politically managed complex organization whose wisdom and reason it can be difficult to spot – but that this is an unavoidable condition to live with. Individuals, and the working communities in which individuals are involved, must keep professional ambitions high and try to get the best out of the situation as far as possible: “We are all committed humans eager to make things work. Thus, we put a great effort to make ends meet.” Learning becomes a key element for handling the applied loads by focusing on professional excellence: “I really think that there is a great collaborative effort to make sure that we do not freeze learning-wise.”

**Jobcrafting**

The concept of jobcrafting is based on the fact that everyone, to a certain extent, does his or her work in his or her own way. All jobs are crafted individually within the collective framework they are situated. There are three types of crafting: crafting of tasks, crafting of relationships and cognitive crafting. Thunman (2016) points out that public sector employees, in order to avoid moral stress due to cuts and reorganizations, change their jobs through omittance, revision, and cheating. This crafting of jobs often creates conflicts in the organization. However, crafting may be necessary in order to translate work processes and make sure to deliver the service expected by citizens.

The introduction of the new IT system prompted employees to launch a massive job re-crafting. In the department which first had the IT-system introduced, 1½ years before we visited the department, it was found that it was very difficult to do legitimate jobcrafting. Formally, errors and inconveniences in the system could be reported. And they were. However, the problems were not resolved. Therefore, staff had to find solutions to the problems themselves. Often, they chose solutions that were illegitimate within the logic of the system and top management priorities.

The system was designed to remove some collaborative processes. The new system ensured that the individual doctor had his patients, and the individual doctor should provide all the functions and activities associated with the individual patient. In addition, it was the responsibility of the doctor to complete the requested documentation. Nurses and other healthcare professionals had their special features, which the doctor could refer to. The secretaries primarily were responsible for receiving patients and answering telephone inquiries. However, employees and local management tried to avoid the individualization. Employees collaborated across professional groups in order to get the patient flow to work. In varying degrees – across the distinct departments in the units – they succeeded. The first step to counter the individualization was a lot of short and informal meetings where staff could present their problems with the system and get collegial support to solve them. As they grew more familiar with the system, they began to develop parallel systems. By means of integrating commonly available programs, they made it easier to keep track of the required information.
With growing familiarity with the system, a consensus was established that employees were not following the system as it was expected. You filled in the 'shell fields' because otherwise you could not finish a patient, but fields that did not require to be filled were skipped. For many of the shell fields that are required to be filled out, some informal standard answers have been agreed upon, in order to make it possible to move on. However, they may not contain highly credible information.

**Temporality**

Temporality, understood as timely conditions and timely patterns in work, are fundamental to how the organization functions. Temporality is about putting time and space together. Using a qualitative perspective on time makes it possible to study the tension between clock time and rhythmic time. It is not only a question about length and placement of work. Rhythms of daily work are an important aspect of temporality. Rhythms can create predictability, and rhythms can make collectivity possible (Hvid 2008, Hvid 2010, Lefebvre 2012). Rhythms in a community of practice are a precondition for learning (Wenger et al. 2002). For most employees in the specialized unit, daily life had a stable basis. Most employees are attached to fixed-time outpatient clinics with fixed hours for opening and closing, and with regular times for the patients. Each professional group had established its strong rhythmic relationships. The secretaries and nurses had a fixed rotation between different tasks — fixed breaks, fixed times for professional development, and places for informal dialogue. Daily work created a rhythm in the relations between the staff groups, and meetings on practical issues were held regularly, with participation from all professions.

However, rhythms can be broken when employees fall behind in the scheduled program for the day. When that happens, each day unresolved tasks pile up. The employee experiences a rise in cognitive demand and a loss of perspective and overview. The ambition for employees was to complete the tasks before going home, because next day it would be too busy to accomplish these tasks also: “The worst thing ever is to get behind schedule. Like, having eight patients, and when you’ve finished the first, you’re already half an hour behind schedule. That is extremely stressful.” For the younger doctors, it often meant very long working hours. For all doctors, it meant that professional upgrading was relocated to their spare time.

For a number of years, it was gradually becoming harder to achieve the task properly within the time available. For a long time, the budget had been reduced by 2% annually. The introduction of the new IT system suddenly increased the pressure on time, because the system itself was complicated and even simple tasks grew complicated: “You consider whether your memory has become weakened, when you cannot remember what you have done.” Many employees responded to this by skipping formal and informal breaks during the day. There was a lack of opportunity for restitution, but also with regard to actually solving concrete tasks in everyday practice: “Our breaks are typically spent on organising the daily work. Including lunch.” Employees and managers were aware that, in the long term, this would be a threat to both professional development and the working community.

The continuous organizational changes gave employees a sense of an unstable temporality. They did not want to return to the previous organization of work, but wished that the contemporary organization could be stable for a long period of time. However, they acknowledged this as an illusion in so far as new organizational changes were expected.
Relational coordination

Gittell (2009) has shown that hospital departments that have a high degree of ‘relational coordination’ achieve both high productivity and a high degree of well-being among the staff. Relational coordination is achieved through common objectives, shared knowledge and mutual respect. Relational coordination is, according to Gittell, maintained through frequent, precise, problem-oriented communication.

The specialized unit was generally characterized by a very high level of relational coordination in daily work. A trusting and open relationship between professional groups was established. Each and every one clearly belonged to a certain professional group, but the relationships with other professions were generally good. To a remarkable degree, the patient, as a whole and complex person, was at the core of this relational coordination.

There was a high degree of respect between the professional groups. It was thus acknowledged that the secretaries were best at assessing which patients should have immediate access to a doctor and who should wait. There was respect for the doctors with their professional knowledge to be able to relieve or treat. And there was also respect for nurses, teaching the patients how to live a good life with the disease. Shared values among the professions were the prerequisites for a development-oriented collaboration.

The changes the unit is undergoing have both positive and negative consequences for the relational coordination. On the one hand, the time pressure increases, and for some staff their employment is threatened. It makes it harder to find time and resources for relational coordination. On the other hand, the outside pressure has to a certain extent created internal cohesion. It is mentioned, for example, that the introduction of the new IT system, at least in a transition period, contributed to greater practical cooperation between the professional groups – despite the fact that the system as such created a sharper division of labour and less cooperation between the professional groups.

Conclusion

Work at hospitals is complex, demanding and time consuming. But it is also challenging in a positive way as well as fundamentally meaningful in so far as the core task is to create improvements in health. The professionals identify with this aim. They do not identify themselves with the hospital as a sector, or their hospital management as such. In fact, they regard the overall management as a major producer of irrational initiatives that compromise quality and create high workloads in everyday life. But they perceive these initiatives, coming from above, as unavoidable – as something they have to live with.

However, it does not mean that staff just adjust themselves to reality and do as expected. There is a strong local opposition to what comes from above. It is a resistance that is highly learning-oriented because it orientates itself toward how to create meaningful and quality-oriented workflows, despite the obstacles that come from outside and above. Employees are actively interpreting, sometimes omitting, ignoring and even counteracting what comes from the outside and above. But they are constantly doing this with the patient and the professionalism as the perspective.

The conditions for this jobcrafting vary from department to department in the hospital. We also found such differences between the different departments of the specialized unit (which we have not explained here). Our study confirmed that the quality of everyday temporality and the quality of the relational coordination are of
great importance for whether a productive and relieving jobcrafting can be done. It is crucial that everyday life has a certain rhythmic structure and that there are times and places for formal and informal exchanges of knowledge, attitudes and experiences. Likewise, the relationship between the professional groups is crucial for positive jobcrafting. Without open and respectful relationships between the professional groups, work is locked into the established division of labour and standard.

We conducted our analysis with employees, local managers and employee representatives. The feedback we have received from those who were involved is that the analysis gave a new and different insight into their own circumstances, and a dialogue about working conditions that was different from the dialogue that otherwise takes place in the departments. More specifically, initiatives were proposed to create better rhythms in everyday life. Among other things, the need for common breaks during the day was pointed out, and it was argued that there was a need for different types of break. There were suggestions for revisions in patient flow. Finally, a number of concrete initiatives were proposed that could improve cooperation between the professional groups – for instance that doctors, nurses and other health professionals should reach a common conclusion after consulting a patient on the condition of the patient and further treatment.

We thus find that the three concepts – job crafting, temporality and relational coordination – can form a productive framework for dialogue-oriented change at work.

References