This thesis is about the organisation of specialists' day to day work in Dutch hospitals. What is the nature of work in patient care in different specialities? What do specialists negotiate? What jurisdiction do they claim?

The information collected in this study was obtained from day to day work as directly as possible: the author observed specialists and asked them for their opinions and experiences, both in interviews and in a national survey. The study presents a picture of specialists' work from within.

Doctors' Orders

Specialists' Day to Day Work and their jurisdictional Claims in Dutch Hospitals

Karen Kruijthof

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Dokterspraktijken

Het dagelijks werk van specialisten en hun aanspraken op zeggenschap in Nederlandse ziekenhuizen

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Doctors' Orders

Specialists' Day to Day Work and their jurisdictional Claims in Dutch Hospitals

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Dokterspraktijken

Het dagelijks werk van specialisten en hun aanspraken op zeggenschap in Nederlandse ziekenhuizen

Promotiecommissie

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Part 1 The Study and its Context, Concepts and Methods

1 The study

1.1 Introduction

This study analyses the nature and organisation of specialists' day to day work in general hospitals in the Netherlands and the claims for jurisdiction specialists make in their work. It is of interest because it presents a picture of specialist work from within. Most studies about the organisation of specialist work address management structures or policy processes in hospital. Not many researchers study the real work of physicians in day to day patient care by observing it directly. The information collected in this study was obtained from day to day work as much as possible.

The title, *Doctors' orders*, is related to two aspects of this subject. In the first place it reflects an element of physicians' jurisdiction: the right to give orders to patients, nurses, and other people and parties surrounding them in hospital. In the second place, more important in this thesis, the title reflects the 'social orders' doctors take part in, together with people and parties surrounding them. In hospitals these orders are kept in balance by continuous small and large negotiations. The social orders doctors work in are 'negotiated orders'.

Specialists do not form a homogeneous group with respect to their work and jurisdictional claims. Several characteristics, for instance age, sex, family life, size of hospital, size of peer group, being self-employed or salaried, speciality, and teaching status, distribute specialists over many potential subgroups. Since this thesis is about work, it takes the speciality as one of the most important characteristics in distinguishing subgroups. The speciality defines the working processes in day to day life.

Three categories of specialities will be used throughout this thesis: 'medical', 'surgical' and 'supporting'. They will be defined in Chapter 2. It is important to know that the term 'medical specialities' refers to 'non-surgical' specialities. Throughout this thesis 'medical' sometimes refers to the total field of physicians, for instance the 'medical profession', and sometimes to the specific field of 'medical' physicians (for instance internists and cardiologists) that distinguish themselves from surgical physicians and supporting physicians. The context of the phrases will usually specify their meaning.

Besides the speciality, other criteria will be used to define subgroups of specialists as well, for instance men and women, and self-employed or salaried specialists.

Summarising, this thesis is about specialists' day to day work in Dutch general hospitals and about the negotiations specialists take part in when maintaining the negotiated order in their day to day work. The three categories of specialities, and certain other criteria, will be used to create subgroups of specialists.

This chapter provides an outline of the study, by discussing its relevance in paragraph 1.2, the history of Dutch policy on specialists' jurisdiction in paragraph 1.3, and the concepts of the research framework in paragraph 1.4.

Paragraph 1.5 contains the aims of the study and the central research question. Paragraph 1.6 and table 1.1 present an overview of this thesis' chapters.

1.2 Relevance

Practical relevance

The practical relevance of science in management and organisation is defined by its connection to the organisational problems in question, by its usefulness in practice, and by its timely availability (De Leeuw 1999).

The organisational problems related to this thesis are found in the continuous changes in specialists' work in hospitals, caused by internal and external developments. Internal developments in the specialities increase and change knowledge, skills and technologies. External developments change the rules and circumstances of work, for instance because funding systems change, because more women enter the specialities, or because shortages emerge in the workforce capacity.

To be able to cope with these changes specialists and other parties need to understand physicians' work in hospital. This thesis aims at understanding this work and its

organisation better, by finding specialists' jurisdictional claims underlying the negotiations that define the order in their day to day work.

The practical relevance of the study is endorsed by finding data as close as possible to day to day specialist work itself, since information was gathered in observations, interviews and a survey. Its usefulness in practice will be enhanced by translating the conclusions into implications for practice and policy, in Chapter 9.

Specialists in the Netherlands, and in many other countries in Western Europe and North America (see paragraph 2.6), face an era of fast internal and external change. In these circumstances the 'timely availability' of studies is hard to measure. Specifically addressing the Dutch agenda, the results presented in this book are timely available to be used in discussing and (re)designing the way specialists organise their work together, the role and position of specialists in management and organisation of hospitals, the management support of specialist work, and specialists work in relation to other disciplines (allocation of tasks).

Furthermore, discussions about specialists' work and about their role and position in hospital are often partly rhetorical, based on biases, assumptions and stereotypical images. By providing a picture 'from within', this thesis may help create a more realistic foundation for these discussions in policy and practice.

Theoretical or scientific relevance

Science in management and organisation should meet the desire for knowledge in organisational practice. Therefore, a focus on practice is not necessarily contrary to scientific development, at least when considered from a long-term perspective (De Leeuw 1999).

Thus, this study's focus on practice has scientific meaning as well, at least when criteria for scientific quality are met, which will be discussed in Chapter 4 on Methods.

What is more, studies are theoretically or scientifically relevant when they add knowledge about the real world to what is already known (Heerkens 1999:110).

This study will add to what is already known about specialists' work, by applying a conceptual framework based on professions and professional work and negotiated orders to the data about specialists' day to day work. Knowledge of specialists' work in hospitals is largely about the 'higher' levels of organisation. The relationship between the specialist staff and the board of directors for instance is analysed in several Dutch studies (for instance Schaaf 2000, Scholten and Van der Grinten 2002).

This study focuses on the operational levels, where 'real work' takes place. Thus, this thesis adds knowledge about the organisation of real specialist work, on a day to day basis, to what is already known about the organisation of specialist work in tactical and strategic perspective.

From a scientific point of view this thesis will show to what extent this conceptual framework of professions and professional work and negotiated orders holds in the practice of science. Conclusions about this point of view, and implications for further studies are discussed in Chapter 9.

1.3 National policy for jurisdiction in hospital: integration and participation

In 1983 the national financial arrangements for Dutch hospitals were reorganised into a budget system. This system was meant to control the ever-increasing amount of money spent on hospital care. The yearly budget for each hospital became the result of a number of fixed parameters. The financial arrangements for specialists were not incorporated in this hospital budgeting system and specialists' payment remained based on a fee-for-service mechanism. The combination of a budgeting system and a fee-for-service system in one organisation caused tension. Hospital management tried to restrict activities, because of the limited budget. Specialists had no incentive for restriction and claimed hospital services and budget for their activities. In 1994 a governmental committee advised "to integrate the costs of specialist care in the total budget of the hospital." (Klazinga 1996). This committee introduced the term "integrated specialist company" to describe the new style hospital (Biesheuvel Committee 1994).

Ever since physicians came into hospitals to stay, the role they should play in hospital management has been discussed and developed. The term 'integration', used since its introduction by the Biesheuvel Committee, not only concerns financial arrangements, but also connects the discussion about specialists involvement in hospital management. The term used for this involvement is 'specialist participation in management', or simply 'management participation', which means:

"the profession's actual involvement and co-responsibility for the organisation of care and policy formation and carrying out of that care, at each of the three different levels."
The three levels are: daily patient care, organisational units for specialist care, hospital organisation as a whole (Committee Medical Specialist and Hospital Organisation I 1991; translation by KK).

The financial and organisational integration of specialists into the hospital organisation was formalised by law in February 2000, in the 'Integration Act'.1 The old law spoke of "medical aid, delivered by specialists". The Integration Act speaks of: "medical specialist care, provided by or on behalf of a hospital." This phrase gives the hospital a leading role in the provision of care, replacing the specialists' role in the old act. A quotation from the Integration Act:

"Notwithstanding the responsibility of the board of directors of a hospital, the responsibility for the medical treatment and care of a patient in a hospital rests with the specialist. The specialist will obey the organisational and financial framework recommended by the board. The board will obey the framework of specialist care recommended by the specialists. The hospital board will consult the specialists before negotiating with insurers." (Integration Act; translation by KK).

Thus, the law specifies the mutual borders of jurisdiction of the hospital board and the specialists. Jurisdiction of the hospital board regards the organisational and financial framework and the negotiations with insurance companies. The framework of specialist care, indicated by the specialists, borders it. Jurisdiction of the specialists regards the framework of specialist care and the treatment and care of individual patients. The organisational and financial framework, indicated by the hospital, borders it.

1.4 Jurisdiction in specialist work: concepts

The policy context in the nineties aimed at organising jurisdiction in Dutch hospitals by a financial and organisational incorporation of specialists and their work into the hospital organisation. Understanding the theme of jurisdiction was the inspiration and motivation for this study, not in its policy context of national decision making and legislation, but in its practical context of specialist work in Dutch hospitals. The research framework used in the study consists of concepts provided by theories about professions and professionals and by theories about negotiated order.

Theories about professions and professionals

Specialists belong to a profession, which is an occupational group that has a more or less exclusive work dominion of abstract knowledge and specialised skills (Abbott 1988, Freidson 2001, Schriesheim et al. 1977). Because of the exclusivity, professions claim control of their own work. This gives the link between a profession and its work a special importance: professional work is linked to professional control, autonomy, authority, and right of say. Abbott (1988:59) takes these aspects together by stating that a profession and its work are linked by 'jurisdiction'. Professions make jurisdictional claims in the arenas of the legal system, public opinion and the workplace (Abbott 1988:59-60).

Theories about negotiated order

Organisations are 'social orders' that are based on rules and agreements which are constructed in interactions between persons and parties within organisations (Strauss et al.1973). The construction of social order is not accidental but reflects the interests that persons and parties have in these organisations (Strauss 1978). These interests are often conflicting and

1 The 'Integration Act' formally is called: 'Act of 24 December 1998 to amend the Sickness Fund Act and the Social Health Insurance Access Act in connection with the introduction of entitlement to specialist care provided by or on behalf of a hospital'. The Act is in force since 1 Februari 2000.

constantly changing. Therefore negotiations define the construction and the continuous reconstitution of social order. The order resulting from these processes is a 'negotiated order'. At any moment in time the output of the constructions is the input for the next round of negotiations.

Professionals claim jurisdiction over their work, which is not automatically granted to them, because other parties want jurisdiction as well. On all levels, between macro and micro, the jurisdiction of a certain party is the net result of ongoing negotiations. These negotiations are "processes of give-and-take, of diplomacy, of bargaining" between a party and its context (Strauss et al. 1973:304, see also: Van Oorschot et al. 1995:12, Mastenbroek 1996:31). The negotiations that professionals take part in to construct the negotiated order in their work reflect their claims for jurisdiction.

This study takes the two fields of theories together. It focuses on the workplace, the hospital, as the context for jurisdictional claims and it takes individual professionals - the specialists - to be the central figures. By identifying and analysing the negotiations that define the negotiated order in specialists' day to day work the study aims at revealing the underlying jurisdictional claims of specialists in Dutch hospitals.

1.5 Aim and central question: finding jurisdictional claims

As mentioned before, the theme of jurisdiction was the inspiration for this study, not in its policy context of national decision making and legislation, but in its practical context of specialist work in Dutch hospitals. The study aims at generating insight in the jurisdictional claims Dutch specialists make in day to day life in their workplace - the hospital.

The central research question:

What is the nature of the negotiations that define the negotiated order in specialists' day to day work in hospitals, and what jurisdictional claims underlie these negotiations?

Table 1.1 describes the elements in this central research question. They will be discussed in more detail in Chapter 3.

The 'specialists' in this question are the specialists working in Dutch general hospitals. The thesis does not address the quality of the content of physicians' work.

Table 1.1: The elements of the central research question

the nature of negotiations	who: - the role perspectives specialists negotiate from in their day to day work - the other negotiators specialists meet how: - the way specialists negotiate; the subprocesses that take place; specialists' tactics and coping mechanisms what: - the issues specialists negotiate about
negotiated order	the social order in specialists' day to day work; at any moment in time an output of continuous processes of "give-and-take, of diplomacy, of bargaining" and an input for the next round of negotiations
jurisdictional claims	what specialists want to have jurisdiction over in day to day work; jurisdiction refers to the combination of authority, autonomy and right of say

1.6 Research questions

The chapters of this thesis are structured by sub-questions. First, the research theme itself needs to be unravelled, then its context and the way the research could and should be done.

The research theme itself

Since professional jurisdiction specifically links a profession and its work (Abbott 1988:59), the nature of specialist work in itself needs to be understood before jurisdictional claims can be understood. Patient care is the area that makes specialist work professional work. Therefore the nature of work in patient care is the central theme:

What is the nature of specialists' day to day work in patient care?

Strauss (1978:98-100) prescribes what to watch in studying negotiated orders. The nature of the negotiations must be found by characterising the negotiators, the subprocesses or tactics in the negotiations, and the issues negotiated. This scheme of aspects is what Strauss calls the "negotiation context".

To be able to analyse the negotiated order and the negotiation context, specialists' work will be approached from different perspectives, defined by the roles they play in work and in the relationships with people and parties around them.

Patient care is the pre-eminent and central activity of specialists in hospital, so it is taken to be the first area where specialists negotiate their jurisdictional claims:

What is the nature of the negotiations in specialists' day to day work in patient care and what jurisdictional claims underlie these negotiations?

Next, specialists work in hospitals in which several relationships define the roles they play:

What is the nature of the negotiations in specialists' day to day work from the perspectives of specialists' roles that are defined by relationships in the hospital, and what jurisdictional claims underlie these negotiations?

Finally, day to day work can not be separated from the rest of life. Outside of the hospital specialists are individual persons, having personal and private lives. Specialists are also professionals, members of the profession of physicians:

What is the nature of the negotiations in specialists' day to day work from the perspectives of specialists' roles that are defined by relationships outside the hospital, and what jurisdictional claims underlie these negotiations?

Context and methods

Strauss instructs the researcher of negotiated orders not only to understand the "negotiation context", but the "structural context" as well: "that 'within which' the negotiations take place, in the largest sense". This calls for perspective in the research theme. Its history and its present should be outlined and some international considerations should be made (Strauss 1978:98):

How did specialist work in Dutch hospitals develop over time, what is the present situation, and what are the main differences with other countries?

Some concepts used in this thesis have been briefly described already. To find the proper language for discussing specialists' work, jurisdictional claims, and the negotiated order, a research framework is necessary:

What concepts and research framework should be used in describing and characterising specialist work and the negotiations and jurisdictional claims in hospitals?

The methods of the study should make the research framework work:

What methods should be used to study specialist work, negotiations and jurisdictional claims in the hospital?

The following chapters will address aforementioned research questions chronologically, as shown in **table 1.2**.

Table 1.2: The research questions and chapters of this thesis

Part 1. **The context of the research theme and the way research could and should be done**	
How did specialist work in Dutch hospitals develop over time, what is the present situation, and what are the main differences with other countries?	Chapter 2
What concepts and research framework should be used in describing and characterising specialist work and the negotiations and jurisdictional claims in hospitals?	Chapter 3
What methods should be used to study specialist work, negotiations and jurisdictional claims in the hospital?	Chapter 4
Part 2. **The research theme itself**	
What is the nature of specialists' day to day work in patient care?	Chapter 5
What is the nature of the negotiations in specialists' day to day work in patient care and what jurisdictional claims underlie these negotiations?	Chapter 6
What is the nature of the negotiations in specialists' day to day work from the perspectives of the roles that are defined by relationships in the hospital, and what jurisdictional claims underlie these negotiations?	Chapter 7
What is the nature of the negotiations in specialists' day to day work from the perspectives of the roles that are defined by relationships outside the hospital, and what jurisdictional claims underlie these negotiations?	Chapter 8

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2 Specialists' work in history, at present, and in other countries

2.1 Introduction

Strauss instructs the researcher of negotiated orders to understand the 'structural context' first, which is "that 'within which' the negotiations take place, in the largest sense", including a (short) history and an introduction to the international context (Strauss 1978:98). This chapter therefore discusses the history of specialist work in Dutch hospitals, the present situation, and a comparison with other countries.

The history needed for the study starts in the nineteenth century, because then the specialities gradually started to develop. Paragraph 2.2 shortly describes the history of the specialities. Paragraph 2.3 discusses the history of the modern hospital, and paragraph 2.4 brings specialists and hospitals together in outlining the history of their relation.

Paragraph 2.5 presents the actual context of specialist work in Dutch hospitals and paragraph 2.6 shortly places this national context and this thesis in an international perspective. This chapter's conclusion is paragraph 2.7

2.2 The rise and development of specialities

Until the nineteenth century the ancestors of modern physicians were found in two occupational groups: the 'doctores medicinae', trained at universities since the twelfth century, and the 'surgeons', who learnt their skills in practice.

The fields of practice of these groups remained relatively untouched by governmental organisation and legislation, but this situation changed in the nineteenth century.

Laws on licenses and training came into force in 1818, bringing provincial committees judging the individual qualifications of practitioners (Meurs 1982:84, Klazinga 1996). In 1849 the Dutch Medical Association (NMG) was established, aiming at revision of the legislation on health care and health care professionals and thus at improvement both of the health of the population and of the status of the profession (Klazinga 1996:73). In 1865 Parliament accepted several laws for regulating education, licensing and control on physician practice. A university training became compulsory for practitioners in medicine. Therefore the theoretical knowledge of the doctores medicinae and the practical knowledge and skills of surgeons were brought together in a joint program, and practitioners without a university training, for instance 'herbal healers', were placed outside the licenses for practice.

At the end of the nineteenth century specialists gradually appeared (Juch 1996, Juch 1997, Klazinga 1996). This matched the context of the time, for new knowledge and skills developed fast. Besides, the increasing availability of electricity stimulated the use of technology, for instance in radiology and electrocardiography (Juch 1997:53).

Between 1860 and 1890 the first sites for specialisation were specialised clinics, especially eye-clinics, clinics for children and women, and 'extramural policlinics'. The 'surgical specialities' (ophthalmology, ear, nose and throat surgery, gynaecology, and surgery) were pioneers in all cities.

At the turn of the century the 'medical specialities'[1] rose, following new diagnostical technologies and scientific developments in bacteriology, clinical chemistry, pathology and radiology. The first medical specialities focused on one disease or category of diseases, for instance diseases of the stomach and intestines, tuberculosis, and venereal diseases and dermatology (ibid:109).

Many specialists were 'half-specialists', combining specialist practice with working as a family doctor. General practitioners feared this development might threaten their sources of income and challenge their competence. This

1 The term 'medical specialities' here refers to non-surgical specialities. Throughout this thesis 'medical' sometimes refers to the total field of physicians, for instance the 'medical profession', and sometimes to the specific field of 'medical' physicians (for instance internists and cardiologists) that distinguish themselves from 'surgical' physicians and 'supporting' physicians. The context of the term will usually specify the use of 'medical'.

caused an internal struggle within the NMG that continued in the twentieth century (Klazinga 1996, Juch 1997). From the beginning of the twentieth century the NMG-rules for establishing practices opposed the practices of half-specialists. Other specialists were 'double-specialists', because they combined two or more specialities.

The scientific and technological developments underlying the rise of surgical and medical specialities gradually created the last group of specialities: the 'supporting or ancillary specialities', for instance anaesthesiology, radiology, pathology, and microbiology.

Radiology at first was combined with other disciplines: GP-radiologists, gynaecologist-radiologists, or internist-radiologists. The general practitioners quite easily accepted radiology as a separate speciality, but the specialists who combined radiology with another speciality objected. They felt they were better equipped to use radiology on their field than physicians specialising in radiology only (Juch 1997:112).

In the cities specialists started to practice in 'policlinics' (Klazinga 1996). Some policlinics were established by specialists themselves, individually or collectively, others were established by the larger sickness funds. Some larger hospitals and academic hospitals also had policlinics. The policlinics were places where the poor could get ambulant specialist care and advice for free or for a small fee only. The well-to-do patients came at the specialists' houses.

The NMG, consisting largely of general practitioners, did not support the development of specialities (Juch 1997:112-3). The general practitioners were afraid of losing too many patients, especially to the medical specialities of internal medicine and paediatrics. Accepting specialists for the feared disease of tuberculosis or for venereal diseases was less problematic than accepting specialists in internal medicine and paediatrics, who might 'steal' half of the patient population from the general practitioners.

Since the NMG did not support the specialists, they established their own platforms in the 'scientific associations', where physicians with interest in a speciality discussed and developed the knowledge. Many of these associations started between 1890 and 1910. On a local level, in the cities, specialists were also organised.

Between 1900 and 1930 the number of physicians calling themselves specialists increased from 100 to 1000.

In 1920 a concept law for a system of sickness funds mentioned specialist work to be a separate area of physician activities, to be paid for by the sickness funds. This concept document was the first governmental acknowledgement of the existence of specialists, and it supported the specialists in their struggle for acknowledgement within the NMG (Juch 1997:236).

The scientific associations started to discuss the need for specialist training, and the formulation of requirements for specialists. The formalisation of post-graduate training for specialists was accepted in 1931, and the NMG established a national committee for keeping the register of qualified specialists in 1932, the 'Specialists Registration Committee' (Klazinga 1996, Juch 1997:329).

Between 1865 and 1931 the specialists as an occupational group thus acquired the characteristics that make them 'professionals' (Schriesheim et al. 1977): they started to work on the basis of specialised expertise, they started to formulate codes of ethics to maintain affective neutrality and universal standards, they organised a collegial maintenance of the standards, they acquired autonomy and self-control, the commitment to their professions and to their work grew, and they developed a system for work and training in which identification with fellow professionals could take place.

2.3 The rise and development of modern hospitals

Hospitals ('guest houses' or 'houses of God') in the nineteenth century, established by the municipality or by private parties, took care of the poor for free. Usually the hospital attendants did not have any knowledge of nursing or of hygiene. The well-to-do were taken care of and even operated on at home or in a sanatorium. The last twenty

years of the nineteenth century brought many changes to hospitals. Modern ideas about bacteriology and about nursing (Florence Nightingale had started the first training program on nursing in 1860 in London), and developing surgical skills stimulated surgery in some hospitals that grew into centres for treatment. The well-to-do started to come into those hospitals too, because major surgery was more convenient to perform there than at home (Juch 1997:61; Rosen 1963:27).

Especially the larger municipality hospitals and private hospitals developed into more modern centres for treatment. They used the growth of technological innovations and developed new diagnostic possibilities using X-rays and electrocardiography. Surgical skills became more refined and the Dutch surgeons were pioneers in surgery of gastric and duodenal ulcers. Complications after surgery could be taken care of more adequately, among other things because of the establishment of blood transfusion services. These developments made hospitals more suitable for the work of specialists and less for the work of general practitioners (Juch 1997:229). General practitioners were gradually kept out.

Until about 1920 the specialists took their own equipment and instruments into the hospital. Later the hospitals took care of that. The 'modern hospital' had a well equipped operation room, laboratories, a sun-lamp, and machines for examinations, for instance for electrocardiography and for radiology (ibid.: 243).

In the mean time, the specialists in the policlinics needed more modern equipment as well, especially if other policlinics around were competing for patients. Many specialists tried to get a place in the policlinics of the hospitals, but these were 'full' quite soon. Policlinics outside hospitals remained until about 1940, but modern hospitals and their outpatient clinics increasingly became an attractive field of activity for specialists since 1920.

The hospitals in the larger cities gradually 'closed' their specialist staffs, which meant inpatients could only be seen by the members of the specialist staff in hospital, and not by general practitioners or specialists from outside. Because hospitals in the cities were difficult to get into, after 1920 specialists dispersed over the country. In middle-large cities hospitals were more often 'open', which meant specialists could treat patients there without the need of a formal relationship with the hospital (Juch 1997:266).

2.4 Relationships between hospitals and specialists in a national context

Since the thirties of the twentieth century the hospital gradually became the dominant specialist workplace.[2] Whether a hospital should be open, granting patients a free choice of physician, or closed, enabling the hospital and its specialist staff to organise patient care together, was a subject of ongoing negotiations for many years. The national specialist organisation said to support the principle of free choice, but in practice the specialists in hospitals feared competition from new specialists, and often supported the establishment of specialist staffs. The hospitals supported the closed structure, claiming this to improve the quality of patient care, because specialists' clinical experience was maintained better in closed hospitals. In real life combinations of these structures were often found, for instance with free specialist choices for well-to-do patients, but not for the poor (Juch 1997:252-4).

The national representatives of hospitals said to favour the 'closed structure' for reasons of quality. In fact, a permanent specialist staff also gave hospital directors or medical superintendents less bother in organisation and authority. Since the thirties most hospitals had a medical superintendent, who was the organisational leader of the hospital, and treated the patients with medical diseases (Juch 1997:259). The increasing numbers of specialists and the worsening economical situation gave specialists a bad starting point in their relationship with the hospital, its board and its medical superintendent. Specialists were forced to treat patients for free or for a small fee, in order to keep their knowledge and skills. Specialists on a staff risked losing their position if they did not accept the conditions in hospital.

These circumstances offered hospitals and their medical superintendents opportunities to take organisational measures (Juch 1997:270-2). Hospitals with a specialist staff agreed with specialists about the days and hours specialists were to be in hospital. Open hospitals made house rules,

2 Parts of the text in this paragraph come from a draft chapter for a Dutch book about Governance in Dutch Health Care; authors: Karen Kruijthof & Annemiek Stoopendaal.

tried to limit the number of specialists they allowed into the hospital, or sometimes appointed one or two specialists. Despite the bad circumstances, specialists were not easily limited by these measures. They felt they had a central position in the organisation and this was confirmed by the respectful way they were usually treated.

On the national level, the occupation from 1940 till 1945 brought the Sickness Funds Act, imposed by the Germans. Government, sickness funds and physicians co-operated harmoniously in implementing this law (Companje 1997).

Since the fifties of the twentieth century, the relationships between specialists and hospitals had different accents in different periods. In the fifties and sixties the 'connection' of specialists with the specialist staff and with the hospital organisation defined the relationships. In the seventies and eighties specialists and hospital management faced the challenge of 'financial control'. From the nineties until now physicians' financial arrangements 'integrated' into hospital arrangements, and specialists started 'participating' in hospital management. The following paragraphs discuss these developments in the Netherlands.

The connection: fifties and sixties

In the fifties the debate about the open and closed hospitals still continued (Klazinga 1996, Tamboer et al. 2002). The national hospital organisations pointed out the efficiency of closed hospitals and the importance of patients being able to choose the hospital they preferred for clinical or ambulant treatment. The national organisations of specialists and medical directors still favoured the open hospital, because they wanted physicians to be able to set up practice freely. Besides, they pointed out the importance of patients being able to choose the physician they prefer. The physician organisations recognised the danger of insufficient specialist co-operation and co-ordination in open hospitals. They intended to circumvent this danger by introducing a new hospital organ: the specialist staff. Every specialist frequently admitting patients in the hospital in question should be a member of this organ. The medical superintendent or medical director should be its chairman.

Since 1960 hospitals were obliged to have a specialist staff and from that moment on physicians increasingly started working in one hospital only. Gradually the open hospital disappeared. Specialists of the same speciality and working in the closed hospitals started formalising their co-operation by establishing partnerships ('maatschappen'), in which they bundled their financial interests and the organisation of their practice (Klazinga 1996:82). Ambulatory specialist care also moved to the hospital premises, making most specialists definitely leave the policlinics outside hospitals and connecting them to hospitals. This connection between hospitals and specialists was organisationally loose. Specialists and hospital had separate contracts with insurers, and specialists took care of business in their partnerships.

The late sixties also brought economists onto the boards of directors. Powers were gradually shifting, especially when the government started focusing on cost and volume containment of health care. Yet, the medical director remained first among equals within the board of directors (Meurs 1982:104).

Financial control: seventies and eighties

Between the late sixties and early eighties the hospitals had two merger waves, responding to the government cry for reducing the number of hospital beds and for spreading hospitals (Van der Lugt and Huijsman 1995). In the eighties government still wanted more financial control. In 1982 the Health Care Tariffs Act was brought into force and in 1983 the hospitals entered the 'function based budget system'.[3] The specialists however still were financed in a fee-for-service system. Thus, hospital management was bound to restrict activities, because of the limited budget, while specialists did not have an incentive for restriction and claimed hospital services and budget for their activities. These conflicting systems brought major issues of financial allocation into the hospitals. The specialist staffs became involved, trying to deal with the conflicts of interests between hospitals and physicians (Tamboer et al. 2002). This involvement of physicians in financial allocation and hence in hospital policy was called 'management participation'. Several institutions developed courses about budgeting and management for specialists.

3 Function based budget system: the Health Care Tariffs Act is carried out by the National Health Tariffs Authority, that defines the rules for hospital budgets in a number of fixed parameters for hospital functions: infrastructure (e.g. buildings), availability (depending on the number of people in the local population), capacity (beds and physicians), and output (e.g. admissions, OPD-visits, daycare).

The focus on cost containment and budgeting rendered management a new and important role in hospital (Scholten and Van der Grinten 1998 and 2000) and it caused management to focus on financial control. The average scale of hospitals increased because of the mergers, making organisation and control important goals in hospital.

Meanwhile the budget allocation by specialist staffs was a laborious process with unclear decision making procedures and blurred mandates (Tamboer et al. 2002).

On the national level the specialists' behaviour in patient care ('over-treatment'), and specialists' income ('over-charging') became separate issues on the government agenda in the seventies (Nicolai 2003). The costs specialists caused were considered to be too high, and the income differences between specialists were considered to be too big. Several secretaries of state and governmental committees in succession made plans and advice for change, causing commotion and opposition among specialists and the national specialist organisation. The government and the national specialist organisation fought each other in several law suits, and the first specialist 'strike' ('Sunday service' on a Monday) was in 1986. Arguments about specialist costs and incomes continued, with 'strikes' and other signals of specialist protest in 1987 and 1988.

Government 'froze' specialist costs for 1990-1992 at the level of 1989 by means of tariff reductions (Companje 1997).

Integration and regulation: nineties

The tariff reductions were an incentive for specialists for performing even more patient care, to compensate for the effect on individual fees (Van Lindert et al.1999). Within the specialist population differences of opinion fragmented the national specialist organisation. A first group separated in 1989 and established a new national organisation, followed by a second group in 1990 (Nicolai:98).

In 1994 a governmental committee advised "to integrate the costs of specialist care in the total budget of the hospital." (Klazinga 1996). This committee, called the Biesheuvel Committee, introduced the term 'integrated specialist company' to describe the 'new style hospital'. In the integrated specialist company the hospital organisation and the specialists working in it should be organisationally connected. According to the Biesheuvel advice the hospital board should negotiate yearly with the insurance companies for the amount of services to be performed and charged. The specialists working in hospital should be bound to the outcomes of these negotiations and to the agreements worked out in hospital. Their income should be provided by the hospital, because the financing of hospitals and specialists was to be integrated in one system. The new arrangements for specialists' finances should also change the major differences of income levels of members of different specialities, grown in the fee-for-service system (Groeneweg et al. 1998, Telgenkamp et al. 1999, Groeneveld 2002).

Within patient care the specialists held responsibility for treatment of individual patients, but their autonomy in this was not absolute. It should be considered to be 'bound freedom', bordered by the company framework and standards (Biesheuvel Committee 1994:34). The Committee felt a labour contract for specialists would be a simple structure for organising relationships between specialists and hospital in the 'integrated model'. Separate contracts holding mutual agreements between hospital and self-employed specialists could arrange the relationship as well (Biesheuvel Committee 1994:36).

The Biesheuvel advice was published in a context of continuing confusion. Dutch government focused intensely on cost containment, frequently reduced the specialist tariffs in the fee-for-service system and threatened to initiate further reductions. Waiting lists for hospital procedures had started to grow. Three national specialist organisations fought each other and the government. The specialists considered the Biesheuvel advice to be a plan for rendering physicians organisationally subordinate and for introducing salaried employment as the financial system for specialists (Scholten 1998:15).

In these circumstances the measures suggested by the Biesheuvel Committee could not be introduced at national level. At local level some initiatives had already been taken since 1993, all aiming at changing the direct relationship between specialist fees and services and at co-ordinating agreements between regional insurance companies, hospitals and specialists. The minister, welcoming attempts to solve the troubles, decided to subsidise and support five of these initiatives and to monitor their results (Ziekenfondsraad 1998). The initiatives were called the 'specialist remuneration experiments'. Other regions

started these initiatives as well, calling them 'local initiatives' or 'local experiments'. The three parties in a local experiment were hospitals, specialists and regional insurance companies. This threesome agreed annually the organisation and finance of specialist care. The specialists of a hospital agreed on the maximum amount of services they would deliver and on the total fee they would charge (Verbeek 1998). This agreement on the total fee was called a 'lump sum remuneration'. Nearly all self-employed specialists left the fee-for-service system and entered the system of lump sum remuneration (Scholten and Van der Grinten 2002). An important motivation for them was the minister's promise to protect specialists entering local experiments from the consequences of tariff reductions. In many hospitals the specialists tried to combine the arrangements of the lump sum remuneration with a long-term system in which the differences of income between specialities would gradually be changed. Decision making about this however was and is very difficult, since in most hospitals the highest income is more than two times higher than the lowest income (Scholten and Van der Grinten 2000).

At national level the organisations of specialists reunited again in 1997, establishing the Order of Medical Specialists. This organisation agreed with the national hospital organisations and the representatives of insurance companies on a series of documents to formalise relationships between specialists and hospitals. In 1997 they published a convention, concluding among other things that specialists are responsible for the process of specialist treatment and care for patients. This connected the primary responsibility and loyalty of specialists with their individual patients (Van der Heyden and Scholten 2000). The second document was a model document for the contract between an individual self-employed specialist and a hospital, confirming the individual entrepreneurship. This was published because the self-employed specialists feared losing their formal status of entrepreneurs in the new relationships, since they were no longer independent contractors. The Ministry of Finance declared these 'individual permits for establishing a practice in hospital', to be mandatory if individual specialists wanted to keep a formal status of entrepreneur (Minister of State 1998). The third model document regulated the relationship between a board of directors and the specialist staff of the hospital. This was the 'specialist staff document', making the staff organ the primary consultative and negotiating partner for the board of directors.

The system of lump sum remuneration gradually made the specialists working in one hospital strengthen their co-operation in order to obtain a firm position in all negotiations with the hospital and the insurance companies. The national specialist association even advised the self-employed specialists to establish a staff partnership to create a solid structure in negotiations. This advice was connected with the fourth model document, the 'regulations staff partnership'. Thus, the system that structurally integrated the relationships between hospitals, specialists and regional insurance companies at the same time caused the specialists to create a separate position of power by organising the mutual relationships within their own group (Scholten and Van der Grinten 2002).

Participation: nineties

The term 'integration', used since its introduction by the Biesheuvel Committee, not only concerned financial arrangements, but connected with the discussion about specialist involvement in hospital management. In this perspective, the Biesheuvel advice suggested to restructure hospitals into organisational units centred around specialist care and to make specialists participate in management, at least at unit level. The term used for involvement was 'specialist participation in management', most often just called 'management participation':[4]

"the profession's actual involvement and co-responsibility for the organisation of care and policy formation and carrying out of that care, at each of the three different levels."
The three levels are: daily patient care, organisational units for specialist care, hospital organisation as a whole (Committee Medical Specialist and Hospital Organisation I 1991; Versluis and Hesselink 1993; translation by KK).

Traditionally hospitals were structured in organisational processes: the clinical department for instance, contained all inpatient wards, the outpatient department contained all

4 The meaning of 'management participation' is in the nineties a different one than in the eighties; it shifts from the involvement of the medical staff in the allocation of budgets to management involvement in a broader sense.

outpatient wards. These departments had a rather tight hierarchy, in which specialists formally had no say. Since the nineties, many hospitals created a decentralised structure that builds up from departments to units or sectors (Ong and Schepers 1998). The organisational units are now centred around specialities. In- and outpatient departments are combined in these units or divisions.

Many hospitals combined the structural changes with the introduction of management participation, introducing specialist managers or management participants. A specialist manager is authorised by his or her partnership (self-employed specialists) or speciality group (specialists employed by hospital) to fulfil this function on a part-time basis. An organisational manager is his or her sparring partner, and together they are the management team of units or divisions. They usually divide tasks and points of attention, but they are both equally accountable for the results in patient care and in management of the unit. This is the integrated management model in practice.

2.5 The present context of specialist work

Today almost 13.000 specialists work in 27 specialities, each nationally organised in its own scientific association. The specialities are still divided into three groups that connect with history. The members of 'medical specialities' cover a wide range of disciplines. The specialities focus on particular organs or disease processes. Medical specialists have the 'doctores medicinae' are their ancestors. The members of the 'surgical specialities' diagnose and treat diseases using surgery as a specialist skill. The 'surgeons' are their ancestors. And finally, the members of 'supporting specialities' in general are specialists in applying knowledge and equipment to support the patient care processes of medical or surgical disciplines. Many of them apply the techniques and knowledge that once enabled medical and surgical specialities to rise.[5]

Table 2.1 shows the specialities and the number of specialists in the Netherlands in 2000. Psychiatry has its own history and nature of work, and its 1.900 specialists are therefore not placed under any of the three groups.

Table 2.1: The specialities (without psychiatry); total numbers of Dutch specialists working, 2000

medical specialities		surgical specialities		supporting specialities	
cardiology	577	cardiothoracic surgery	92	anaesthesiology	941
clinical geriatrics	79	ear nose throat surgery	383	clinical genetics	61
dermatology	312	neurosurgery	86	microbiology	173
gastroenterology	171	obstetrics & gynaecology	700	nuclear medicine	109
internal medicine	1.539	ophthalmology	509	pathology	289
neurology	598	orthopaedic surgery	419	radiology	730
paediatrics	894	plastic surgery	144	radiotherapy	150
respiratory medicine	362	surgery (general)	855	rehabilitation medicine	273
rheumatology	159	urology	261		
	4.691		3.449		2.726

(Van der Velden 2002)

5 Some supporting specialities, however, have 'own' patients, whom they diagnose or treat independent of the referring specialities (for instance clinical genetics, radiotherapy, rehabilitation medicine).

In 1999 the Capacity Body for Postgraduate Physician and Dentist Education was established. This organ annually advises the Minister of Health about the expected demand for postgraduate training for physicians and dentists, based on the expected demand for care and the expected behaviour of the workforce.

The government and the health care organisations fear for an increasing shortage of physicians and specialists, and the capacities for training physicians in university (medical school) and for training specialists in hospital (postgraduate specialist training) gradually increased since about 1999, following recommendations of the Capacity Body.

To understand the actual context of specialist work this paragraph will further describe legislation, the health care system, and the present specialist-hospital relationships.

2.5.1 Legislation

The laws of 1865 that regulated education, licensing and control on physician practice, were replaced in the eighties and nineties of the twentieth century. Three categories of laws are worth mentioning, because they provide the legal framework for specialist work in hospitals (Kahn 2001:11). This framework of legislation, completed by other laws on specific subjects, for instance medication and abortion, regulates the provision of specialist care.

Patient legislation

The Medical Treatment Contracts Act (Wet op de Geneeskundige Behandelingsovereenkomst) was one of the important laws in patient legislation. It codified the patient's right to be informed about his or her diagnosis, and to being treated only after 'informed consent': first patients must know the options for treatment and the consequences, then they can decide on further treatment. This law also concerns record keeping and professional secrecy. Within the framework of this law physicians and other workers in health care take care of and communicate with patients.

Quality legislation

The second category of new laws concerns quality legislation. The Professions in Individual Health Care Act (Wet op de Beroepen in de Individuele Gezondheidszorg) provided the new framework for education, registration and licensing. It protects a number of titles (for instance physicians and dentists) from being used freely, and it provides the legal frame for the system of the registration of specialists. The law declared the parties 'in the field' responsible for control of the educational programs that are related to titles and specialisation. Since only the titles are limited, and not professional work as such, the law also defined a number of services that are reserved to be performed only by licensed professionals, or under their supervision, for instance surgical procedures and giving anaesthesia. The act also regulated the system of disciplinary law.

Within the framework of this act, the Central Board of Specialities (Centraal College Medische Specialismen) defines the specialities in patient care, the titles connected with these specialities, the requirements for specialist training programs, the requirements for specialist trainers and for the institutions for training, and the requirements for the registration and the revalidation of specialists. The Specialists' Registration Committee (Specialisten Registratie Commissie) is responsible for keeping the registers of specialists, for appointing the chiefs of training and acknowledging the institutions for training, and for controlling whether training institutions and trainers follow the recommendations of the Central Board. The Specialists' Registration Committee developed the 'visitatie system' to control the speciality groups and partnerships that teach residents in specialist training. A visitatie committee, which is a team of peers, visits the teaching speciality groups and partnerships every five years to monitor the training conditions. Based on the visitatie report the Specialists' Registration Committee decides on prolonging the teaching status (Van Gennip 2002:212).

The Care Institutions Quality Act (Kwaliteitswet Zorginstellingen) laid down the responsibilities of health care providers and the State Inspectorate of Health for quality of care. Health care institutions should provide justified care that should be effective, efficient and aimed at the needs of the patient, and they should systematically monitor and enhance their quality of care.

Within the framework of this act, hospitals introduced quality systems to set and maintain standards for quality of hospital care. In 1998 the 'Netherlands Institute for Accreditation of Hospitals' was established by the national associations of hospitals and by the national specialist

organisation. On a voluntary basis hospitals or hospital departments can be tested and accredited after a peer audit of their quality systems (Van Gennip 2002:212). The specialists are participants in this system, but hospital management is the party addressed and responsible. For judgement of the conditions for realising quality specialist care, the scientific associations of the different specialities developed a visitatie system for non-teaching specialist practices (Lombarts 2003). In this system the specialists are the party addressed and responsible, and hospital management only takes part in the visitatie by a team of peers, every five years. Both quality reviews of hospitals and specialist practices are not required by law and do not have formal consequences (yet).

Health insurance fund legislation: the Integration Act

The financial and organisational integration of specialists into the hospital organisation, was formalised by law in February 2000: the Integration Act.[6] The former act spoke of "medical aid, delivered by specialists". The Integration Act speaks of: "specialist care, provided by or on behalf of a hospital." This phrase gave the hospital a leading role in the provision of care, replacing the specialists role in the old act. A quotation from the Integration Act:

"Notwithstanding the responsibility of the board of directors of a hospital, the responsibility for the medical treatment and care of a patient in a hospital rests with the specialist. The specialist will obey the organisational and financial framework recommended by the board. The board will obey the framework of specialist care recommended by the specialists. The hospital board will consult the specialists before negotiating with insurers." (Integration Act; translation by KK).

The Integration Act formalised the Biesheuvel recommendation about the hospital board becoming the party to negotiate with insurance companies, and the specialists working in hospital being bound to the outcomes of these negotiations and to agreements worked out in hospital.

2.5.2 The health care system

The funding of the health care system is largely based on social and private premiums or contributions of employers and employees, and of individual policy-holders. The government only contributes a small amount of money from taxation. About 7% of the total account in health care is paid for by the patient 'out-of-pocket', about another 7% is paid for by the government, about 15% by private health insurance, and about 70% is covered by social health insurance premiums (Scheerder 2002:203).

Although government is only a small financier, it regulates health care finances quite firmly in a variety of ways. The government yearly sets the national budget for health care. Furthermore the government regulates the spending of this budget in detailed legislation on planning and building, and on pricing and tariffs. The National Health Tariffs Act was implemented in 1982, to regulate and control costs. The National Health Tariffs Authority controls if the parties in health care follow the recommendations of the law, and it sets the guidelines upon which insurers and providers can base their negotiations for budgets and tariffs. The golden rule used to be 'budget is budget'. If the hospital overspended, it was left with a negative reserve that had to be paid back the next year (Scheerder 2002:200-205). The golden rule still applies to the national budget for health care, but at a local level hospitals, specialists and insurers are now allowed more flexibility. Since 2000 the local parties are free to apply the *pay on the nail principle* for some categories of patients and diseases. Following this principle the actual number of patients treated in one year defines the reimbursement by insurers, and this reimbursement is not limited in a budget. Between 2000 and 2002, this resulted in a serious increase of expenses in health care (Schut 2003).

General practitioners are the 'gatekeepers' of the curative sector in Dutch health care and insurers will only accept patients visiting a specialist when they were referred by their GP (except in case of emergency of course). In the Dutch primary care system, every citizen is enlisted in the practice of a general practitioner.

6 The 'Integration Act' formally is called: 'Act of 24 December 1998 to amend the Sickness Fund Act and the Social Health Insurance Access Act in connection with the introduction of entitlement to specialist care provided by or on behalf of a hospital'. The act was brought into force on 1 Februari 2000.

7 In Dutch: " het boter-bij-de-vis principe"

The financing system of function based budgets and tariffs is planned to be replaced gradually, starting in 2005. The new arrangements create a system for output pricing that includes the costs of specialists. The system is based on Diagnosis and Treatment Combinations (DTC; Diagnose Behandel Combinaties, DBC's), which are a more detailed kind of Diagnosis Related Groups (DRG's). A Diagnosis and Treatment Combination is the whole of the hospital and specialist activities and services arising from the demand for care with which a patient consults a specialist in a hospital. Thus the DTC-price, to be negotiated locally by insurers and hospitals, will include both hospital costs and specialist fees. The income for self-employed specialists now is a product of formulas for the distribution of the lump sum remuneration that hospitals and insurers yearly agree on. The way the specialist fees should be incorporated into the DTC's, and the hourly specialist wages that should be taken into account in the DTC-formulas, were subjects for intense discussions and negotiations between the national specialist organisation and the government during the period of this study.

The new arrangements for the financing of hospitals and specialists are part of major changes in the organisation of Dutch health care, under discussion since 1974. The current cabinet (Balkenende-II) wants to put an end to the division between social health insurance and private insurance. In the new system, that is planned to come into effect in 2006, every citizen will have general insurance. The basic package of this general insurance will be a responsibility of the state. Insurers will purchase patient care from providers on behalf of their insurants. The new system will introduce market forces, by having insurers compete with each other, and by having providers compete with each other.

A new health care system is necessary, among other things, to bring Dutch health care into line with European regulations (Raad voor de Volksgezondheid en Zorg 1999).

2.5.3 Hospital - specialists relationships

The sector of general hospitals receives almost 20% of all health care insurance contributions in the Netherlands.8 The hospital sector, like other health care sectors, are characterised by strong interdependencies between public, private and professional aspects, and this makes a hospital a "hybrid organisation" (Putters 2001:447): hospitals are private, non-profit organisations (usually foundations), serving public goals. The doctors in Dutch hospitals, although integrated under the Integration Act, still have an autonomous position, both professionally and organisationally.

Hospital structures and specialist participation

The traditional hospital structure of departments, based on organisational processes (clinical department for inpatient wards, outpatient department for outpatient wards, etc.), gradually makes way for the modern structure of organisational units centred around specialities or patient care processes. In 1999 40% of the hospitals still had a traditional structure (Van Lindert et al. 1999), and in 2002 this percentage was brought down to 24% (Van Lindert et al. 2003). Bigger hospitals more often have a modern structure than smaller ones. Modern structured general hospitals on average hold 600 beds, traditionally structured hospitals on average hold 450 beds (Kruijthof 2003).

About 80% of the specialists work in hospitals that have introduced management functions for specialists. Most of these functions are at unit and division level (Kruijthof 2003, Versluis and Hesselink 1993:91). Often specialist managers occupy these positions for a limited period, balancing between a period long enough to gain sufficient knowledge to effectively exercise managerial influence, but not beyond the length in which alignment to managerial power distances the specialist from other physicians (Ong and Schepers 1998).

Specialists are also involved in the hospital organisation by being members of committees. About 70% of all specialists sit on a hospital committee (Kruijthof, 2003).

8 The 2004 estimate of the Ministry of Health, Wellfare and Sport allocates almost € 8,5 billion of insurance contributions to the general hospitals and the specialised clinics. The eight university hospitals take about € 2,5 billion. The amount for all parties in the curative sector is € 17 billion and the total budgetary framework for health care covers about € 44 billion.

Self-employed and salaried specialists

Many hospitals house self-employed as well as salaried specialists. Sometimes even different specialists of one speciality are paid in different systems, but usually a monospeciality group is either a partnership of self-employed specialists or a speciality group of salaried specialists employed by the hospital. In 2003 71% of the specialists working in general hospitals were self-employed, 24% were employed by hospitals and 5% had a mixed arrangement (Kruijthof 2003, Van Lindert 2003). The relationship between a salaried specialist and the hospital organisation is formalised in a labour contract. Self-employed specialists have an individual contract with the board of directors, an individual permit to establish a practice in hospital, based on the national model for this permit, which protects the entrepreneurship. Theoretically the labour contract creates a hierarchical relationship between the salaried specialists and hospital management. In practice this relationship is hardly claimed by hospital management. The salaried specialists seem to benefit from the position of the majority of self-employed specialists (Van Lindert 1999).

The specialist staff

The specialist staff, usually having the legal structure of an association, negotiates for its members' collective interests with the hospital board. The staff formally is the partner of the board of directors when it comes to hospital policy and management, in conformity with the specialist staff document. However, Scholten and Van der Grinten (2003) explain that the specialist staff in the long run can hardly be expected to be a partner in hospital policy and management. The staff board members, the staff's representatives, do not have enough freedom of decision, continuity (time), and managerial skills to participate fully in decision making about hospital policy. Besides, staffs have formally regulated their internal decision making processes on democratic principles, although in practice the principles of egalitarianism and informality seem hard to get rid of. Decision making by consensus is still the favourite method, causing the staff agenda to be dominated by non-controversial issues and a defensive attitude towards outside initiatives. These aspects often make members of staff boards focus on participation in hospital decision making in itself, rather than on the content of long term hospital policy and management (Scholten and Van der Grinten 2003).

Because of the importance of lump sum negotiations, the self-employed specialists in a hospital often organise their own interests apart from the specialist staff. In 60% of the hospitals the self-employed specialists have established a staff partnership (Van Lindert 2003).

Are specialists now integrated into the hospital?

Hospital - specialist relationships might be considered to know three stages over time (Miseré 1997:33, stages based on Nelson and Burns 1984). The period of the fifties and sixties reflected the stage of co-existence, when hospitals and specialists were connected in an organisationally loose way. From the seventies the financial scarcity forced specialists and hospitals into a stage of dialogue and co-operation. In the nineties specialists' financial arrangements were integrated into hospital arrangements, and specialists' formally entered hospital management. This may be considered to be the stage of integration.

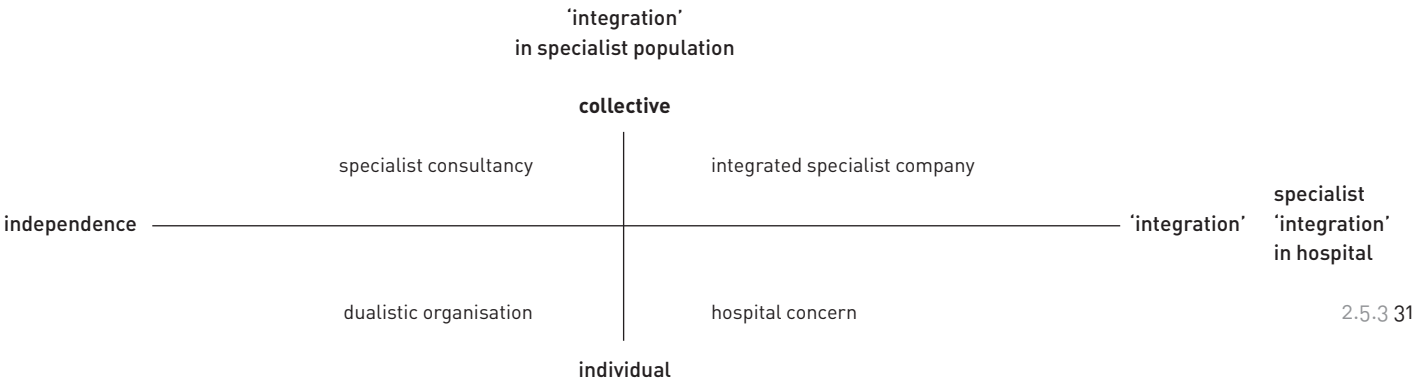
Specialists do not only have relationships with the hospital, they also have a relationship with the specialist staff. A combination of specialist - hospital relationships and specialist - staff relationships can be visualised on two axes (see **figure 2.1**). The vertical axis reflects the internal integration within the specialist population of a hospital (soloist and individual below; collective above). The integration of the specialists into the hospital organisation is put on the horizontal axis (independence left; integration right) (Plochg 1998).

The four quadrants reflect four models for specialist and hospital relationships. First, in a 'specialist consultancy' specialists get together in business, independent from the hospital organisation. Second, the 'dualistic organisation' is the system where most hospitals and specialists come from: specialists work individually, maybe organised in partnerships and speciality groups, but hardly in a specialist staff, and they are not involved in the hospital organisation. Third, in the 'hospital concern' the specialists are employees of the hospital, not or hardly organised in a mutual staff structure. And fourth, the 'integrated specialist company' is the model specialists and hospitals are supposed to create. Specialists are organised in a specialist staff and their practice is integrated in the total of the hospital company.

In terms of this picture most specialists and hospitals in

the Netherlands may seem to have entered the stage of integration in the variant of the integrated specialist company: specialists are collectively organised in specialist staffs and staff partnerships, their finances are linked with the financial arrangements of the hospital company, and they are involved in the hospital organisation by management participation and hospital committees. It seems the picture of the integrated specialist company is realised, at least in its organisational structure.

Figure 2.1: Four variants of integration



(Plochg 1998; translation by KK)

Different parties, however, (for instance self-employed specialists, salaried specialists, and hospital managers) still have different interests, which makes the topmost structure of the hospital a negotiated order in itself (Scholten and Van der Grinten 2003): the specialist staff wants its interests to be represented at the top, and it wants to influence hospital policy; the hospital board wants the specialist staff to be a partner in decision making about hospital policy. The self-employed specialists have strengthened their collective power in hospital. Seen from the top, this has actually restored the dualistic organisation, with much more integration and organisation within the specialist staff this time (Scholten and Van der Grinten 2000).

The integrated specialist company seems to have brought a functional integration rather than an economical one, and it certainly brought the communication between hospital management and specialist staff into a context of contracts, regulations and agreements. More appropriate than the term 'integrated specialist company' might be the term 'regulated specialist arena' (Schaaf 2000:257). Some authors even suggest the present situation should be designated as separation rather than as integration (Scholten and Van der Grinten 2002).

Nevertheless, specialist - hospital integration, at least in terms of specialist participation in management, and in terms of connected financial arrangements, is a fact. About 80% of the specialists work in hospitals with formal specialist positions in management, which means the dualistic organisation in its original form is gone. Specialists are not subordinate to hospital management, which means present hospitals do not match the picture of the hospital concern. At the moment, they are not leaving hospitals to start specialist consultancies either. Thus, present hospitals in the Netherlands can safely be regarded as integrated specialist companies. This does not mean interests are integrated as well. Different interests bring dualistic elements in the integrated structures.

2.6 The international context

The structural context "in the largest sense" (Strauss 1978:98) requires an outline of the international context, to enable foreign readers to distinguish the elements in this study that might be of value outside the Netherlands.

Hospitals are strategic subjects for making cross-national comparisons that reveal the surrounding social institutions (Glaser 1970:5). Nevertheless, the scope of this thesis only permits a superficial outline. The following paragraphs will address characteristics of health care and hospitals, and developments in health care and hospitals. The last paragraph will put the research theme in an international context. The international perspective is limited to western Europe and North America.

Characteristics of health care and hospitals

The Dutch health care system is largely financed by social insurances, combined with a small private segment. This is a variant of the 'Bismarck model'. Other variants are found in Germany, most German-speaking countries, France and Belgium. The United States' system is based on insurance as well, but with a larger private component than in Europe. The most important alternative for this system is a tax-based structure known as the 'Beveridge model', named after the creator of the National Health Service in the United Kingdom. Variants are found in Scandinavian countries, southern Europe, and Canada (Smith 1992).

The 'gatekeeper' role of general practitioners, with the majority of citizens enlisted in one of the GP practices, is an important feature of Dutch Health care. It is found in the United Kingdom, Denmark and Norway as well (Boerma 2003). In other countries, for instance Belgium, Germany, Switzerland, Sweden, and the United States, patients are free to choose whether to visit a general practitioner or a specialist. In Germany the primary care sector is composed differently to other countries, because internists, paediatricians, and gynaecologists belong to this sector too. This causes relationships between primary care and hospitals to be different to other countries (Ankoné 2000).

Dutch hospitals are 'closed', the patients are taken care of by one of the specialists of the hospital's staff, and outside specialists cannot admit patients. Specialists are usually on the staff of one hospital only, at most of two hospitals. About 15% of the specialists in general hospitals work in more than one hospital (Kruijthof 2003:50). Also in the rest of Europe a permanent staff generally provides care. In the United States hospitals are 'open', which means physicians usually follow their patients into the hospital, where they continue to attend them (Tap and Schut 1987).

Specialist treatment of ambulatory patients is fully integrated in the hospital services in the Netherlands, while in some other countries outpatient departments for specialist care exist outside hospitals.

The self-employment of the majority of Dutch specialists is different to most other countries in western Europe (except Belgium and Luxembourg), and it causes the specific dual characteristics of Dutch hospitals (Lindert et al. 1999). The duality puts the specialists on one side, responsible for the clinical processes, self-employed, horizontally and collegially organised in partnerships, and the hospital organisation on the other, responsible for the organisational support and human resources, with a salaried workforce, vertically and hierarchically organised.

'Integration' and 'management participation' were established in the Netherlands to decrease the impact of the dualistic elements. Comparable structures are found in Belgium since the 1986 Amendment on the Hospital Act that provided hospital decision-making with a compulsory, detailed enquiry procedure between hospital board and physicians. In practice this decision-making model is often esteemed to consolidate duality rather than enable integration, and the discussions seem to be limited to contributions towards expenses (Eecklo et al. 2002). Self-employment of Belgian specialists is combined with a financing system on the base of fee-for-service both for specialists and hospitals. This makes both parties have interest in working efficiently. It also causes hospitals and specialists to compete for patients more than in the Netherlands (De Brauw 2003).

Self-employment of specialists is found as one of many different physician practice forms in the United States as well, where all kinds of variants result from combinations of fee-for-service or salaried arrangements, and of different relationships between specialists and hospitals, outside or within the contexts of health maintenance and managed care organisations (Kelley 1999).

Developments in health care and hospitals

Most western countries have similar elements in the recent history of hospital and specialist care, with an emphasis on cost containment as a reaction to spiralling health care costs since the eighties, and a shift of attention to cost-effectiveness since the nineties (Ong and Schepers 1998, Busse and Schlette 2003). These developments confronted hospitals in many countries with organisational changes. Two forms of changes occurred, and still occur, in the majority of hospitals in the United States, Canada, and increasingly in hospitals in Europe (Aiken and Sloan 2002). The first concerns system changes involving hospitals, leading for instance to multi-hospital alliances and mergers, vertical and horizontal integration of services and the creation of integrated delivery systems, joint purchasing, outsourcing management and similar reforms. United States hospitals for instance have developed a variety of structural arrangements to deal with managed care, which is an organised system of health care delivery, designed to control costs and quality. The structural arrangements are usually called "organised delivery systems", and if hospitals try to align physicians in these systems this is referred to as "vertical integration" (see for instance Burns et al. 2001).

The second form of changes is focused on internal hospital restructuring, known as "process re-engineering", changing the design of clinical care and the relationships between carers.

Both forms of changes are often combined with an increasing participation of doctors in hospital management (Guthrie 1999, Succi and Alexander 1999). Ong and Schepers (1998) compared the UK with the Netherlands in this aspect. They found doctors in both countries increasingly taking a lead in guiding management decisions about service developments and clinical quality. In the UK this development took place in the context of "clinical governance", while in the Netherlands the input of doctors was embedded in new alliances between physicians, hospitals and insurers. On the theme of power in hospital, they found a shift towards decentralised units and specific spheres of influence such as investment committees in both countries. This created a reframing of physician power within the broader domain of managerial power, "whereby the interdependence of the medical and management paradigm is underlined". On the theme of the management participation model the UK presented the model of 'clinical directorates', drawing doctors into management below the board level in the majority of English hospitals since the nineties, but being questioned in terms of its flexibility. The Netherlands offered a wide variety of management participation models, with participation at different levels and with the emphasis sometimes shifting from changing structure to changing culture.

Ong and Schepers (1998) found a "reframing" of physician power. Davies and Harrison (2003) mention "undermining". They explain the organisational changes in hospitals in "developed liberal countries" are connected with three trends that affect physicians. First, physicians' knowledge is subject to increasing "systematisation", for instance through methods that measure physicians' work for managerial purposes such as case-mix measures for Diagnosis Related Groups or variants (United States, United Kingdom, Germany, Australia, and the Netherlands). Systematisation of knowledge is also related to making and using clinical protocols or guidelines, and to designing and using "patient pathways". Second, the financial and other incentives offered to doctors get a lot of attention, and especially the arrangements of managed care are introduced in many countries. Third, state regulations regarding physicians' practice are changing. Governments for instance aim to reduce the supply of doctors (Germany, France, Italy), aim to reduce the near-monopoly of the institutions of physician registration (United Kingdom, Belgium, Spain), or aim more directly at modifying clinical practice, for instance by introducing compulsory clinical audit, publishing league tables of hospitals and clinic performance indicators (United Kingdom, United States, Germany and Belgium). These developments have "undermined, constrained, or curtailed" professional dominance and autonomy (Davies and Harrison 2003, Harrison 2004:57).

An international perspective on this study

This study is situated in the Dutch health care context, which has characteristics that differ from other nations' contexts. Despite the contextual differences, the study addresses themes of international relevance, since the developments mentioned earlier affect specialists and specialists' workplaces in many countries. The developments at least cause a "reframing" of physician power, and maybe even an "undermining" of physician dominance. Relationships and balances in hospitals are changing in many nations. This

thesis provides a framework for describing these changes in terms of changing negotiated orders. It analysed specialist work in terms of negotiations for jurisdiction and reveals the jurisdictional claims specialists make in the workplace.

The features of specialists' negotiations for jurisdiction in the workplace may be more universal than the features of health care contexts, because specialists' work processes are more universal than health care systems. This makes the results of the study partly applicable to specialists in other countries as well.

Negotiated orders in specialist-hospital relationships change in many countries. This study will at least provide specialists, hospital managers, researchers, and policy makers in other countries with suggestions for analysis of their own negotiated orders.

2.7 Conclusion

This chapter should answer the question: "How did specialist work in Dutch hospitals develop over time, what is the present situation, and what are the main differences with other countries?"

The historical context provides physician specialists with ancestors. In the rise of the specialities three categories emerged. Medical specialists (for instance internists and cardiologists) originate from the doctores medicinae, and surgical specialists (for instance general surgeons and gynaecologists) from the surgeons. Specialities rose and developed from the end of the nineteenth century, following the increasing knowledge and technology that provided the roots of the third specialist category, the supporting specialists (for instance anaesthesiologists and radiologists). The formalisation of post-graduate training for specialists was accepted in 1931, and the national organisation of physicians established a national committee for keeping the register of qualified specialists in 1932. The increasing knowledge and technology that caused physicians to specialise, caused hospitals to modernise into centres for treatment. Specialists gradually replaced general practitioners in hospitals.

In the last twenty years of the twentieth century cost containment and scarcity drove specialists and hospital organisations closer together.

The present brings integration of specialist and hospital finances and participation of specialists in hospital policy and management. In 2000 the Integration Act came into force. It gave the hospital board the responsibility for all negotiations with insurers and it gave the specialists in a hospital the responsibility for establishing a framework for specialist care. By then, many hospitals had also decentralised their organisational structure into units based on specialities or patient processes, and introduced formal management positions for specialists. Hospitals in the Netherlands seem to have changed into 'integrated specialist companies'. The specialists are collectively organised in specialist staffs and staff partnerships, their finances are linked with the financial arrangements of the hospital company, and they are involved in the hospital organisation by management participation and in hospital committees. However, this is rather an integration of functional procedures than an integration of interests, for conflicts of interests continue at all levels of the integrated specialist company. Specialist and hospital functions and procedures are integrated now, specialist and hospital interests are not.

A comparison with other countries characterises Dutch health care by strong interdependencies between public, private and professional aspects. The funding of Dutch health care is mainly based on social insurances ('Bismarck model'), and general practitioners are the 'gatekeepers' of the curative health care sector. Dutch hospitals are closed, meaning a permanent specialist staff takes care of patients, and ambulatory specialist care is part of specialist care in hospital. The majority of Dutch specialists in general hospitals are self-employed. These system characteristics create differences between the Netherlands and its international context of countries in western Europe and North America. However, recent history has brought similar developments in different countries, with changes in health care structures that affect the organisation of hospital and specialist care in most nations. Relationships and balances in hospitals are changing, which means negotiated orders are changing.

References Chapter 2

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3 The research framework

3.1 Introduction

One theoretical perspective chosen for this study takes specialists to be 'professionals' and their occupation in medicine to be a 'profession'. A second theory is the concept of 'negotiated order', which will help in defining specialists' jurisdictional claims.

These two basic theories result from the exploration of theories, which will be reported on in paragraph 3.2.

Paragraph 3.3 explains what kind of work professional work is and paragraph 3.4 discusses the relation between professional work and its context. Paragraph 3.5 presents the theory of negotiated order and explains why jurisdictions are negotiated orders.

These three paragraphs provide the ingredients for the research framework that is set out in paragraph 3.6.

Paragraphs 3.3, 3.4 and 3.5 concern professions in general, although some examples come from specialists working in hospitals. The framework in paragraph 3.6 focuses specifically on specialists.

3.2 A journey through theories and concepts

Since specialists' occupation belongs to the professions, choosing theories about professions and professionals was easy. These were studied to find the concepts for analysing specialists' work in the first place. The concepts will be discussed in paragraphs 3.3 and 3.4.

Finding the appropriate concepts for analysing jurisdiction, especially in its relationship with specialists' work in hospitals, was more difficult. Many different angles seemed to be available; a few of which will be discussed here.

Parties in a (loosely coupled) system

Jurisdiction is an issue in hospitals, because specialists are not the only group working there. Other groups are residents, nurses, assistants, technicians, cleaners, managers, etc. The different groups make a hospital organisation a conglomerate of parties rather than a social and cultural system (Lammers et al. 2000:514-5). Like educational organisations, hospitals might be considered to be "loosely coupled systems" (Weick 1976, Tap and Schut 1987): the elements in the organisation are responsive, but each also preserves its own identity and some evidence of its physical or logical unity. "Loose coupling also carries connotations of impermanence, dissolvability, and tacitness" (Weick 1976).

The "loosely coupled" specialist groups in hospitals might be considered to be a transactional network (Moen and Abma 1992).

Glouberman and Mintzberg (2001) even see four different worlds in hospitals. The world of cure (physicians), the world of care (nurses), the world of control (managers), and the world of community (trustees). "The hospital ends up being not one organization but four, as each part structures itself in an independent way."

In short, "a hospital consists of variegated workshops - places where different kinds of work are going on, where very different resources (space, skills, ratios of work force, equipment, drugs, supplies, and the like) are required to carry out that work, where the divisions of labor are amazingly different, though all of this is in the direct or indirect service of managing patients' illnesses." (Strauss et al. 1985:6)

Making sense of means and ends

Groups in hospitals converge on issues of means rather than on issues of ends. "Individuals come together because each wants to perform some act and needs the other person to do certain things in order to make performance possible. People don't have to agree on goals to act collectively" (Weick 1979:91). Thus, different groups, although agreeing on means, may have different goals and different perspectives for making sense of everything that goes on in organisations (Weick 1995). Jurisdiction might be related to the concepts of means, ends and sense making.

Power

Professionals distinguish themselves from other groups in hospitals, among other things because of autonomy and self-control (Hulst and Schepers 1999, Flynn 2004:16), which renders them power in relations. Power is a property of relationships between people, "the capacity to get decisions and actions taken and situations created which accord with, and support, one's interests." (Dawson 1996:169).

Perrow (1963) suggests that "over the long run, an organization will be controlled by those individuals or groups who perform the most difficult and critical tasks. The characteristics of this dominant group (social background, career, ideology or point of view, personal interests, and so on) will determine major operating policies and thus organizational goals." So, finding out who performs the most difficult and critical tasks in hospital may reveal the distribution of jurisdiction. Perrow's analysis was indeed "over the long run", since it was an historic study of control in a hospital. For a study of a shorter time span this approach might be less appropriate.

Some sources of power might be observed in practice: formal position in organisation, personality and personal features, expertise and skill, and informal position or position in decision-making (Koopman and Pool 1992). Of course the concept of power can be used in combination with other perspectives, for instance decision making (Pfeffer and Salancik 1974).

Thus, power is a property of relationships, partly defined by several sources of power.

Culture

Processes of power and influence are strengthened or weakened by symbolic action, for instance language and ceremonies (Pfeffer 1991), which means concepts of organisational culture may add important possibilities in analysing jurisdiction in hospital (Van Hoewijk 1988, Sanders and Neuijen 1988). At every organisational level, culture is a pattern of basic assumptions and beliefs that are shared by a given group because it "has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems" (Schein 1985:9). Thus, the different parties in the hospital system might all have different beliefs about work and jurisdiction.

Professional bureaucracy or organised anarchy

The processes discussed so far take place in hospitals, which are organisations that Mintzberg called professional bureaucracies (Mintzberg 1983:189-213). The techno-structure and middle line of management can do little to co-ordinate the operating work, which makes the professional bureaucracy a highly decentralised structure. This concept takes us back to the special features of professions and professionals, since "not only do the professionals control their own work, but they also seek collective control of the administrative decisions that affect them" (Mintzberg 1983:197). How are these administrative decisions made? Organisational decision making tends to be irrational (Brunsson 1982). Hospitals might be considered organised anarchies, since they are characterised by problematic preferences (the set of preferences is rather a loose collection of ideas than a coherent structure), unclear technology (its own processes are not completely understood by its members), and fluid participation (involvement varies) (Cohen et al. 1972, March and Olsen 1976, Hood 1999). Decision making in organised anarchies follows the garbage can model, in which a choice situation is seen as a garbage can: "a meeting place for issues and feelings looking for decision situations in which they may be aired, solutions looking for issues to which they may be an answer, and participants looking for problems or pleasure." (March and Olsen 1976:25).

Thus, finding out how specialists manifest jurisdiction might be supported by finding out how decisions are made in professional bureaucracies or organised anarchies, for instance by analysing decision making with help of the garbage can model.

Negotiated order

In theories on dynamic systems, organisations are always in between stability and instability. Chaos and order are not opposite, but next to each other (Boonstra 2000). Nevertheless, human beings in general don't like chaos and prefer order. Strauss et al.(1973) suggest order is kept by continuous reconstitution of the basis of concerted action in organisations, the agreements and contracts that give us "an expectable, non-surprising, taken-for-granted, even ruled orderliness".

This process of reconstitution takes place in negotiations, which can have many different forms, either coercive in nature or happily co-operative (Strauss et al. 1985:267). Especially in "loosely coupled structures" there may be

increased pressure on members to construct or negotiate a social reality (Weick 1976). The social order that results from these continuous processes is a negotiated order. Game theories may support understanding negotiations (see for instance Dowd 2004, Holt and Roth 2004).

The most suitable concepts

The theories and concepts given in this paragraph create too wide a framework to make sense in fieldwork. The core concepts were selected by following the inspiration and motivation for the study, which was the "theme of jurisdiction, not in its policy context of national decision making and legislation, but in its practical context of specialists' work in Dutch hospitals". Because of the importance of the practical context at least a part of the data had to be found there. Therefore the concepts should be suitable for qualitative methods in observations and interviews (Chapter 4 will discuss the methods).

The central theme of jurisdiction in specialists' work led to choosing concepts from theories about professions and professionals, since these theories enable the research to take work itself as a starting point. Specialists belong to a profession, which is an occupational group that has a more or less exclusive work dominion of abstract knowledge and specialised skills (Abbott 1988, Freidson 2001, Schriesheim et al. 1977). Because of the exclusivity, professions claim control of their own work. This gives the link between a profession and its work a special importance: professional work is linked to professional control, autonomy, authority, and right of say. Abbott (1988:59) takes these aspects together by stating that a profession and its work are linked by 'jurisdiction'. Professions make jurisdictional claims in the arenas of the legal system, public opinion and the workplace (Abbott 1988:59-60). This study focuses on the jurisdictional claims specialists make in the workplace of the hospitals, and their work will be analysed using concepts from theories about professions and professionals.

Specialists will probably hardly voice their jurisdictional claims explicitly. Therefore, the theory about negotiated order was chosen to be the most suitable framework for understanding the dynamics of jurisdictional claims. Claiming jurisdiction only makes sense when having jurisdiction is not completely self-evident. Specialists make their claims in relationships with other persons or parties who may claim jurisdiction as well. Analysis of these dynamics needs a model for understanding interactions between persons and parties in a social constellation. The theory on negotiated order provides such a model. Besides, it can be used for analysing situations (negotiations) in the practical context of specialists' day to day work. Thus, this study exposes the jurisdictional claims specialists make in their work by analysing the negotiations that define specialists' negotiated order.

All other theories discussed in this paragraph may add ingredients to understanding specialists' work and their jurisdictional claims. The main research framework, however, considers specialists to be 'professionals' who work in 'negotiated orders', where they make 'jurisdictional claims' in relationships with persons or parties around them.

The following paragraphs will first outline the concepts of the research framework, found in theories about professions and professionals, and in theories about negotiated order. Then paragraph 3.6 combines these concepts in the research framework.

3.3 Professional work

A professional in the context of this study is not someone who makes a living in sports or someone who is just good at his or her job or hobby. A professional, in this thesis, is a member of a profession, which is an occupation with specific features. First of all professional work is based on a body of knowledge that is strongly structured and expected to give results that are more made to measure than routine. Van Delden (1995) compares professional work with other kinds of work in **table 3.1**.

Table 3.1: Nature of results of work and structure of knowledge

	structure of knowledge weak	structure of knowledge strong
results easy to specify (routine)	CRAFT - drawer - planner - administrator	KNOWLEDGE WORK - calculator - laboratory worker - programmer
results hard to specify (made to measure)	ARTS - designer - writer - actor	PROFESSION - architect - researcher - physician

(Van Delden 1995:13; translation by KK)

Second, professions are occupations with an exclusive social and legal position, which they acquire when they can convince the public their services are trustworthy. To gain public trust they should not only perform technically competent, high-quality work, but also prove they adhere to a service ideal. Devotion to their clients' interests will guide their decisions more than personal or commercial profit, when the two are in conflict (Wilensky 1964).

Table 3.2 enumerates the features of professions showing up in most definitions. Abbott (1988:8) describes professions simply in one sentence: "exclusive occupational groups applying somewhat abstract knowledge to particular cases."

Table 3.2: Features occurring in most definitions of professions

1. "specialized work in the officially recognized economy, that is believed to be grounded in a body of theoretically based, discretionary knowledge and skill and that is accordingly given special status in the labor force;
2. exclusive jurisdiction in a particular division of labor created and controlled by occupational negotiation;
3. a sheltered position in external and internal labor markets that is based on qualifying credentials created by the occupation;
4. formal training program lying outside the labor market that produces the qualifying credentials, which is controlled by the occupation and associated with higher education; and
5. an ideology that asserts greater commitment to doing good work than to economic gain and to the quality rather than the economic efficiency of work."

(Freidson 2001:127)

What do professionals do then, applying their somewhat abstract knowledge? Professional practice contains three acts (Abbott 1988:40-52). The first act is getting to know the particular case they're dealing with. They have to classify the problem in question. This is the 'act of diagnosis', a mediating act, bringing specific information into the professional knowledge system. The act of diagnosis requires two processes. The process of 'colligation' is getting a 'picture' of the client and applying the rules for finding relevant and valid evidence about the problem in question. The process of 'classification' brings the picture into the dictionary of problems known to the profession. The act of 'diagnosis' removes clients' extraneous qualities, assembles their relevant needs into a picture and then places this picture in the proper diagnostic category (ibid: 41).

The second act is taking action, the 'act of treatment'. Treatment, like diagnosis, is an intermediating act, taking instructions out of the professional knowledge system. Treatment also has a classification system that categorises the various possible treatments. Its results are brought back to the client in a brokering process. "Just as the diagnostic system removes the human properties of the client to produce a diagnosed case, so also the treatment system must reintroduce those properties to make treatment effective for real clients" (ibid:46).

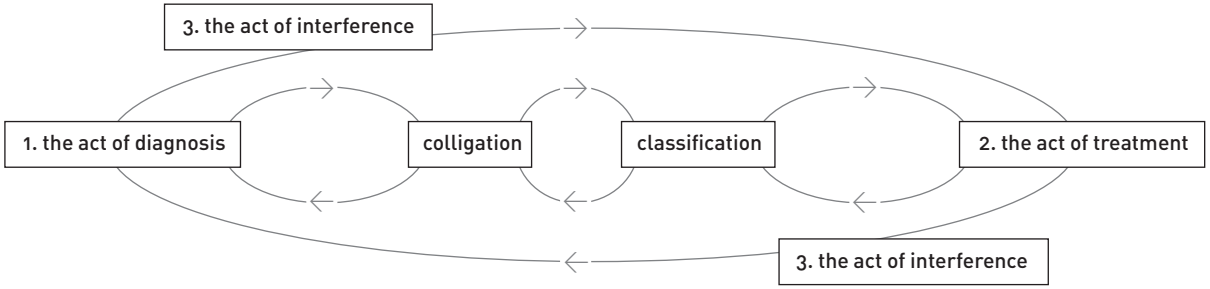
The move from diagnosis to treatment is not necessarily one-way. Thinking and reasoning about this, is the 'act of inference', not a mediating act but a purely professional one. Inference is the middle game that relates professional knowledge, client characteristics, and chance in ways that are often obscure (Abbott 1988:48). It is more important when these connections are unclear. In general inference can work by exclusion or by construction.

Professionals can reason by exclusion when they get second chances, gradually ruling out areas by special diagnostic procedures. In the medical profession gradual exclusion is quite often applied. When costs of failure are low, physicians will prescribe the most likely treatment and see what happens. They have to reason by construction when the number of chances is limited, maybe even one chance only, for instance when a patient is in a precarious condition. Inference then focuses on the odds of success or failure.

Inference makes physicians organise and communicate their interpretative work through the telling of stories. "Knowing the patient's story" is important and students are encouraged to develop their storytelling abilities (Tanenbaum 1994). Inference and storytelling are related to professionals' self-management, because professionals "learn to proceed one step at a time in their tasks, and at each step, they stop to inquire about their own progress. This is the essence of self-management." (Raelin 1985:204)

The professional acts are taken together in **figure 3.1**. Every arrow reflects the act of inference.

Figure 3.1: The professional acts



(Abbott 1988; picture by KK)

The sequence of the acts is not necessarily always the same, neither are the acts performed completely separately. Professionals often take them together, or combine them. As explained before, diagnosis by treatment is quite common in the medical profession (Abbott 1988:49).

3.4 Professions and professionals in their context

Summarising the essentials discussed so far, professionals belong to "exclusive occupational groups applying somewhat abstract knowledge to particular cases". They deliver made to measure services to individual clients and their work for

clients is defined by the acts of diagnosis, treatment, and inference. In these processes, the clients' problem is being translated into professional categories (diagnosis), dealt with (treatment), and reasoned about (inference).

This paragraph describes professions and professionals on the levels of society, organisations, groups and individuals.

Professions in society

In the eighteenth century, Smith opposed monopolies of occupations in The Wealth of Nations, but he granted professions the right to regulate their own entrance and competition in order to guarantee professionals adequate reward, because we "trust our health to the physician; our fortune and sometimes our life and reputation to the lawyer and attorney. Such confidence could not safely be reposed in people of a very mean or low condition. Their reward must be such, therefore, as may give them that rank in the society which so important a trust requires." (Smith, quoted in Dingwall and Fenn 1987)

The trust society grants professions must not be damaged. To this end the professions need to regulate their practices in a system of entrance control, specialised education, ethical codes and disciplinary law (Schepers and Klazinga 1993; De Swaan 1996:241). Public trust also requires accountability. Physicians for instance, need to develop mechanisms for justifying the way they practise their profession (Hulst and Schepers 1999, Lombarts 2003, Van Herk et al. 2001). Physicians in western societies seem to develop and maintain these mechanisms by having their own organisations on national level continuously focusing on control and improvement of education and practice (for instance Committee on Quality of Health Care in America 2001; Metz 2001; General Medical Council 2003). Although relationships between physicians and governments are different in different countries (De Swaan 1996:247, Lanier et al. 2003), medical umbrella organisations in every nation co-operate with governments, being granted exclusive rights to practice patient care under self-regulation and professional control.

Thus, contracts are made between professions and societies. Professions get public trust and exclusive rights in return for quality professional work and accountability.

Professionals in organisations

Professionals in organisations need to have freedom to develop and use the expertise and judgement, which account for their recruitment, but also need to be aligned to the rest of the organisation they work in (Dawson 1996:35). Therefore an organisation with professionals by definition holds a dilemma between the autonomy of the professionals and their coherence with the organisation (Van Delden 1996:118), in which its managers represent the organisation.

Freidson (2001) discusses and analyses this dilemma, defining three logics for control of work in organisations. When the managers are in control, this is the logic of bureaucracy or managerialism. The consumers play the leading role in the logic of free market or consumerism. The third logic brings control in the hands of occupations and their members, which is called the logic of professionalism (Freidson 2001:179). None of these three models exists in pure format in real life. Finding the optimum composition is an important policy issue.

The three logics for control of work may be combined with three modes of governance in the medical profession (Gray 2004:4-5). In the 'command mode' of governance a sovereign body provides the rule of law and governance is delivered through a scalar chain of superior and subordinate authority. The 'communion mode' of governance is based on common values and creeds. In the 'contract mode' of governance parties agree on an inducement-contribution exchange.

Professional work needs organisations, for instance because of economy of scale and concentration of technology (see Chapter 2 for the rise of the modern hospital). But organisations themselves might be considered threats to professionalism, for they seem to provide an alternative (Abbot 1988). In the profession of physicians for instance, the phenomena of specialisation and division of labour force professionals to work in teams, which are organisational structures encoding professional knowledge. These and other organisational structures could provide rules and arrangements, largely connected to managerialism, which might replace professionalism.

The introduction of professionals more or less openly identified as 'professional administrators' might connect with this gradual replacement.

These developments together might gradually draw professionals into the organisations, "where they become well-paid workers of high status who exercise a relatively large degree of independence, but only within boundaries, channels, and goals carefully established by their employers." (Freidson 2001:210). At present however, professionals still distinguish themselves from "well-paid workers" in claiming and being granted privileges and the right of autonomy (Van Oorschot et al. 1995:15). The contract giving a profession self-regulation on society level holds on organisational level as well. Professional autonomy makes individual professionals base their decisions on internalised norms and expert knowledge and it implies their work is only subject to evaluation by peers (Van Herk 1997, Flynn 2004:16). Autonomy for specialists means they are free to decide on the content and practice of work and on the way they control the quality of practice (Van der Wee 2000:78).

Professionals in groups

From the perspective of professionalism on the level of societies and organisations, professionals have to protect and regulate their occupation together, among peers.

Medical school, internships and residencies provide the environment for gaining skill and learning the attitudes that are considered appropriate to the profession. Through this process of socialisation or professionalisation, students and young doctors acquire a professional identity (Shapiro et al. 1988), which gives professionalism a second definition, on the level of groups and individuals: "the specific combination of knowledge, skill, temperament and ethos, necessary to function correctly within a certain profession." (Keizer 1997:280)

Professionals have a commitment to a subject matter, method of application and their professional peers, rather than to an organisation (Dawson 1996:35). They share work, practice, interests, professional membership and identity. This makes peer groups important starting points for professional life. Peers on all levels of aggregation also have to design and maintain regulatory systems for controlling each other. These simultaneous roles of peers cause dilemmas in shaping the mutual relationships in their groups. Two norms are important in defining colleague relationships (Wilensky 1964). 'Do what you can to maintain professional standards of work', which for instance makes professionals honour the technical competence of the formally qualified and which makes them avoid criticising colleagues in public. And 'Be aware of the limited competence of your own speciality within the profession, honour the claims of other specialities and be ready to refer clients to a more competent colleague.'

Traditionally, hierarchical structures within groups of professionals are not common, because of the importance of peers being equal. 'Egalitarianism' makes professionals favour equal individual positions in a group and dislike hierarchical structures in joint decision-making (Van der Wee 2000:78). On the other hand, other kinds of structures give different group members different group positions. The mutual honouring of professional status makes knowledge, skills and experience important personal features, and sources of power. Having secondary functions in education, research or in the system of self-regulation also renders individuals higher esteem than others.

Wilensky (1964) discusses professionals' tendency to protect their status by limiting their acts to their speciality and by referring clients to someone else if necessary. Nevertheless mutual referral is not always self-evident. Abbott (1988) reveals the 'system of professions'. Professions exist in an interrelated system in which they sometimes try to expand themselves at the expense of other professions. "Many occupations fight for turf, but only professions expand their cognitive dominion by using abstract knowledge to annex new areas, to define them as their own proper work." [..] "As is traditional, abstract knowledge is central. But the justification for it is new; knowledge is the currency of competition." (Abbott 1988:102)

Specialists in hospitals share two kinds of peer groups. In the sixties specialists of the same speciality working in one hospital started formalising their co-operation by establishing partnerships ('maatschappen'), in which they bundled their financial interests and the organisation of their practice (Klazinga 1996:82). Self-employed specialists are still organised in partnerships. Salaried specialists are organised in speciality groups. Both kinds of groups are speciality peer groups: groups of specialists sharing the same speciality.

A second peer group in hospital are the other specialists. In the Netherlands, all specialists in one hospital are members of the specialist staff, which is the formal organ that represents the specialists in hospital (Miseré 1997:24).

Individual professionals

In the heart of professions and of professional work, the individual professionals are the ones dealing with their clients and the particular cases clients bring. As explained in the former paragraph, becoming a professional is not only learning knowledge and skill, it is also learning how to think and behave as a professional, a member of a group that is trusted with specific rights and privileges. The context of professional work, discussed so far, makes the public and the media expect specific features from individual professionals. Doctors for instance are often assumed to have a vocation rather than a job, and thus trainees implicitly agree to long hours and self sacrifice when they become doctors (Falder 1998). From within the profession these implicit demands on individuals are gradually being questioned in most western countries. An editorial in the British Medical Journal in 2001, titled 'Why are doctors so unhappy?' (Smith 2001), gained a huge response, giving the impression that the pressure on individual professionals in medicine is becoming too big. Several articles discussing this impression point out the "change in the psychological compact between the profession, employers, patients, and society so that the job is now different from what doctors expected" (Edwards et al. 2002, Prins and Van de Wiel 2003). Smith (2001) mentioned the 'bogus contract' in the article this debate started with (**table 3.3**).

Table 3.3: Doctors and patients: redrafting a bogus contract

The bogus contract, the patient's view:
- Modern medicine can do remarkable things: it can solve many of my problems
- You, the doctor, can see inside me and know what's wrong
- You know everything it's necessary to know
- You can solve my problems, even my social problems
- So we give you high status and a good salary

The bogus contract, the doctor's view:
- Modern medicine has limited powers
- Worse, it's dangerous
- We can't begin to solve all problems, especially social ones
- I don't know everything, but I do know how difficult many things are
- The balance between doing good and harm is very fine
- I'd better keep quiet about all this so as not to disappoint my patients and lose my status

The new contract, both patients and doctors know:
- Death, sickness, and pain are part of life
- Medicine has limited powers, particularly to solve social problems, and is risky
- Doctors don't know everything: they need decision making and psychological support
- We're in this together
- Patients can't leave problems to doctors
- Doctors should be open about their limitations
- Politicians should refrain from extravagant promises and concentrate on reality

(Smith 2001)

Developing and maintaining professionalism, in the sense of keeping the combination of knowledge, skill, temperament and ethos up to date, requires continuous reflection. Schön (1983) puts the 'reflective practitioner' opposite the 'expert'. An expert is a professional with more or less static knowledge and skill, and without flexibility. A reflective practitioner is aware of new situations, adapts his or her attitude to different conditions, and evaluates his or her actions. Physicians who find themselves subject to a bogus contract might not have been able to cope with changing circumstances as reflective practitioners. However, a thorough analysis of this phenomenon in the medical profession or in other professions is not available yet.

Turning full circle by getting back to the level of society: the contract between a profession and society is reinvented in every single contact of a professional with a client. Clients grant professionals their trust in return for professional services. The relationship is defined by this equilibrium.

Individual professionals do not only have relationships with their clients, they also have relationships with parties and persons on aforementioned levels of their context: in peer groups, in organisations, and in society. These relationships all regard different aspects of professionals' work, and they make individual professionals play different roles: the role in relationships with clients has other features than the role in relationships with peers, or managers.

Professionals' jurisdiction is a result of social processes in these different relationships. To understand these processes, the next paragraph will discuss the concept of negotiated order.

3.5 Negotiated order and jurisdiction

Professionals, especially those who work in organisations, have relationships with many different persons and parties in their context. A constellation of agreements and contracts enables them to perform concerted action. These agreements and contracts are not binding for all time. Organisations change, and persons and parties within the organisations change or at least try to change as well, for instance because they strive for improvement of their situation in the constellation of agreements and contracts. Therefore organisations are always in between stability and instability. As said before, chaos and order are not opposite, but next to each other (Boonstra 2000). In short, the basis of concerted action must be reconstituted or 'worked at' continually. This is why Strauss et al. (1973:303) emphasise the importance of negotiation, "the process of give-and-take, of diplomacy, of bargaining - which characterises organisational life."

Negotiation is "one of the possible means of 'getting things accomplished' when parties need to deal with each other to get those things done" (Strauss 1978:2). The social order resulting from these negotiations in societies, organisations and groups is, at any moment in time, a negotiated order.

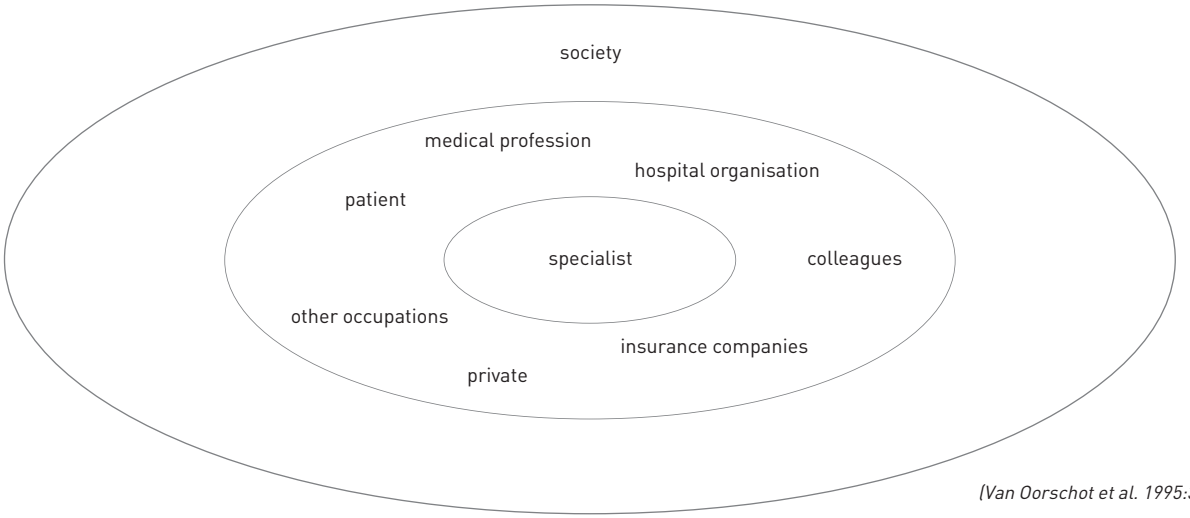
One of the larger issues in negotiations in professional life is the equilibrium between autonomy and interdependency. Van Oorschot et al. (1995) explored this for specialists in hospitals. The authors explain a specialist has many different relationships in which a negotiated order defines the balance between autonomy and interdependency.

The exclusive social and legal position of professions and professionals, discussed in paragraph 3.4, is granted them in negotiations with society because of the work professionals do. Their work really matters to society. This makes the link between a profession and its work central in professional life. Abbott (1988) calls this link 'jurisdiction'. In claiming jurisdiction, a profession asks society to recognise its cognitive structure through exclusive rights (Abbott 1988:59). The arenas for jurisdictional claims are: the legal system, public opinion and the workplace.

This makes the concept of jurisdiction refer to the combination of authority, autonomy and right of say of professions and its members. Jurisdiction, at each moment in time, results from continuous or repeated negotiations between professions or professionals, and parties around them. Underneath the issues and the tactics of the actual negotiations lay the jurisdictional claims that specialists mean to make in relationships with persons and parties around them.

Figure 3.2 shows the most important relationships in which specialists' jurisdiction is negotiated. The sharp lines drawn here do not reflect sharp and stable jurisdictions in real life. The lines are negotiated continuously and the outcome of negotiations may give different lines at different moments.

Figure 3.2: Specialist in network of relationships



(Van Oorschot et al. 1995:31)

The concepts discussed here, found in theories on professions, professionals and negotiated order, will now be combined in the research framework.

3.6 The research framework

So far, the paragraphs of this chapter concerned professions and professionals in general. The theories and concepts discussed here were used in the research framework that provided the conceptual scope for the study this book is about. This paragraph regards the research framework, and it focuses on specialists in hospitals.

3.6.1 Studying the nature of specialists' day to day work in patient care

Professional work is the centre of professional life. For specialists, professional work is defined by patient care.

Therefore the nature of day to day work in patient care must be understood before studying other aspects of specialist work.

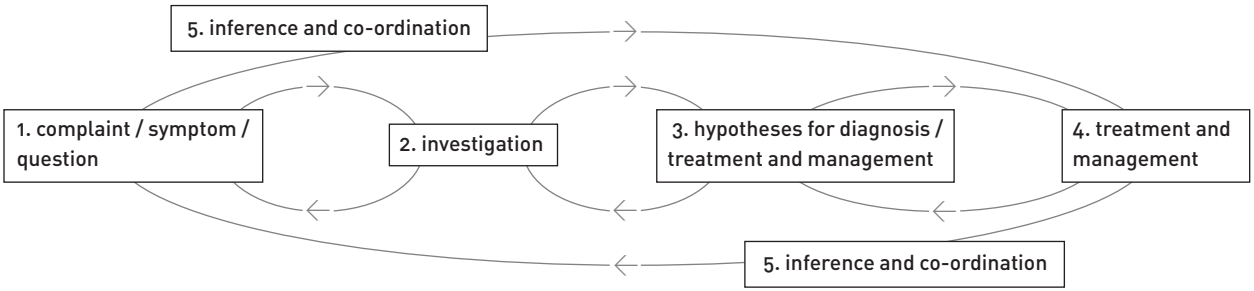
Three groups of specialities

Chapter 2 explained that three categories of specialities can be distinguished: medical specialities, surgical specialities and supporting specialities (see paragraph 2.5). Patient care processes in each of these categories have specific characteristics, so the nature of specialists' work in patient care may be expected to be different in each of these three categories.

Three acts in five steps

In each of the three groups, work in patient care was analysed by using the professional acts discussed in paragraph 3.3 (Abbott 1988). **Figure 3.3** applies Abbott's professional acts to work processes in patient care, which makes a five-step model.

Figure 3.3: The five-step model for specialist work in patient care



The first three steps in the five-step model form the act of diagnosis, which is a mediating act, bringing specific information into the physician's knowledge system. In step 1 the patient seeks the physician's help because of a complaint, symptom or question. The physician usually gets oral information from the patient and written information from the patient's general practitioner or from another referrer. Step 2 reflects the process of colligation, getting a 'picture' of the patient and applying the rules for finding relevant and valid evidence about the problem at stake. The physician investigates the patient by physical examination and by ordering further tests, for instance at the departments of pathology, radiology, and the laboratory. Sometimes a colleague from another speciality is asked for advice.

The process of classification brings the picture into the dictionary of problems known to the speciality. This is step 3. The net result in the medical profession is usually a 'diagnosis' or at least a set of hypotheses about the diagnosis (differential diagnosis). Diagnosis removes the patient's specific qualities and reveals the problem in professional terms (Abbott 1988:41).

Step 4 reflects the act of treatment, which is, like diagnosis, an intermediating act that takes instructions out of the physician's knowledge system. Its results are brought back to the patient, for instance in a prescription. The patient, performs the actions when for instance taking medication, exercises or a dietary regimen are prescribed. The physician, other physicians or experts perform the actions on the patient, for instance when surgery or physiotherapy are indicated.

All arrows in the picture reflect step 5, which combines inference and co-ordination. The act of inference is the pre-eminent professional act. It is hardly a separate step, because it reflects professional thinking, which runs through all other steps. Inference is the middle game that relates professional knowledge, client characteristics, and chance, connecting all steps in a continuous process of reasoning and evaluation. Specialists can use the approach of exclusion (try the most likely treatment) when they get second chances. They have to use the approach of construction when a patients' precarious condition forces them to build a conclusive argument, based on the odds of success or failure.

Co-ordination relates to the phenomenon of professional self-management (Raelin 1985). Besides inferring about the "arc of work", physicians need to organise the work process. All tasks and lines of work require co-ordination, which Strauss et al. (1985:151) call "articulation work". On the topmost level, the main physician is in charge of articulation work, because he or she has the largest view of the course of illness; the physician has the big picture (ibid:155).

The five steps in the figure are not necessarily completely separable from each other in real life, neither is the sequence of the steps always the same. This five-step model is used in this study to find the characteristics of specialist work processes in patient care.

The organisation of work in patient care

Self-management in patient care makes speialists organise the care processes for individual patients. In addition to studying the individual processes, three other aspects have

to be studied as well: places where work is done, times at which work is done, and persons with whom work is done (Carlson 1951/1991:32).

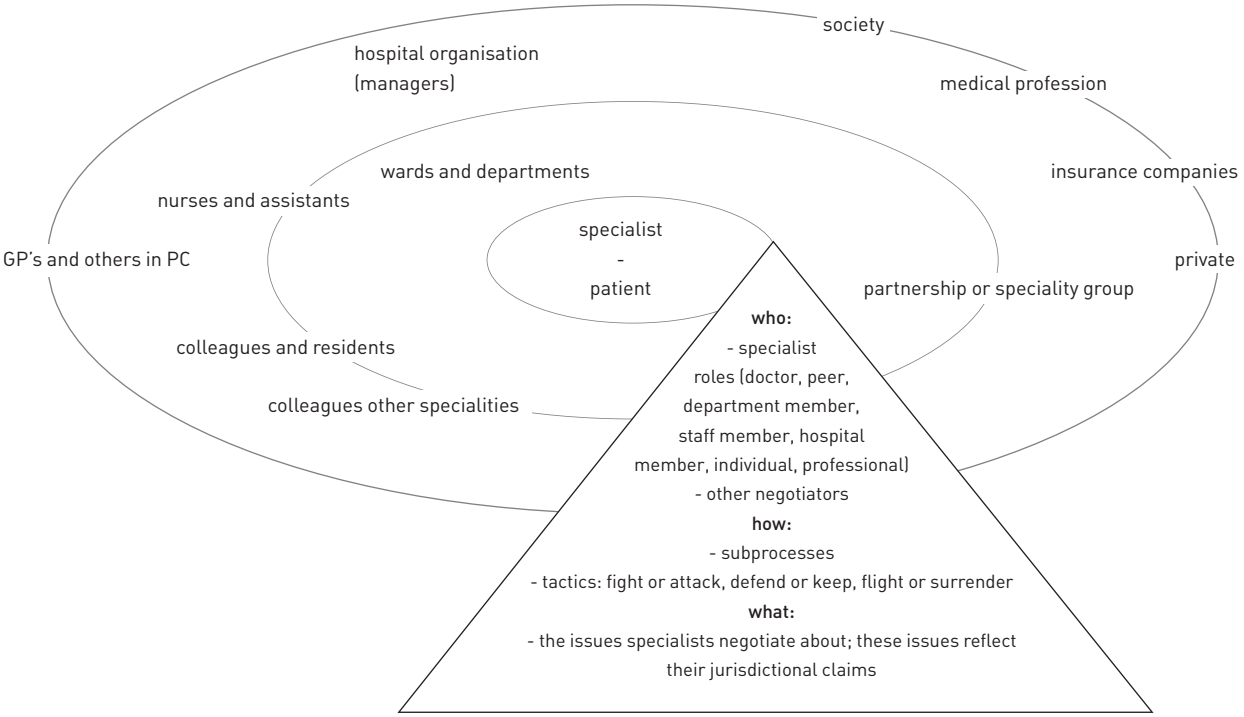
These aspects were studied as ingredients of the organisation of day to day work in patient care, not necessarily in respect to individual processes, but in respect to specialists' work in patient care in general.

3.6.2 Studying specialists' day to day negotiations

After analysing the nature of day to day patient care, this study analysed the negotiations that define the negotiated order in specialists' day to day work. Strauss (1978:98-100) prescribes what to watch in studying negotiations in negotiated orders. First of all the negotiators must be found and characterised, for instance their numbers, and whether they represent themselves or others. Second the negotiations must be described. For instance, are the transactions visible or covert? Are the negotiations one-shot, repeated, sequential, serial, multiple or linked? What subprocesses or tactics take place, for instance trade-offs, obtaining kickbacks, working towards a compromise in the middle, reaching negotiated agreements? Could negotiations be avoided by alternative modes of action? And third the issues must be taken into account, for instance their number and complexity and the clarity of their legitimate boundaries. This scheme of aspects is what Strauss calls the 'negotiation context'.

An elaborated version of the picture presented by Van Oorschot et al. (1995:31; see paragraph 3.5) was used to describe and analyse the negotiation context of specialist work. **Figure 3.4** will be discussed in the following paragraphs.

Figure 3.4: The negotiation context of specialist work



Who: negotiators

Following Strauss' instructions, first of all the negotiators have to be described. This thesis focuses on specialists as the central group of negotiators. The specialist - patient relationship is put in the middle of the negotiation context, because patient care is at the heart of specialist work, directly related to the knowledge and skills acquired in specialist training.

As discussed in paragraph 3.4, professionals, especially those working in organisations, do not only have relationships with their clients, they also have relationships with other parties and persons around them. These relationships all concern different aspects of professionals' work, and they make individual professionals play different roles.

For specialists the organisational settings and relationships with parties in their context define seven roles they play. Five roles are defined by settings in the workplace, two roles are defined by settings outside the workplace. The roles are summed up in **table 3.4**.

Table 3.4: Specialist roles in different settings and relations

	Setting / relation	Explanation
Defined in the workplace		
doctor	specialist - patient	the role of seeing and treating patients in the speciality or being representative of the patient
peer	specialist - colleagues own speciality	the role of being member or representative of a partnership or a speciality group, practising medicine in the same speciality and having a shared organisation
department member	specialist - colleagues + other occupations, own speciality	the role of being a member or representative of a department, co-operating with colleagues, residents, nurses and other workers on the wards and units of the speciality
staff member	specialist - colleagues own + other specialities	the role of being a member or representative of the specialist staff, which is the group of all specialists providing patient care in one hospital and being organised in the specialist staff organ in hospital
hospital member	specialist - hospital organisation	the role of being a member or representative of the hospital organisation
Defined outside the workplace		
individual	specialist - personal and private context	the role of being an individual or a member or representative of the personal and private context
professional	specialist - profession + society	the role of being a member or representative of the profession of physicians and of the own speciality

Depending on the relation or setting in question, specialists negotiate from the perspective of one of these seven roles. The persons and parties in the circles of figure 3.4 all are potential negotiators. They are summed up in more detail in **table 3.5**.

Table 3.5: Candidate negotiators

Van Oorschot et al.	Specific parties in this thesis
patients	patients
colleagues	specialist colleagues of the same speciality and/or of the same department (peers) partnership or speciality group specialist colleagues of other specialities or other speciality groups specialist staff or fellow members of the specialist staff residents and students
other occupations	nurses, other personnel in care other employees hospital
hospital organisation	managers hospital organisation
medical profession	general practitioners and other professionals in primary care profession
society	workers / parties from outside (for instance technicians and pharmacists) other hospitals insurance companies other external parties, media, politics

How: negotiations

Negotiations in daily work can have many different forms, either coercive in nature or happily co-operative (Strauss et al. 1985:267), explicit or implicit. Implicit negotiations give tacit agreements or understandings (Strauss 1978:224). Sometimes the parties are aware of what they are doing, maybe not calling these processes 'bargaining', but surely regarding their products as some sort of agreement. Sometimes they are not thoroughly aware that they have engaged in or completed a negotiated transaction. If this kind of agreement gets broken by one of the parties however, the other will experience some feeling, whether surprise, disappointment, annoyance, anger, a sense of betrayal or exploitation, or in some cases relief.

Negotiation is always found in conjunction with other processes, other alternatives to getting things done, for instance coercion, persuasion, manipulation, and the like (Strauss 1978:235).

In describing negotiations in this study, the specialists' perspective was pivotal. Their tactics and coping mechanisms were studied. In general, tactics have three variants, connected with the results the acting party aims at.

'Fighting or attacking' aims at protecting the own stakes in a defensive situation and at expansion of the stakes in an offensive action. 'Defending or keeping' refers to methods to protect the stakes in a defensive situation or to prevent further damage when losses are inevitable. 'Flight or surrender' is giving up when the stakes are not worth negotiating for any longer or when the other negotiators are unbeatable.

The tactics that were observed in each of these three variants are summed up in appendix 2.

What: issues as indicators of jurisdictional claims

Specialists and the parties in their context will probably hardly ever openly specify the stakes they negotiate for. Maybe they are not even aware of the specific stakes. Therefore, the issues of negotiations and transactions must be analysed: what do specialists and parties in their context discuss, fight, argue or negotiate for, and what issues provoke exclamations of anger, frustration, surprise, sadness, or happiness?

Collecting and analysing these issues will expose the stakes specialists negotiate. These stakes are connected to the claims for jurisdiction specialists make in relationships with persons and parties around them, because something worth negotiating is something worth having jurisdiction over. Jurisdictional claims are not visible in the negotiations themselves, therefore the issues in negotiations will be analysed to reveal specialists' underlying jurisdictional claims.

Summarising this second and most essential part of the research framework, this study will describe the nature of the negotiations that define the negotiated order in specialists' day to day work by answering three questions:

- who: from what role perspectives do specialists negotiate in their day to day work, and who are the other negotiators specialists meet;

- how: how do specialists negotiate; what subprocesses take place; what are their tactics and coping mechanisms;

- what: what are the issues specialists negotiate about.

The issues specialists negotiate about will reveal the underlying jurisdictional claims: what do they want jurisdiction over in day to day work?

3.6.3 Studying the 'structural context' of negotiations

Specialist work is embedded in a context of several layers, described for professionals in general in paragraph 3.4. in studying negotiated orders, the structural context must be studied as well, which is "that 'within which' the negotiations take place, in the largest sense" (Strauss 1978:98). Chapter 2 already discussed the historic and international context of specialist work and jurisdiction. Empirically, the study focused on specialists' opinions and experiences about the structural context of the workplace. Therefore a third part of the research framework was necessary.

Professional orientation

Professionals pre-eminently are lead by the content of their work and by the interests of their clients (for instance Wilensky 1964; Dawson 1996:35; Hulst and Schepers 1999; Freidson 2001). Applied to specialists, this makes specialists think that patient care and specialist work processes should provide the standard measures for decision making and organising in hospitals. In later chapters this principle is called 'professional primacy'.

Based on the contract with society and organisations, professionals have discretionary rights and autonomy (for instance Van Oorschot et al. 1995; Van Delden 1996, Van der Wee 2000). This is the second principle in the professional orientation. It reflects the idea that specialists should perform patient care and specialist practice without interference or control by others. 'Collective autonomy' means the profession decides on standards for clinical work. 'Individual autonomy' means an individual specialist is free in deciding on the diagnosis and treatment for individual patients (Hulst and Schepers 1999).

Relationships within groups of professionals are characterised by a dislike of mutual hierarchy (for instance Van der Wee 2000:78). This is the principle of 'egalitarianism'.

Because of the importance of peer relationships in professions, specialists may be expected to be more positive about the relationship with colleagues than about the relationship with the hospital organisation as such. The study tried to get a general picture of specialists' feelings towards their working context.

Specialists' alignment with the hospital

As explained before, the issues in daily negotiations were analysed to understand and find specialists' jurisdictional claims. To understand these further, specialists' experiences with decision making in hospital were gathered and analysed.

As discussed in Chapter 2, specialists in the Netherlands play a formal organisational role more often than before. The concepts of 'integration' and 'participation' pulled specialists into the hospital organisation. To some extent specialist managers (specialists who participate in management) might be expected to be the professional administrators mentioned by Abbott (1988) when he explains organisational arrangements might gradually replace professional ones. Specialists' position in its relation with the hospital hierarchy may be gradually changing because of integration and participation.

The control and governance mix

Freidson's concepts (2001) for control, discussed in paragraph 3.4, can be used for jurisdiction as well. When managers have jurisdiction over the organisation of work, the logic of managerialism applies. In the logic of consumerism clients have jurisdiction over the organisation of work, and the logic of professionalism provides occupations and their members with jurisdiction over the organisation of work.

To what extent does professionalism apply to specialists' work, with specialists being in charge of their own work? And to what extent does this study find professionalism mixed with consumerism and managerialism?

The analysis of the various aspects of negotiated order in specialists' day to day work will reveal information about the control mix in specialists' work, which will be discussed in the chapter on conclusions and discussion.

Specialists' style in negotiation tactics and their opinions and experiences regarding their professional orientation and their alignment with hospital may be interpreted in terms of Gray's models (2004) for governance, discussed in paragraph 3.4 as well. To what extent do specialists endorse some scalar chain of superior and subordinate authority, related to the command mode of governance? In how far do they share values with persons and parties around them, creating a communion mode of governance? And what situations may reveal a contract mode of governance, with parties agreeing on an inducement-contribution exchange?

The chapter on conclusions and discussion will reflect on these modes of governance as well.

3.7 Conclusion

The research question to be answered in this chapter is: "What concepts and research framework should be used in describing and characterising specialist work and the negotiations and jurisdictional claims in hospitals?"

The research framework found its concepts in theories about professions and professionals, and in theories about negotiated order. It has three parts.

For studying the nature of day to day specialist work in patient care, this chapter presented a five-step model, constructed from the professional acts of diagnosis, inference and treatment, described by Abbott (1988). Three more aspects were added to the framework: the places where work is done, times at which work is done, and the persons with whom work is done. These aspects were studied as ingredients of the organisation of patient care. The nature of work was studied separately for medical specialities, surgical specialities and supporting specialities.

For studying the day to day negotiations that define the negotiated order of specialist work, the study focused on specialists as the central negotiators. Depending on the relationship or setting in question, specialists negotiate from the perspective of one of their seven roles (doctor, peer, department member, staff member, hospital member, individual or professional). All parties and persons in their context are potential negotiators. Daily negotiations can have many forms, either overt or covert, and explicit or implicit. The research framework distinguishes three coping methods in the transactions (fight/attack, keep/defend, flight/surrender).

Because jurisdictional claims will hardly ever be self-evident, the issues found on the 'surface' of negotiations and transactions must be analysed to reveal specialists' underlying jurisdictional claims.

For studying the 'structural context' in which negotiations for jurisdiction take place, the professional orientation and specialists' alignment with hospital were taken up in the research framework. The logics of Freidson (2001), managerialism, consumerism and professionalism, help understand the mix of control mechanisms in specialist work in hospitals.

Table 3.6 presents an overview of the most important concepts and theories used in this study.

Table 3.6: The most important concepts and theories used in this study

Chapter 5 the nature of specialists' day to day work in patient care	*day to day work in patient care* - professional acts (Abbott 1988) - organisation of work in terms of places, times and persons (Carlson 1951/1991)
Chapters 6, 7 and 8 the nature of the negotiations in specialists' day to day work and the jurisdictional claims underlying these negotiations	*day to day negotiations* - negotiated order (Strauss 1978, Strauss et al. 1985) - relationships of specialists that define their seven roles (Van Oorschot 1995) - jurisdictional claims (Abbott 1988)
	'structural context' in which negotiations take place - professional orientation (Hulst and Schepers 1999, Van der Wee 2000, Wilensky 1964) - specialists' alignment with hospital (Dawson 1996, Van Delden 1996, Van der Wee 2000) - control mix (Freidson 2001) and governance mix (Gray 2004)

References Chapter 3

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4 Methods

4.1 Introduction

This chapter is the last chapter of Part 1 and it addresses the methods used for answering the research questions, discussed in Chapter 2, and for translating the research framework, discussed in Chapter 4, into operational concepts (Carlson 1951/1991:23).

De Groot (1969) sums up five types of investigation researchers can choose to perform. The circumstances of the research and the research questions define the optimum choice for the type of investigation. The leading questions in the first part of this thesis require two kinds of investigation. The 'interpretative-theoretical study' type is necessary to prepare the study by describing and interpreting the historical, actual and international context of specialist work (Chapter 3), and the theories that were used for the research framework (Chapter 4). The type of 'instrumental-nomological investigation' was used for the construction of the questionnaire and this will be discussed in this chapter (paragraph 4.3). Part 2 of this thesis is about the empirical study of specialist work, especially specialist work in terms of negotiations and juris-dictional claims in the workplace. This part requires the type of 'descriptive investigation', for systematic description and classification of phenomena. It also requires the type of 'exploratory investigation', in which the researcher takes as a starting-point "a more or less vague theoretical framework". The researcher "is indeed out to find certain kinds of relationships in his data, but these have not been antecedently formulated in the form of precisely stated (testable) hypotheses." (de Groot 1969:306)

The results of this exploratory investigation will provide testable material, so Part 3 of this thesis will present suggestions for the investigation type of 'hypothesis testing'.

Table 4.1 summarises the investigation types chosen for the different research questions.

This chapter will discuss the qualitative and quantitative methods used in the exploratory investigation. Observations allow the researcher to study specialist work, and to look for negotiations and jurisdictional claims in real life. Thus qualitative research methods were chosen for obtaining in-depth information about specialist work in hospitals in seven case studies, discussed in paragraph 4.2. To broaden the perspective of the study these methods were complemented with quantitative research to obtain information from a large group of Dutch specialists, discussed in paragraph 4.3. Both kinds of research are complementary and bring triangulation to the study. Other aspects such as reliability, weaknesses and strengths of this study are discussed in paragraph 4.4.

Table 4.1: Research design

research question	appropriate type of investigation
Part 1 of this thesis	
How did specialist work in Dutch hospitals develop over time, what is the present situation, and what are the main differences with other countries?	***interpretative-theoretical study*** preparing the study by using existing theories to design the research framework
What concepts and research framework should be used in describing and characterising specialist work and the negotiations and jurisdictional claims in the workplace?	***instrumental-nomological investigation*** questionnaire construction
What methods should be used to study specialist work, negotiations and jurisdictional claims in the workplace?	
Part 2 of this thesis	
What is the nature of specialists' day to day work in patient care?	***descriptive investigation*** systematic description and classification of phenomena
What is the nature of the negotiations in specialists' day to day work in patient care and what jurisdictional claims underlie these negotiations?	***exploratory investigation*** collecting data to find relationships and to make theories or hypotheses (induction)
What is the nature of the negotiations in specialists' day to day work from the perspectives of the roles that are defined by relationships in the hospital, and what jurisdictional claims underlie these negotiations?	
What is the nature of the negotiations in specialists' day to day work from the perspectives of the roles that are defined by relationships outside the hospital, and what jurisdictional claims underlie these negotiations?	
Part 3 of this thesis	
Conclusions and recommendations	***recommendations for hypothesis testing*** (deduction)

(De Groot 1969:301-9; Juttmann et al. 2004)

4.2 The case studies: 51 specialists

The in-depth approach to the exploratory investigation was designed as a 'multiple case study' (Van der Zwaan 1999). A case study design was considered to be a suitable method, since it meets the needs of this study. It is "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident." The case study inquiry therefore deals with a multitude of variables, relies on multiple sources of evidence (triangulation), and benefits from the prior development of theoretical propositions to guide data collection and analysis (Yin 1994:12-3).

This thesis takes the day to day work of specialists to be the most important source of information about specialist work, about negotiations at work, and about underlying jurisdictional claims. Daily specialist work takes place in the context of peer groups: a partnership with self-employed specialists or a speciality group with salaried specialists. This study takes specialist peer groups as units for the case studies in the in-depth exploratory investigation.

4.2.1 Selection of the peer groups

The descriptive and exploratory investigation aimed for in this thesis requires theoretically driven or purposeful sampling (Glaser and Strauss 1967, Jonker and Pennink 1999:63, Hutjes and Van Buuren 1992:62-63). Therefore the case sites were selected on the basis of the research questions and research framework.

The empirical questions and the research framework start with the nature of specialist work in patient care, using concepts from theories about professions and professionals. The five-step model (paragraph 3.6.1) takes the patient care process as a starting point for analysing specialist work in three groups of specialities. The three major groups of specialities (medical specialities, surgical specialities, supporting specialities) have different histories and different processes. They are therefore expected to be of different nature. Each of the three groups of specialities provided two cases to this study, making a sample of six cases. To be able to design the research framework for observations, one case study preceded the other six.

Paragraph 3.6.2 discussed the research framework for the questions about day to day negotiations and figure 3.4 showed the elements of the 'negotiation context'.

The variety of these elements for different peer groups in various hospitals is huge, and it is impossible to find a concise selection of peer groups that reflects this variety.

However, to bring some variety of contextual elements into the case sample the peer groups were selected from two different hospitals: the Medical Centre Haaglanden (MCH) and the Vlietland Hospital (VH). The following paragraphs outline the regional and hospital characteristics.

Regional characteristics

The Medical Centre Haaglanden is a two locations hospital in The Hague and Leidschendam. The Hague provides the hospital with an urban context. Leidschendam can be considered to be suburban. Because of the size and impact of the urban location, the urban character is dominant.

The Vlietland Hospital is a two locations hospital in Schiedam and Vlaardingen. Both small cities provide a suburban context.

Several other hospitals are located in both regions.

Hospital characteristics

In 1998 MCH was established after a merger of Westeinde Hospital in The Hague and Hospital Antoniushove in Leidschendam. The two hospitals continue to be the two locations of MCH. It is a teaching hospital, offering clinical clerkships to students and resident training programs for nine specialities. With 750 beds in total it belongs to the larger Dutch hospitals. In 1999 MCH started developing plans for restructuring the organisation and introducing management participation for specialists.

VH was also established in 1998 after the merger of Schieland Hospital in Schiedam and Holy Hospital in Vlaardingen, both small cities in the neighbourhood of Rotterdam. It is now a two location hospital in these cities, planning to build one new hospital that will replace the two locations. A few specialities offer clinical clerkships for students. The hospital does not offer training programs for specialists. With 600 beds in total VH belongs to the middle category of Dutch hospitals. Anticipating the new hospital building, the hospital discusses new organisational structures and the introduction of management participation for specialists. Some

aspects of these plans are intended to be introduced before the new building is finished.

The seven cases and the considerations in selecting them are shown in **table 4.2**. This case study design is a 'multiple case study', which enables the researcher to compare different units (Van der Zwaan 1999).

Table 4.2: Selected peer groups

Medical specialities

1. general internal medicine, MCH (12 specialists, self-employed)
   - 'mother' of the medical specialities; expected to represent medical work and jurisdictional claims
   - in MCH: supervision and training of residents in specialist training
     use of the two locations on the agenda
     merger of the partnerships expected in case study period
2. cardiology, VH (6 specialists, self-employed and salaried)
   - expected to represent medical work and jurisdictional claims on smaller scale than general internal medicine MCH
   - in VH: supervision of residents not in specialist training
     co-operation / merger of the speciality groups expected in case study period

Surgical specialities

3. general surgery, MCH (9 specialists, self-employed)
   - 'mother' of the surgical specialities; expected to represent surgical work and jurisdictional claims
   - in MCH: supervision and training of residents in specialist training
     use of the two locations on the agenda
     merger of the partnerships just before case study period
4. obstetrics and gynaecology, MCH (8 specialists, self-employed)
   - surgical speciality, with medical accents (for instance in reproductive medicine and oncology);
     therefore the first case in time; to provide data for designing research framework in cases
   - in MCH: supervision and training of residents in specialist training
     use of the two locations on the agenda
     merger of the partnerships just before case study period
5. obstetrics and gynaecology, VH (4 specialists, self-employed and salaried)
   - expected to represent surgical work and jurisdictional claims on smaller scale than general surgery MCH
   - in VH: supervision of residents not in specialist training
     use of the two locations on the agenda

Supporting specialities

6. anaesthesiology, VH (8 specialists, self-employed)
   - expected to represent supporting work and jurisdictions mainly in relationships with surgical specialities
   - in VH: use of the two locations on the agenda
   - merger of the partnerships expected in case study period
7. radiology, MCH (11 specialists, self-employed)
   - expected to represent supporting work and jurisdictions in relationships with all medical and surgical specialities
   - in MCH: supervision and training of residents in specialist training
     use of the two locations on the agenda
     merger of the partnerships expected in case study period

Critical assessment of case selection

The weak point of this selection, considering external validity, is the relatively limited reach of the cases, using only two hospitals, and in an urban-suburban agglomeration.

Given the exploratory aim of the study on the other hand, the selected cases theoretically represent the characteristics expected to define the nature of day to day specialist work in patient care and the nature of negotiations and jurisdictional claims in day to day work.

4.2.2 Case study design

Focus on daily specialist work

Hospitals have three levels of organisation (Committee Medical Specialist and Hospital Organisation I 1991): daily patient care processes, units and wards for patient care, and the hospital organisation. Most specialists spend most of their time on patient care. They meet rules and regulations of their own units and of other units, but they also have to work within the policy and rules of the hospital organisation. In so doing, specialists meet all levels of hospital organisation in their daily work. Therefore, within the cases observing individual specialists' daily work was the most important research activity.

Permission and planning

Permission for performing research in the hospitals was first obtained at executive level, both with the boards of directors and with the boards of the specialist staffs (communication with the research field: Maso and Smaling 1998:41-45). The research program was called "Managers in white, specialists in organisation" [1] and its focus was announced as "the organisation of specialist work on a daily operational level and its connection with the organisation on hospital level". The boards of the specialist staffs in both hospitals informed the specialists about the study taking place, upon which the partnerships and speciality groups selected for the case studies were asked for permission separately in writing. All seven selected groups agreed on participation. Only one case study was postponed because of understaffing at the time planned for the case study. After obtaining permission for the case study, all individual specialists were again asked for participation separately.

Information about individual patients was of course kept strictly confidential, in conformity with the ethical codes for researchers and the ethical codes for physicians (both apply to the researcher). The specialists introduced the researcher to patients and other people met during observations, either as "researcher" or as a "colleague". Most specialists asked patients permission for her presence. On approximately five occasions a specialist wanted to speak with a patient in private, and one patient asked for a private consultation.

The case studies took place between January 2001 and December 2003. The periods of research activities varied with each case study, depending on the researcher's other activities in the study (surveys). In the first research design, every case study was planned in two periods, with the second one being a concise version of the first one. This was meant to bring a prospective element into the research as well as a possibility for evaluating the introduction of management participation for specialists in its meaning for jurisdictional claims. The first obstruction in this design was the postponement of the introduction of specialist management functions in Vlietland Hospital, because of other items on the agenda (problems concerning the building of the new hospital). The second problem was planning: the tight design required periods with activities in different case studies simultaneously, which appeared to be impossible to realise in combination with other activities. Therefore the only case study that holds a second period being a repetition of the first, is the case study that preceded the other ones in time: obstetrics and gynaecology in the Medical Centre Haaglanden. Anaesthesiology also had two periods, but that was because the national survey was performed in between; the second period here is not a repetition of the first.

The schedules for the case studies are shown in **table 4.3**. Between January and July 2004 interviews were held with one of the specialists of all case studies, to update the information used in this study.

1 Inspired by 'Boys in white' (Becker et al. 1961). The act of 'management' was referred to in its meaning of 'getting things done'.

Table 4.3: Case studies in time

case study	concentration of activities
1. general internal medicine, MCH	2003: July - September
2. cardiology, VH	2003: November - December
3. general surgery, MCH	2001: December - 2002: March
4. obstetrics and gynaecology, MCH	2001: January - March / 2002: June - July
5. obstetrics and gynaecology, VH	2001: August - October
6. anaesthesiology, VZ	2002: November - December / 2003: May - June
7. radiology, MCH	2003: September - November

Data collection in the case studies

In five of the seven case studies every individual specialist was observed for at least four consecutive hours. In the two larger speciality groups a selection of the specialists was observed. The peer group of general internal medicine held ten general internists and two gastroenterologists. The ten internists had three sub-specialities, oncology, nefrology and endocrinology. For an overview of the medical work, negotiations and jurisdictional claims, the observations were focused on locations with various patient populations. The specific departments for oncology and dialysis were left out of the study. Six general internists and one gastroenterologist joined the observations. The peer group of radiology consists of 11 radiologists. At random nine radiologists were selected for observations.

All individual specialists who were asked to join the study agreed to be observed for one or two periods of at least four consecutive hours. In total 51 specialists were observed doing their daily work. The moments of observation are shown in the table. This design is called "sequential observation": each of the specialists is observed during at least one integrated period (Noordegraaf 2000:110).

Observing individual physicians also meant observing group activities when attended by the specialist being accompanied at that moment (for instance daily morning meetings and case presentations on multidisciplinary staff meetings).

Quite often it was possible to ask questions and have conversations during the observations. If this was not possible, an appointment for an interview was made.

Separate documents were collected in the course of the case studies (instructions, schedules, standard procedures). In the updating interviews the agendas of the meetings of the peer group over the last half year (2003) were asked and received (multiple sources of evidence: Yin 1994:13).

Table 4.4 outlines the activities in the case studies. Meetings for members' checks, and presentations for peer groups, specialist staffs and management teams are left out of this table.

Table 4.4: Contacts in case studies

	general internal medicine	cardiology	surgery	obstetrics & gynaecology MCH	obstetrics & gynaecology VH	anaes-thesiology	radiology	total
morning meeting								
- number	4	-	8	10	3	-	-	25
- time (hours)	2,3	-	1,5	3,9	0,7	-	-	8
- patients discussed	26	-	48	61	14	-	-	149
rounds / wards / department / Casualty								
- number	4	7	10	3	4	8	14	50
- time (hours)	5,5	5,8	4,5	2	2,7	3,6	35,9	60
- patients met / discussed / images	30	27	41	16	14	28	309	465
OPD								
- number	4	3	5	7	5	4	-	28
- time (hours)	12,4	11,7	19,1	25,5	13,8	14,4	-	97
- patients met	54	40	102	106	64	72	-	438
OR / procedures								
- number	1	1	5	2	4	11	3	27
- time (hours)	3,4	4,7	12,8	10	9,4	17,8	4,5	63
- patients met	7	1	9	9	9	17	3	55
discussion / multi-disciplinary meeting								
- number	2	-	6	7	-	1	2	18
- time (hours)	2,1	-	3,9	2,6	-	1,1	0,9	11
- patients discussed	24	-	107	40	-	4	15	190
meeting in class / training								
- number	-	-	1	6	-	-	1	8
- time (hours)	-	-	1,3	3,6	-	-	0,7	6
various								
- number	4	3	5	4	-	2	2	20
- time (hours)	5	2,8	4,1	4,5	-	0,9	1,4	19
organisational meeting / work								
- number	3	-	2	7	-	2	1	15
- time (hours)	3,3	-	3,4	12,5	-	1,5	1	22

	general internal medicine	cardiology	surgery	obstetrics & gynaecology MCH	obstetrics & gynaecology VH	anaes-thesiology	radiology	total
number of separate interviews / conversations	6	1	2	11	10	6	6	42
total number of contacts in case study	28	15	44	57	26	34	29	233
time (hours; interviews not included)	34	25	51	65	27	39	44	285
patients seen / discussed	141	68	307	232	101	121	327	1297
specialists	7	6	9	8	4	8	9	51
	men: 5	men: 6	men: 7	men: 5	men: 4	men: 7	men: 9	men: 43
	women: 2	women: 0	women: 2	women: 3	women: 0	women: 1	women: 0	women: 8

Critical assessment of case study design

The focus on day to day specialist work limited the observations to everyday specialist work. Outside daily work, specialists have other activities that are related to their work and to jurisdictional claims, for instance in meetings, and in working at home.

To obtain data from peer group meetings, three meetings were observed in two groups, and the agendas and minutes of a series of peer group meetings (over six months) were collected.

Other meetings taking place outside regular working hours or outside the hospital were not observed or otherwise studied. Thus, for instance data about negotiations among the specialist staff, and in national committees, were gathered only indirectly, from specialists' reports of these meetings. These limitations must be taken into account in the interpretation of the results of this study. Everyday specialist work provided the direct observations, which may leave specific areas related to specialist work (the specialist staff, activities at home, or outside the hospital) relatively under-exposed. This limitation was accepted, because the details of daily specialist work, highlighted here, are often left under-exposed in recent literature about specialist work in hospital.

Obstetrics and gynaecology MCH was the first case study in time, used to try and adjust the research framework, to get to know the researcher role, and to practice observing, interviewing and taking notes. This made this case study the largest one in moments, time, and interviews. It also adds to the number of observations in the group of surgical specialities, leaving the observations out of balance. If judged by quantities only, the surgical dominance might be expected to narrow the scope of the study or to create a 'surgical bias'.

This is unlikely to have happened, because the research framework, discussed in Chapter 4.6, and used to structure the observations, was based on professional work in general.

Another critical element in this design is the presence of the researcher. Could it influence the work a specialist does? Mintzberg asked the same question regarding his observations of managers:

"Does the presence of a researcher influence the work that the manager does? There is reason to believe that it does not, although it may influence his style of performing the work." (Mintzberg 1973:269)

In some occasions work was slowed down by the presence of the researcher, because the specialists wanted to inform the researcher about their work or patients or opinions. The style of performance and communication may have been influenced as well. Nevertheless, the actual nature of specialist work in patient care cannot be influenced by the presence of a researcher. Neither will day to day negotiations and jurisdictional claims be fundamentally altered by being observed. In this respect the "social and institutional embeddedness" of the work (Noordegraaf 2000:113) facilitated observation. First of all the researcher wore white, which made her look like a member of the hospital workforce. Second, the researcher is a physician, which enabled her to ask questions about patient care, to 'break the ice', and which enabled the specialists to use jargon when talking about their work. Third, most specialists and patients are used to being accompanied by students now and then, which makes the presence of another person in white, only taking notes, not a completely new phenomenon. And last, the specialists soon came to trust the researcher when she explained not being interested in their working 'well' or 'badly' or 'efficiently', but that she was finding out how they 'get things done' and what they feel they should or should not be doing in 'getting things done'. Then specialists usually opened up and gave their opinion about their work, their responsibilities and about the support they need or want.

In short, some influence by the researcher is inevitable, but the impact of this influence on fact finding is considered to be inconsequential (Hutjes and Van Buuren 1992:96).

Jurisdictional claims and negotiations about them by definition involve other parties than specialists only, but the perspectives of these parties were not systematically studied. In every case study at least one manager was interviewed and in both hospitals the boards of directors were interviewed, to obtain an impression of other perspectives besides the specialist focus. The data gathered in these interviews however were not systematically analysed and reported in this thesis, as that would not do justice to other parties, for instance nurses, OPD-assistants, and other workers in the specialist context. The specialist focus is an all over limitation of this study. Within the scope of the study, aiming at insight into specialists' work, this limitation was accepted.

4.2.3 Semi-structured observations and conversations

The research framework, discussed in paragraph 3.6, made the observations and conversations with the specialists "semi-structured":

"For during semi-structured observation, the researcher has no predefined theoretical model of managerial work, and he consciously leaves room for the gathering of unexpected, anecdotal evidence. At the same time he partly knows what to look for: he might have a simple conceptual scheme, which is composed of procedural categories, as is illustrated by Mintzberg's research; he collected both structured data, as well as anecdotical data." (Noordegraaf 2000:107)

The structuring of the observations contained the following aspects (see also Carlson 1951/1991:32):
- name of specialist being observed;
- sort of work being done;
- time of scheduled activities and meetings;
- persons with whom the work was done;
- places where work was done;
- number of patients seen or discussed;
- shortly: patients problem;
- time taken for each patient (direct contact or discussion);
- number and time of non-scheduled meetings or phone calls;
- subjects discussed in non-scheduled meetings or phone calls.

Furthermore, the observations of specialist work, the gathering of anecdotal evidence and the questions asked were led by the conceptual schemes discussed in Chapter 3: the five-step model for patient care (figure 3.3) and the 'negotiation context' for specialist work (figure 3.4).

4.2.4 Processing, analysing and reporting data: four steps

Step 1: processing data

All data were collected in writing on the site, because tape recording would be technically and ethically difficult in clinical settings: walking rounds or watching surgery is hard to record on tape and ethically not correct because

of the patient information recorded that way. Because only written data were collected, the data were processed in Microsoft Word as soon as possible after collecting them. The fieldnotes in each case study were arranged in separate files by date, by activity and by the individual specialist being followed.[2] Each of these files contained a summary of the essential elements in the observations or document analysis.

These summaries were all separately filed in text-files and processed using Atlas/ti, version 4.1 for Windows 95 and Windows NT, software that facilitates qualitative analysis. Because the primary documents in Atlas/ti kept their own name, the complete set of fieldnotes could always be traced in the Word files.

The data of the seven cases were filed in 223 separate documents (Microsoft Word), and in seven hermeneutic units (Atlas/ti).

Every word, line, sentence, paragraph or text can be marked as a 'quotation' in Atlas/ti. Quotations can be coded. The volume of most quotations in this study is about four lines. each quotation has one to five codes.

An important instrument in Atlas/ti is the Query Tool. This allows the researcher to retrieve quotations defined by formulas of four Boolean operators:

- the OR operator finds all quotations that are coded with any of the codes in the formula;
- the XOR operator finds all quotations that are coded with exactly one of the codes in the formula;
- the AND operator finds all quotations that are coded with all of the codes in the formula;
- the NOT operator finds all quotations that are not coded with any of the codes in the formula.

Using this and other search instruments on the data enables the researcher to find patterns within the data and, very important in this study, to find differences between different documents and thus between different persons and groups.

To find patterns and differences, finding different numbers of quotations for specified codes or code combinations (in the Query Tool) was considered to be a first signal. Of course the content of the quotations was studied carefully as well. Thus, the results in this study were found in a continuous analysing process of going through the data in terms of codes and queries, then finding the wider contexts of the codes and queries back in the documents with raw data, and interpreting or making sense of the suggested patterns in the perspective of the research framework of Chapter 3 (Glaser and Strauss 1967; Pope and Mays 1995a; Schatzman and Strauss 1973).

Appendix 2 shows numbers of quotations. These numbers are shown to give impressions of patterns and differences, to condense the results and make them easily intelligible, not to suggest quantitative evidence. The approach to the analysis is still qualitative since the counted data were coded on theoretical grounds (Pope and Mays 1995b).

Step 2: nature of specialist work in patient care

The codes used in Atlas/ti for making the first analysis of the data were based on the research framework discussed in paragraph 3.6.1.

The five-step model was used in this study to find the nature of specialist work in patient care. Three more aspects of work were analysed (Carlson 1951/1991:32): places where work is done, times at which work is done and persons with whom work is done. These aspects were studied as elements of the organisation of patient care.

By going through the fieldnotes again and again, the nature of specialist work in patient care was found in terms of the five-step model and in terms of organising patient care, for the three different groups of specialities.

The codes connected with these aspects of the framework are shown in appendix 1. The coding of the observations and interviews gave over 3000 quotations in the first analysis.

2 for instance some documents in the folder "MCH - general surgery":
"011212a-morning meeting" = daily morning meeting with surgeons and residents on 12 December 2001
"011212b-ICU CU" = rounds on the intensive care unit with surgeon CU on 12 December 2001
"011212c-rounds CU" = rounds on the clinical department with surgeon CU on 12 December 2001
"011212d-OPD CU" = out patient department with surgeon CU on 12 December 2001
"011212e-ICU meeting CU" = daily meeting on intensive care unit; observing surgeon CU on 12 December 2001
"011212f-afternoon meeting" = daily afternoon meeting with surgeons and residents on 12 December 2001
"011212g-rad + vascular" = surgery-radiology meeting with vascular case presentations on 12 December 2001

The first analysis was laid down in the reports for the peer groups in the case studies. These codes helped find the nature of specialist work in the different cases and in the three groups of medical, surgical and supporting specialities. The results are reported in Chapter 6.

Step 3: nature of negotiations, and jurisdictional claims

The second analysis took the research to the level of finding negotiations and jurisdictional claims in the data, based on the research framework discussed in paragraph 3.6.2. In this step, the quotations reflecting these signs were identified and coded. The quotations were identified in a search for fieldnotes about dilemma's, frustrations, arguments and exclamations concerning:

- power and right of say of specialists or other parties;
- autonomy, freedom, independence or dependence of specialists;
- 'ownership' of patients and patient care;
- 'ownership' of tasks and responsibilities;
- 'ownership' of work;
- mutual relationships between specialists;
- relationships between specialists and parties in their context.

Following the research framework in paragraph 3.6.2, each of the quotations was subsequently coded for:

- the role of the specialist (codes: doctor, peer, department member, staff member, hospital member, individual, professional);
- the party involved in the negotiation (codes: patients, colleagues, other occupations, hospital organisation, profession, society);
- the nature of the negotiations and tactics (codes: fight or attack, defend or keep, flight or surrender);
- the issues the negotiations were about (codes: individual, patient care, logistics, tasks and responsibilities, organisational arrangements, relations, external).

Except for the issues-codes, the codes given between round brackets here were drawn from the research framework (paragraph 3.6.2). In the iterative analysis and coding of the data, most codes became several subcodes, shown in appendix 2.

The issues found to be the subjects of negotiations were not drawn from the research framework, since they were found in the analysis of the data. From the quotations emerged 25 different sorts of issues, in the seven categories mentioned above between round brackets. The last table of appendix 2 outlines the issues.

The analysis of negotiations, and the interpretation of underlying jurisdictional claims is made in Chapters 7, 8 and 9.

The coding of the observations and interviews gave over 750 quotations in the second analysis.

Step 4: reporting

The analysis of the nature of specialist work in patient care was reported in case reports that were sent to and discussed with the participating specialists (members' check).

This thesis reflects the results of the steps of processing and analysing the data: the analysis of the nature of specialist work in patient care is discussed in Chapter 6 and the analysis of day to day negotiations and their underlying jurisdictional claims in Chapters 7, 8 and 9. These chapters report the results drawn from the observations and conversations. The evidence for these results is built on argumentations that follow the research framework.

To illustrate the argument, quotations from the data are shown now and then. As mentioned before, these quotations are collected in taking fieldnotes on the site, so the data are not laid down verbatim. However, quotation marks are used to specify the data quotations.

4.2.5 The researcher in the case studies

"The best cure for biases is to try to become increasingly aware of our own biases and how they slant and shape what we hear, how they interfere with our reproduction of the speaker's reality, and how they transfigure truth into falsity. It is for this reason that we support, with Wax (1971), Reinharz (1979), and other writers, the injunction that each case study, evaluation report, or research report contain a section on researcher reactions and changes." [..] "We tend to leave the self-realization to another time and place. That is an unfortunate omission, since in the process of becoming aware of other value perspectives and cultures, we also become more aware of ourselves as persons, as professionals, and as scientists." (Guba and Lincoln 1982:148)

At the time of the case studies the author of this thesis was a member of the management support staff of the Medical Centre Haaglanden, one of the participating hospitals. The combination of being an employee and a researcher in one organisation has weaknesses and strengths. The researcher risked being prejudiced about the subject or about individual participants in the study, for instance because of former experiences. Also she may have had blind spots for weaknesses of the organisation or for weaknesses of individuals within the organisation. In a worst case scenario participants may deliberately have given the researcher wrong or incomplete information because of considerations related to her work position.

There are positive effects as well. Working in the field of research improved the relationship between science and practice. Thanks to familiarity with the organisation, information was easily available. And finally, because of existing relationships, participants in the study already trusted the researcher.

Apart from having two roles in one hospital, the researcher has two roles in her background, which also may have affected her research: she is a physician and a master in public administration. Being a physician, and not being a specialist is maybe even more important for the relationships with the specialists in the study than having two roles at work. This is illustrated in some fragments of the research diary of the researcher, at the beginning of the case studies:

"Like all junior physicians, I think of specialists as "chiefs". Had I chosen a career as a physician, I would probably be halfway through some residency now. Halfway specialist training, people slowly get used to the idea that their chiefs will be their colleagues, peers and partners in business. But I'm not in training. After graduation, I was a non-trainee resident in surgery, for two years. And then I chose to specialise in the organisational world of hospitals. I never reached the moment specialists become colleagues or peers. This might mean that I will keep thinking about specialists as "chiefs", and not as colleagues. Then again, maybe this has also something to do with age. The average specialist is at least ten or fifteen years older than me.

Anyway, I am biased in looking at / talking to / listening to doctors, especially specialists, because:
- *As a physician, I'm one of them, though I'm not one of them, for they are specialists;*
- *I don't think I want to be one of them, but I do want to be known as understanding them more than other workers on the organisational side of the hospital;*
- *I think they generally underestimate the challenges of policy and management;*
- *I wonder if they should really integrate in the hierarchical patterns of the hospital, because actually I don't think they are good leaders in general; I don't think they have the skills I find necessary in leadership (coaching, managing culture and atmosphere, motivating, stimulating etc)."*

Being trained to be a physician also had important positive effects on the study. Understanding and speaking the language enabled the researcher to observe and understand all situations in patient care. Being a doctor also improved the accessibility to the population of physicians in general.

In this study, the following aspects supported the positive effects and moderated the risks of the different roles and biases of the researcher (Maso and Smaling 1998, Spradley 1980, Swanborn 1990, Hutjes and Van Buuren 1992):
- the scientific autonomy of the researcher was laid down in an appendix to her labour contract;
- the researcher had no managerial responsibilities in hospital, only responsibilities in management advice and support;
- the researcher had a 'zero budget labour contract' with the Institute Health Policy and Management; the contract formalised her researcher role and gave her access to the academic community of the Institute;
- in every contact with participants in the study the researcher explained her study belonging to her university contract and being separate from her role in hospital;
- the activities performed and used in the study were all part of a research design, known to the participants;
- the activities performed and used in the study were all recorded in writing, and the structure of data storage made the steps in information processing retraceable (trackability);
- the researcher kept a diary about her own bias and roles;

- the data collected in the own work place were complemented with data from another hospital and with data from a questionnaire (triangulation);
- the first analysis reports were all checked by and discussed with participants (members' checks);
- field situations in which the researcher herself was questioned or addressed were separately coded, personal thoughts and remarks as well ('dialogue relation', see appendix 3 for these quotations);
- the researcher rendered account of her bias and role in this thesis.

Members' checks

The first analysis was laid down in a report about each case study. The case reports were sent to all specialists observed. At least one specialist in each group was asked to respond to faults or misunderstandings and to discuss the descriptions of specialist work.

Confirmability

Organising members' checks and the other methods discussed here, supported the positive effects of the researcher's influence and moderated the negative ones as far as possible. In these attempts 'confirmability' of the data and interpretations was considered to be more important than 'objectivity' (Smaling and Maso 1990:19). This means this thesis must clearly show the links between data and information, so any reader is able to understand the interpretations drawn from the data. The methods used in processing, filing and analysing the data (paragraph 4.2.4) also made these links accessible for other researchers.

"But to imagine that an evaluator, by an act of will or by virtue of clever methodology, can rid himself of subjectivity is the worst kind of fantasy. No human being can ever be objective in that sense. The requirement that information be confirmable rids the inquirer of this impossible constraint; it simply asks that the inquirer report his data in such a way that it can be confirmed from other sources if necessary." (Guba and Lincoln 1982:126)

Taking all aspects together, the risks of multiple roles and biases were moderated by the aforementioned measures. The combination of roles and backgrounds largely enabled the researcher to be a privileged observer of specialist work.

4.3 The surveys: 819 specialists

To obtain a broader perspective on specialists' work and their juris-dictional claims than the perspective of 51 individual specialists in seven groups, the method of surveying was added to the exploratory investigation. In the two hospitals that participated, a local survey was sent to all specialists and all managers. After adjusting the questionnaire, the survey was repeated on a national level, among specialists only.

4.3.1 Themes in the surveys

The interpretative-theoretical studies and the research framework provided the themes for the surveys. In particular the questionnaire designed by Van der Wee was used as a base for the surveys in this study (Van der Wee 2000).

The nature of specialist work in patient care

To be able to put patient care in the perspective of other activities in specialists' day to day work, the survey asked for the average number of working hours per week, and for the distribution of these hours in hospital over the different work areas of patient care, supervision and training, research and education, and organising. The respondents also gave their preferences for changes in this distribution. The analysis of the response was linked with the three categories of specialities.

The 'structural context' of negotiations

As set out in the research framework in paragraph 3.6.3 the professional orientation of specialists presumably provides them with the principles of 'professional primacy' and 'autonomy'. These were translated into several statements in the survey.

Relationships within groups of professionals are characterised by a dislike of mutual hierarchy. To explore specialists' opinion on that, the surveys contained statements about this principle of 'egalitarianism'. Another phenomenon in relationships within professional groups is their commitment to peers, rather than to the organisation they work in. That is why the surveys also asked the respondents about their feelings towards the working context.

The importance of collective forms of specialist organisation (the partnership or speciality group, and the specialist staff) might be expected to decrease when specialists strengthen their position in hospital by management participation. This suggestion was asked for in the surveys as well.

To study the alignment of specialists to the hospital they work in, the respondents were first asked for the measure of present involvement in decision making and the measure of desired involvement in decision making.

The items of involvement in decision making referred to the organisation of:
- specialist patient care and specialist training;
- patient care on wards and outpatient departments;
- hospital policy and distribution of hospital means.

Subsequently, the specialists were asked for their opinion about the need of formal organisational involvement of specialists, about specialist integration and incorporation into the hospital organisation, and about the hierarchical position in relation to other members of the hospital. Then, the surveys asked about the role and position of specialist managers.

Table 4.5 shows an overview of the themes in the surveys.

Table 4.5: The themes in the surveys

the nature of specialist work:	the 'structural context': *professional orientation*	*alignment with the hospital*
working hours	professional primacy	involvement in hospital decision making on the organisation of:
distribution of time over:	autonomy	- specialist care & training
- individual patient care		- wards & OPD's
- care related activities	egalitarianism	- hospital policy & means
- supervision & training		
- research & education	feelings towards working context	formal organisational role / participation
- organisational activities		
	expected future importance of collective forms of specialist organisation	integration and incorporation
preferences concerning distribution of time		relation to hospital hierarchy
		position and role of specialist managers

Background / characteristics of respondents and their context

To relate the findings to individual characteristics, some personal features were obtained (speciality, self-employed or salaried, sex, age). Furthermore, specialist participation in organisation is not an exclusivity of specialist managers. Other kinds of secondary functions create organisational involvement in certain areas of organisation as well, and the surveys asked for the specialists' involvement in these functions too.

4.3.2 Local surveys: pilots

All specialists and managers in both hospitals were asked to respond to a survey about the aforementioned themes. The response rate among the specialists was 55% (138 specialists). Among the managers the response rate was 75% (66 managers). The data in the survey were processed using SPSS[3] 10.1 for Windows.

The results of the local questionnaires were laid out in a report for each hospital and were explained in presentations for the management teams of the hospitals and the boards of the specialist staffs. Within the scheme of this research, only the specialist data were used as a base for the national survey. The local surveys were thus used as pilot studies to design the national survey and to find the scales for the variables studied in the survey.

4.3.3 The national survey

Every variable within the themes discussed in paragraph 4.3.1 was worked out in a set of statements. The results of the pilot surveys were statistically categorised using factor analysis, to adjust the composition of the sets of statements for each variable. Most statements used a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree).

Based on the pilot survey, the minimum amount of respondents needed for statistically adequate processing was set at 400. The expected response rate was estimated to be about 25%, therefore at least 2000 specialists should be sent a questionnaire.

In February 2003 2.107 specialists in Dutch general hospitals, specialised clinics and rehabilitation hospitals received an addressed questionnaire. The recipients were a random sample of all 8.953 specialists working in non-university hospitals. A sample of specialists working in university hospitals also received the questionnaire, but this group was left out of this thesis. The Order of Medical Specialists, the national organisation of specialists in the Netherlands, sent a letter of recommendation with the questionnaire and one week later all physicians in the study received a reminder. A reaction was sent by 804 physicians, which is a response rate of 38%. The number of questionnaires available for analysis was 747, which gave a higher response rate than expected (35% in stead of 25%).

The data presented in this thesis only reflect the opinions of specialists in general hospitals, because the specialised clinics and rehabilitation hospitals are different in organisational character. The research population of specialists in general hospitals consists of 2.000 specialists, of whom 681 returned the questionnaire (34%).Non-response analysis has not been performed because of the anonymity of the respondents and because of practical limits. The questionnaires were scanned by a computerised system (by Scan Serve, Leidschendam). The software of SPSS 10.1 was used for analysis.

A report on all results, including university hospitals, specialised clinics and rehabilitation hospitals was published in 2003 and handed over to the Order of Medical Specialists to be used in policy making (Kruijthof 2003).

External validity (generalisability)

The specialities are categorised in three speciality groups using the composition given in table 2.1. One adjustment has been made though. Psychiatry is usually categorised separately. Since the population analysed in this thesis consists only of specialists working in general hospitals, leaving out psychiatric hospitals, most psychiatrists are consulting specialists. Because their services are secondary to the services of the attending physicians, psychiatrists are categorised in the supporting specialities. For an overview of the categories, the specialities are summed up once more in **table 4.6**.

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Table 4.6: Sample and response national survey

	sample: n (% of total sample)	response: n (% of total response)
medical specialities	739 (37,0)	233 (36,0)
cardiology		
clinical geriatrics		
dermatology		
gastroenterology		
internal medicine		
neurology		
paediatrics		
respiratory medicine		
rheumatology		
surgical specialities	742 (37,1)	249 (38,5)
cardiothoracic surgery		
ear, nose and throat surgery		
neurosurgery		
obstetrics and gynaecology		
ophthalmology		
orthopaedic surgery		
plastic surgery		
surgery (general)		
urology		
supporting specialities	519 (26,0)	165 (25,5)
anaesthesiology		
clinical genetics		
microbiology		
nuclear medicine		
pathology		
radiology		
radiotherapy		
rehabilitation medicine		
psychiatry		
male	1650 (82,5)	569 (84,5)
female	350 (17,5)	104 (15,5)

34 missing values for specialities;
8 missing values for sex

As mentioned before, 34% of the specialists provided responses that were used in the analysis. Speciality and sex are the only features traceable both in the sample and in the response group. The differences between sample and response are small, as shown in table 4.6. Relatively the biggest difference is found in the group of female specialists. They gave the lowest response, causing a slight under-representation of this group.

In traceable features the response group is hardly different from the sample. Since the sample is a random selection, the response group represents the population of specialists working in Dutch hospitals. Whether untraceable features cause the responding specialists to be biased is hard to tell. On one hand specialists who are interested in organisational aspects of their work and profession might be expected to respond and cause a bias related to their commitment to their profession and/or hospital. On the other hand, specialists who are fed up with the debates about specialist - hospital relationships might also be expected to respond and cause a bias related to grievances about organisational aspects.

In short, the results of this survey give a picture of the opinions of Dutch specialists. Based on traceable features of the respondents this picture may be expected to be of value for all Dutch specialists. Nevertheless the potential bias of untraceable features limits drawing generalised conclusions without caution.

In this thesis the results of the survey are intertwined with the results of the case studies. The chapters in Part 2 all present survey results connected with the content of the chapter.

4.4 Strengths and weaknesses of this study

Throughout this chapter the most important strengths and weaknesses of this study have been discussed. They are summed up in **table 4.7**.

Table 4.7: Strengths and weaknesses of this study

	weaknesses	strengths
selection of cases	limited scope: 2 hospitals urban - suburban agglomeration	selection connected with exploratory aim and with characteristics related to specialist work and jurisdictional claims
case study design	focus on 'everyday specialist work', leaving out some other areas (specialist staff, activities at home, outside hospital)	'everyday specialist work' often under-exposed in other studies, highlighted in this one
	surgical dominance in quantity and in period of framework try-out	careful use of neutral research framework for structuring observations
	presence of the researcher: some influence on specialists is inevitable	'social and institutional embeddedness' and researcher skills to gain specialists trust
	only one side of negotiations included: specialists	possibility for in-depth analysis of link between specialist work and jurisdictional claims
researcher's characteristics	multiple roles (work and research) and double background cause the researcher to have multiple biases	several measures to enhance reliability; the multiple roles and backgrounds enable researcher to be privileged observer
survey	untraceable features might cause biased response	traceable features show generalisable response

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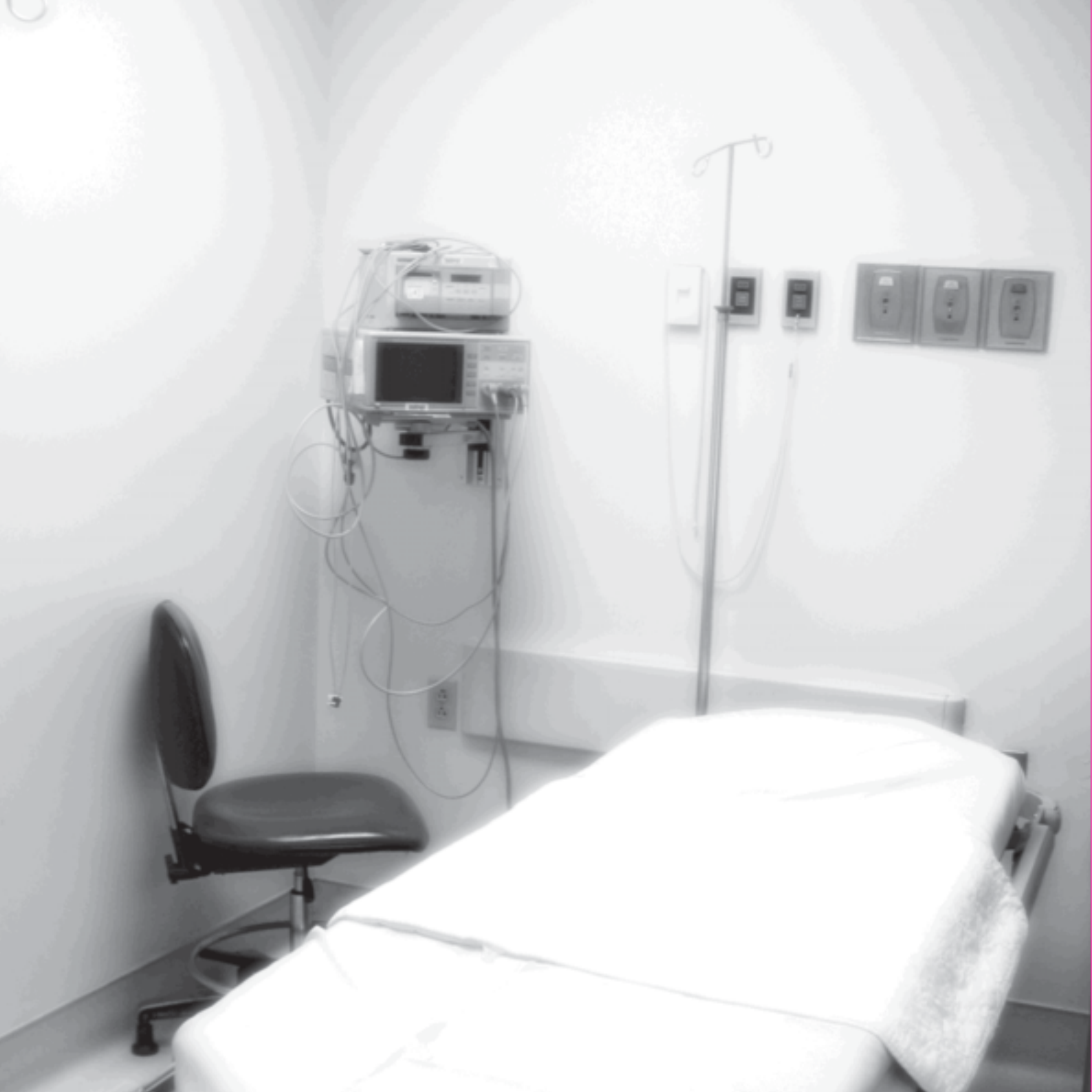

Part 2 Results

Empirical prologue

Introduction

To introduce the reader to the empirical field of this thesis, this prologue gives a 'thick description' of specialists' day to day work (Guba and Lincoln 1982:119, Hutjes and Van Buuren 1997:97, Swanborn 1990:69, The 1999:18). It presents three specialists' working days, one in each of the three different groups of medical, surgical and supporting specialities. The prologue is merely meant to create a feeling of daily routines in specialists' work. The three days will speak for themselves here and further interpretation or conclusions are left aside.

Every situation described in this prologue comes from the observations in the case studies. The three days are composed of different observation days, so the specialists in the three stories do not reflect three real specialists.

A working day in a medical speciality

Start: 8.10 a.m. in own room

Coming from outside, the specialist changes clothes in her own work room. She puts on whites (long coat over regular clothes) and puts some notes from her desk into her pocket. The pager beeps. She answers by phone and listens. "Okay, I'll visit her later today." She needs to check on a patient later.

Then she gets a cup of coffee from the pantry around the corner and walks into the meeting room.

Morning meeting: 8.15 a.m.

Every morning all residents and staff gather to discuss patients seen in the casualty department the day before and those in-patients requiring special attention.

Six fellow specialists, six residents and three students are present. The specialists and the residents are sitting at the table. The students are sitting at the side against the wall.

The physicians on call present information about five patients. One of the specialists asks the students a few questions about metabolic acidaemia and teaches them the essentials of the acid-base balance. The physicians responsible for the wards also present five patients. One patient has not been diagnosed yet and the specialists discuss what to do. One of the residents says: "Well, maybe it's really nothing." The specialist gets angry: "Nothing? You can't say that just because we haven't got a proper name yet!".

The meeting takes about 40 minutes. Afterwards one of the residents, not in specialist training, asks the specialist whether she got the message of her quitting her job. She will start working in another hospital in five weeks. "So I'm just supposed to look for a replacement?", the specialist asks. She doesn't like being confronted with residents just leaving, but she knows she cannot stop them. After finishing the discussion she walks to the outpatient department (OPD).

OPD: 9.00 a.m.

Twenty-three patients are scheduled for appointments this morning. The specialist first takes coffee and tries to drink it immediately. She doesn't like drinking coffee in the consulting room because that's not polite towards the patients. The OPD-assistants take care of the files; the specialist collects each file at the counter, takes a short look at it and asks the patient to come into the consulting room. She prepared most appointments the day before, by reading the files. As recommended by the scientific association of the speciality, ten minutes are available for each appointment. Thirty minutes for new patients, but there are none scheduled for this morning.

All the patients' names for this morning are listed on the monitor. Clicking on a name reveals patient data available. This system is not a full electronic patient record because the physicians can't put anything in. They still have to put their notes in paper files. The electronic data are convenient though, for instance for lab and radiology results that are not yet filed in the record. Besides, the program is adjusted for recording the information needed for DTC-recording. DTC means 'Diagnosis and Treatment Combination', which is the most important element of the new financing system in the Netherlands. Preparing its introduction, all Dutch specialists have to keep track of their activities in each patient contact. After each patient contact in OPD hours, the specialist has to click her way through some dialog boxes to record the adequate DTC-information.

Since no new patients are scheduled, she knows everyone she meets this morning. She starts most conversations with a short outline of previous problems, asking the patient how he or she is doing now. She asks them more about specific somatic problems and about medication. She makes a few notes in the file.

Most patients had their blood taken a few days before this appointment, or had X-ray imaging or other procedures. She discusses the results of these tests and relates the results to the problems in question. Some patients need a physical examination, which takes place on the bench behind the curtain. Some only need to have their blood pressure and weight checked. The specialist writes down this information as well. She then explains the patient whether to continue the treatment or to change some elements in medication or in life style, and discusses when to meet again.

For most patients she fills in forms to order tests that should be done before the next appointment. She walks with the patient to the counter of the OPD-assistants. The patient makes a new appointment there. The specialist asks her next patient in the waiting room to join her to her consulting office.

In the same corridor two specialised nurses meet patients too. They walk into her office twice this morning to ask for her advice. She also gets three phone calls about patients on her ward and three visits from colleagues dropping by.

She works on the outpatient department until 1 p.m. On average she uses nine minutes to meet a patient. She spends 77% of her time in direct contact with her patients. The rest of the OPD-time is spent on reading the files, advising the specialised nurses, recording the patient data, answering the pager and drinking coffee.

Most patients have to wait for five or ten minutes after their scheduled appointment. The last patient can be seen 25 minutes after the appointment time.

Lunch: 1 p.m. own room

She brought sandwiches and eats them in her own room. In the mean time she calls some people about patients and trials and checks her e-mail and regular mail.

Back to the OPD: 1.30 p.m.

The specialist left some files in her consulting room about patients whose general practitioner needs to be informed. She uses a dictating machine to make two letters.

She also calls three patients with whom the OPD assistants made an appointment for a phone call.

One of the specialised nurses is also finishing administration and she asks some questions about the treatment of one of their patients.

Visit to secretaries: 2.30 p.m.

She takes the tapes to the secretary who types out the letters. Some other letters are finished, so she can check and sign them. She congratulates and kisses a secretary who is having her birthday today. One of the other specialist colleagues has taken care of the flowers, on behalf of the partnership. She eats cake with the secretaries.

Wards: 2.40 p.m.

After finishing the cake, she rushes to the ward she is supervising, where one of the residents is supposed to be waiting for her. Twice a week she joins him for rounds. But he is in a meeting with a relative of one of the patients, so she has to wait for him now. She gets coffee from one of the nurses, served in a plastic cup for artificial teeth, because they're out of coffee cups. Waiting for the resident she talks with one of the nurses, refuses to have another piece of cake and takes a quick look at some files of admitted patients.

At 3.00 p.m. the resident runs into the room and they start discussing the patients on the ward. The nurses are too busy to join the meeting, they will join rounds later. The specialist is in no hurry now, her next appointment is at 4.45 p.m.

Six patients are on their ward. Most of them very sick. They talk about each patient for six or seven minutes. For every patient the resident shortly gives information about the reason for being admitted, about how he or she is feeling in general now, and about the new results of tests. The specialist asks questions about results of physical examination, parameters, for instance: temperature, biochemistry (results of tests of blood and urine), and if available further tests from radiology and pathology. Since

the nurses cannot join the pre-rounds meeting, the resident has to look some things up or ask them later. For each patient they also discuss what to do further. What medication is used now? Should this be adjusted? What tests should be performed? What other experts might be asked for consultations (other specialists, dieticians, physiotherapists, specialised nurses). When appropriate the options for discharge are discussed.

The resident takes notes and writes information in the files.

During the meeting, the specialist is paged twice and two nurses come to ask the resident something. The specialist tells the nurses to come back later. One of the other specialists walks by to discuss one of his patients.

At 3.40 p.m. they are ready to meet the patients. The resident takes the cart with files with him. They call the nurse to join the rounds.

The corridors are crowded with personnel and relatives. A daughter of one of the patients greets the specialist in the corridor and asks her a few questions about her father. A new dietician is on the ward and she introduces herself to the specialist and the resident. Contact precautions have to be taken visiting one patient suffering from a contagious disease, which means the physicians have to change clothes. One of the patients belonging to another specialist wants to go home now, although her attending specialist is supposed to meet her before leaving. The specialist cannot convince her to wait for her attending doctor and she tells the patient to make an appointment at the OPD soon, as an alternative. They finish rounds at 4.40.

Multidisciplinary meeting: 4.45 p.m.

The specialist drinks a glass of water in the kitchen on the ward. Then she takes the elevator down and walks to the multidisciplinary meeting room. At the meeting today, the group of specialists here discusses patients with some specialists in a university hospital. They use a video-conferencing system that sometimes breaks down at the moment the meeting starts. Today the system works.

Fifteen physicians are present here. The meeting room has a big table in the centre, where the chairman and some specialists are seated. The residents and the specialists coming in late sit at the tables along the sides. Three consulting colleagues in the university hospital join the meeting by videoconferencing. They are visible here on a big screen on the wall.

All patient information is available in a kind of Power Point Presentations that can be seen on both sides of the video meeting. The slides from radiology and pathology are also presented on both sides.

The physicians talk about six surgical patients, four respiratory medicine patients, three gastroenterology patients, and one general internist patient. The specialists and residents present the patients' cases. The consultants in the university hospital give advice about further investigation and treatment. One patient will be transferred to the university hospital.

The specialist is almost falling asleep. Especially when the lights go down because of the pictures. The pager beeps, so she walks to the corridor to answer the phone.

Back in the room, she joins the discussion about a patient she knows.

At 6 p.m. the meeting is over. The specialist stays in the room to discuss some patients with her colleague.

One more patient: 6.15 p.m., ward

She was paged during the meeting because relatives of one of the patients on the ward would like to ask some questions. Usually she likes them to make an appointment, but today she will walk by immediately because she wants the family to take care of some arrangements for discharge. She discusses treatment and discharge.

After meeting the family she walks by the nurses office at the ward. "Any problems here?", she asks the nurses. She wants to prevent them from calling her just after she leaves hospital. The nurses have a few questions about patients.

Change clothes: 7 p.m. own room

She changes clothes in her own room and puts some notes on her desk. Then she goes home.

A working day in a surgical speciality

Start: 7.30 a.m. in specialists office

She shares a big office with all specialists of the department. Everybody changes clothes there. She puts on white trousers, a clean T-shirt from her closet and a white jacket.

Some letters she dictated earlier are printed and ready to sign. She reads them carefully.

A few colleagues walk in, together they walk to the meeting room.

Morning meeting: 7.45 a.m.

The morning meeting never takes long. At 8 a.m. the next group of physicians wants to use this room, because it's the only room offering videoconferencing with the other location of this hospital, and all speciality groups doing shifts for both locations want to use this equipment for their morning meeting.

This morning the residents have found the television channel on the system, and MTV brings loud music into the meeting room. When the specialists walk in, the residents switch the channel back to videoconferencing. The camera in the other hospital has a strange position, so most physicians there are not visible here. But everybody can be heard, probably about seven people are present there. Five specialists are on this side today, eight residents and seven students.

Every morning all residents and staff meet to discuss the patients seen in casualty, difficulties at the wards and daily practicalities, for instance the availability of beds for emergencies, the distribution of tasks, especially if one of the physicians is absent, or the request to inform the secretaries about holidays.

Last night two patients were admitted in the night clinic at the casualty department. Their situation will be evaluated this morning. The doctors discuss the availability of beds when the patients in the night clinic have to be admitted to one of the wards.

At 7.55 a.m. the meeting is over. The specialist asks a colleague if she can switch a night shift next week.

Rounds: 8 a.m. intensive care unit

Every morning the specialists treating ICU patients meet each other at a multidisciplinary meeting. Today two specialists are present, three residents and two medical students. After a short discussion in the coffee room, they see the patients together.

Today five patients are at the ICU, every patient being taken care of by one nurse. Three patients are on the ventilator, all are attached to monitors and pumps.

The physicians have a look at the file and discuss the things to do and watch today with the nurse. The specialist makes contact with the patients who are conscious. She strokes their arm, asks a few questions and reassures the patients.

Surgery: 8.25 a.m. operating room

The OR is on the same floor. She walks to the dressing room and changes her whites for greens, puts on a cap and takes a mask. The pager beeps: a ward nurse with a question about medication. On a white board against the wall of the corridor the OR program for today is written down. Some names are aside. These are the patients that also might have to be operated today. It is going to be a tight program.

First she has to supervise one of the experienced residents in training. He has already started the procedure and after scrubbing she joins him. They are assisted by an OR nurse. Another OR nurse is present to bring in extra materials if necessary. An anaesthesiology assistant works the machinery for anaesthesia, supervised by one of the anaesthesiologists who walks in now and then. A student watches the procedure.

The resident knows what he's doing, so the specialist quietly assists him. They finish at 9.05 a.m. The resident will dictate the report on the procedure.

She checks on another resident performing surgery. The resident is experienced and should be able to finish the procedure on her own. But because of the tight schedule, the specialist calls a colleague who is doing his paper work this morning. He should come in and speed up the procedure. He agrees.

The specialist finishes a quick cup of tea and walks back to the OR, where another specialist colleague is getting ready to perform surgery with her. It's a complex procedure and she likes working on this together with a more experienced colleague. During surgery they discuss some policy matters of the partnership. The main issue these days is hospital capacity: a shortage of beds and OR-time, mainly because of a shortage of nursing staff. When the physicians want to get patients off the waiting lists, they have to plan procedures. But when many procedures are planned, no spare capacity is left for acute patients. Lately several procedures on planned patients had to be cancelled because of acute patients. These issues are discussed during surgery. What percentage of beds and OR-time should be kept for acute patients? What member of the partnership should make the new schedules? How can both hospital locations be used efficiently?

The procedure takes until 9.35 a.m. The specialist takes a cup of tea and looks at the white board. One of the OR co-ordinators walks by. She is scheduling the extra patients for today. The specialist suggests a certain planning to squeeze in the extra patients. "Mm, first we'll wait and see what time it is when this is ready on OR 3.", the co-ordinator replies. The specialist gets irritated: "Why do you say that, why can't you respond to my suggestion? It is such a negative reaction if you just say you'll wait and see." The co-ordinator says she didn't mean it in a negative way, but she really doubts the planning of the suggestion. The specialist walks away from her. She has to visit the admissions planning office and changes back into her whites.

Admissions planning office: 9.45 a.m.

The specialist is co-ordinating the planning for her department. Every day she visits the planning office to discuss the admission forms with one of the employees and to plan the procedures. Today ten new forms have to be discussed. The specialist and the employee take each form and try to plan the patients. They use a big diary. The planning of the complex procedures comes first. Shorter procedures are planned later. When this first planning is made, the employee calls the patients to discuss the date.

A resident who needs help on the OPD pages the specialist. She promises to walk by in a few minutes.

Outpatient department: 10.05 a.m.

The resident working the OPD is not sure about the best treatment for a patient. That's why she's paged the specialist. The patient looks surprised when the specialist walks in. The resident says: "Yes, another woman! You were surprised to meet me as the attending physician, but I even have a female chief."

The specialist asks some questions and performs a physical examination of the patient. She discusses treatment with the resident and leaves. The patient still looks a bit confused.

Back at the OR: 10.15 a.m.

After changing whites for green again, she checks the white board. The extra patients are not planned yet. She makes a phone call to one of the residents and tells him to suggest her plan to the OR co-ordinator.

She scrubs for another procedure with a resident. Inside she asks for some music. She assists the resident and advises her about techniques. They finish the procedure at 12 and she leaves the room. The resident will dictate their report. The specialist phones the daughter of the patient, to tell her everything went well.

Lunch: 12.10 p.m. restaurant

The specialist buys lunch in the restaurant and joins a table with a few residents in her speciality. They discuss the activities of a consulting psychiatrist. He ran a lot of complicated tests on one of their patients, without discussing this with them. He didn't even make notes in the file! And there's more fuss with the consulting colleagues: one of the residents tells he stopped the insulin pump of a patient and started oral medication again. The internist was furious that the resident had interfered with his treatment.

Rounds: 1 p.m. ward

The nurses expect rounds later today. They're not ready yet, but they will join the pre-rounds discussion anyway. Three nurses join the meeting, one at the time, when their patients are being discussed. For each patient they discuss the expected length of stay and the necessary arrangements for discharge. They discuss eleven patients. The specialist is paged three times, every time about the OR planning. Because of the visiting hours they decide to skip meeting the patients. The resident only needs advice about two patients, so they visit these two patients, amidst a lot of visiting relatives.

Teaching students: 1.30 p.m. meeting room

The students in this department have a weekly class with one of the specialists. The specialist tries to make the students think logically themselves, so she asks questions and makes them discuss the topic.

Secretary: 2.20 p.m.

After finishing class, she walks to the secretaries' office to check on some letters. She discusses the letters with the secretary. The residents usually dictate letters about discharged patients too late. She promises the secretary to make a remark again.

One of the residents pages: he needs supervision of a consultation on another ward.

Consultation: 2.35 p.m.

She meets the resident who is in the room with the patient. She also examines the patient and agrees with her junior colleague: this is not a patient to perform surgery on easily. They discuss at the desk in the hall and find out the attending physician is in his pre-rounds meeting in a room at the ward. They walk into the room and discuss the options for the patient they've seen, watched by two residents, one nurse and a medical student who are all joining the meeting. The attending physician agrees. "Good, I'll eat one of your strawberries on our agreement then!", the specialist says and she takes a strawberry from the bowl at the table. "They're unwashed!", the other specialist says. "I don't mind. I don't wash anything, no problem at all." The other specialist grimaces: "Blah, I never want to be operated on by you then!"

ICU: 2.55 p.m.

The specialist visits the patients she performed surgery on this morning. One of them is already awake. She tells the patient she phoned her daughter. Her daughter will be visiting her tonight. She looks at the files and gives some instructions to the nurses.

Afternoon meeting: 3.30 p.m.

Another daily meeting with specialists, residents and students. They discuss the patients planned for OR tomorrow. The files are available, brought there by one of the secretaries. A medical student starts the first presentation, but the specialist soon interrupts him: "Please, start with information that really matters: the age of the patient, the reason he is admitted and the procedure planned to be done. Then give us the essentials for evaluating the decision to perform surgery: history, physical examination and further test results."

The student tries to complete his presentation in the given order.

They discuss eight other patients. Four of them were planned for surgery already, four of them are extra patients. But the extra patients today probably also have to be planned for tomorrow. The specialist will discuss this with the planning co-ordinators after the meeting.

The meeting continues with an evaluation of the procedures performed today. No specific problems occurred during the procedures.

Radiology: 4.05 p.m.

The physicians then walk to the radiology department. Everyday they discuss the radiological procedures performed on their patients. Seventeen people are present: specialists, residents, also from radiology, and students. First one of the radiologists discusses the CT's and X-rays. Then a second radiologist discusses the ultrasounds. Images of ten patients are being discussed.

Office: 5 p.m.

Usually she stays for some paper work (lab results, letters, dictating) but tonight the partnership has a meeting in the other location. She wants to speak to one of her colleagues there before the meeting at 6 p.m., so she changes now and leaves the hospital at 5.15 p.m.

A working day in a supporting speciality

Giving a general picture of a working day in supporting specialities is more difficult than in medical and surgical disciplines, because of the specific working processes in various supporting specialities. A choice for one of the disciplines is necessary. The specialist here is a radiologist.

Start: 7.25 a.m. own room

He shares a room with one colleague. Most colleagues start later, but he has to report and discuss the X-rays made during the last 24 hours at the casualty department. The meeting there starts at 8 a.m. and he has to look at the images before that.

Now he changes his regular clothes for whites: white trousers and a white jacket. Then he takes the elevator down.

Casualty department: 7.30 a.m.

One of the radiology residents in specialist training is waiting for him. They look at the images together and check the conclusions that were made by the physicians in casualty by reading the patient card. Most of the images are studied and checked briefly. They discuss some patients a little bit longer, for instance a child with fractures: "Check if the child is also known in other hospitals, because it might be child abuse," and an interesting history on the patient card: "Patient suffers from headache when thinking."

A few minutes before eight the residents in emergency medicine and their supervisor, one of the surgeons, walk in. They discuss the images. The specialist repeats his remark about the child with fractures.

The radiologist is paged and answers by phone: "No, you'd better wait for the CT before you plan surgery."

At 8.15 the meeting is over.

Reporting: 8.20 a.m. own room

The radiologist was scheduled to perform gastrointestinal X-rays but had hurt himself playing hockey the night before. He suffers from a muscle strain in his back now and he cannot work the heavy machines used for the program. So he switched programs with a colleague. He will be dictating reports of images this morning.

The urologist walks by, he was called by another radiologist to have a look at an interesting CT-scan. All images are stored in a PACS, a Picture Archiving and Communication System. This enables physicians everywhere in the hospital to look at images. It is a lot easier than having all pictures on film. The radiologist finds the image in question in the PACS and discusses it with the urologist.

One of the radiology assistants asks him to give one of the patients an IV for the intravenous contrast. He walks with her to the patient, brings in the IV and leaves again.

Instructing: 8.50 a.m.own room

He waits for the secretary to give him the order forms with requests for the images that he has to report. In the meantime he performs some deskwork: writing instructions on radiology order forms. Physicians who want to order radiological procedures have to fill in these forms. Sometimes the procedures are standard and the radiology assistants know what to do. Requests that are not standard are checked by one of the radiologists for further instructions.

He looks up previous pictures of a patient for whom a procedure is requested and he finds out that this patient has seven different entries in the PACS. This is why they have to switch to bar codes real soon. Filing by name and date of birth is confusing.

One of the order forms requests a procedure that is not a routine one. The name of the attending physician is not readable and he doubts the match between the information needed and the requested procedure. By calling the ward the patient is admitted to he finds out the name of the specialist who filled in the form. He calls the specialist and tells him he thinks it's better to perform another procedure. The specialist wants to discuss this with a colleague. He'll get back to him later.

Radiology assistants walk by about five times, to get his approval of the technical quality of pictures or to ask for instructions. He also discusses the planning in one of the rooms for this morning: two more patients for an intravenous urogram, one for an MRI of the knee and at 10.30 a.m. someone is scheduled for a balloon angioplasty.

Advising a colleague: 9.10 a.m. ultrasound room

One of his colleagues is doing the ultrasounds this morning. He needs some advice and they discuss further investigations. Back outside the pager beeps. It's the specialist who requested the procedure the radiologist doubts. The requesting specialist still wants this procedure to be done. The radiologist promises to discuss it with his colleague and then calls a colleague radiologist in the other location to discuss the request. They decide to perform the requested procedure. The patient will be referred to the other location, because the radiologists there are more experienced.

Deskwork: 9.20 a.m. own room

The radiologist continues his deskwork. He is paged again. A nurse from one of the wards tells him the T-drain of a patient scheduled for this afternoon came out! "What happened?" the radiologist cries out. The patient had a T-drain, a drain in the bile ducts that leaves the body through the skin. The surgeon put it there. The patient is scheduled for a stent placement in the bile ducts this afternoon, performed by the radiologist. The radiologist needs the T-drain as an entrance. Now he can only hope the drain gave some scar tissue that will help him locate the bile ducts. The specialist will perform the procedure this afternoon with a colleague. He finds the colleague and tells about the T-drain. "How can they destroy a T-drain?"

Instructing and reporting: 9.35 a.m. own room

A radiology assistant asks for approval of the CT. The specialist agrees. He gives instructions for the next CT procedure. Then he starts reporting the CT's made this weekend.

Coffee: 10.10 a.m. room of colleague

One of the other radiologists has a real fine coffee machine. Daily they meet here to drink coffee and discuss work and other items. Today their financial advisor phones them during coffee break. The radiologists will start co-operating with an external commercial company that wants to establish a diagnostic centre in town. They have asked their financial advisor what they can do in this centre, given the existing contracts with insurance companies. The advisor now phones to tell them he doesn't know yet, but he will find out.

Continuing CT reports: 10.40 a.m. own room

This weekend 25 CT's were made. They have to be reported today.

A neurologist walks in to ask for a picture. The radiologist looks in the system and discusses the picture with her. Another colleague asks advice about an MRI. He looks into one of the books, a PhD thesis on the topic. They decide about the message in the report.

At 11 he starts dictating again. He dictates reports on the images of 18 patients. In between he is asked for instructions three times by radiology assistants, he makes one private phone call and one phone call to a general practitioner about abnormalities on a chest X-ray. Also a general internist walks by with a student and a resident; he wants to discuss a patient.

At 12 a.m. the specialist dictates a report about a patient seen at the casualty department. He looks in his forms for the report of the physician on call and reads this patient got plaster. But the patient suffers from gout, causing the lesions seen on the X-ray! There's no fracture.

The radiologist walks to casualty and finds the resident who reported on the patient. He explains the mistake. The resident will make sure the patient is re-admitted and is released from the plaster again.

Before lunch, the radiologist dictates five more reports, instructs three assistants and inserts two IV's.

Lunch: 12.30 p.m. restaurant

At lunch four radiologists eat together in the restaurant. They discuss people who wish to have a total body scan in a check-up. The reliability of these procedures is very limited because of larger numbers of false positive and false negative outcomes. The scientific association had a meeting yesterday. They want to take a stand in this matter.

Another item discussed is the way quality assessment should take place in medicine. Some Dutch organisations want to give 'stars' to good hospitals and physicians. "But the best neurosurgeon gets the worst results. Because he gets the toughest patients! We really have to be careful with this kind of ranking."

The specialist sees the colleague in nuclear medicine and walks over to discuss a patient and a new national instruction about certain scans.

Back on the department: 1.15 p.m.

The specialist takes a look at his e-mail.

Start of procedure: 1.25 p.m.

The patient who needs the stents in his bile ducts is here. While one of the radiology assistants gets the patient ready for the procedure, the two specialists put on protective clothing (an apron with lead) and sterile coats and gloves.

The patient is being covered with a sterile sheet. He is lying in the X-ray machine, with the camera above his right abdomen, and gets sedatives intravenously, because the procedure might take some time and may hurt him.

One radiology assistant assists the specialists in the room. Behind the screen is another radiology assistant who operates the light and the instruments that store the pictures made during the procedure.

The radiologists try to insert the catheter into the bile ducts, using the route made by the T-drain. They check the position of the catheter by X-ray imaging. One of the radiologists operates the X-ray camera by foot. They look at the pictures at monitors.

With the T-drain missing, putting in the catheter needs to be done very carefully. Alternately the radiologists handle the catheter. They are relieved to find out the T-drain left some scar tissue and they can find their way into the bile duct. Still, they have to operate slowly and carefully. When they doubt the route the catheter is taking, they withdraw it a little and try to find the right way again.

They manage to put two stents next to each other into the bile duct ('kissing', which means the stents are touching each other).

At 3 p.m. the procedure is finished.

Supervision: 3.10 p.m. shared room

The radiologist discusses the images of thirteen patients with one of the residents. Then he dictates reports of six patients himself. In between he looks for some codes in the tariff system for one of the radiological procedures, makes the radiologists schedule for the next two weeks and writes it down the white board in one of the rooms. With a colleague radiologist he discusses a series of national meetings about the new financial arrangements.

Meeting with colleague: 5.30 p.m. own room

The minutes of the last partnership meeting always hold some homework. The radiologist now discusses with one of his colleagues the activities that need to be done before the next meeting takes place, like organising a day out with all personnel of the department and teaching the radiology assistants to inject intravenously.

They also discuss some issues that should be on the agenda of the next meeting: their participation in the diagnostic centre and the expected amount of MRI's to be performed next year. The radiology participation in the diagnostic centre is an item on the agenda of the specialist staff next week. They already know some staff members oppose their co-operation.

When the discussion is over, the specialist switches off his computer. He changes back into his regular clothes and leaves the building at 6.20 p.m.

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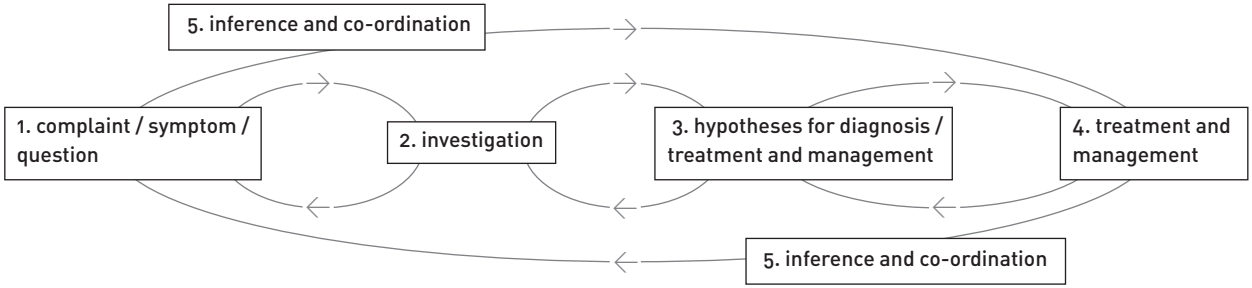
5 The nature of specialist work in patient care

5.1 Introduction

This chapter will describe the nature of specialist work in patient care. Following the research framework in paragraph 3.6.1 work in patient care was analysed by studying the five-step model for individual patient care processes. For the sake of convenience **figure 5.1** presents the five-step model again. All arrows in the picture reflect step 5, which combines inference and co-ordination. This step continuously runs through other steps.

Figure 5.1: The five-step model for specialists work in patient care



Following to the research framework in paragraph 3.6.1 work in patient care was further analysed by studying the organisation of day to day work in patient care: places where work is done, times at which work is done, and persons with whom work is done.

In the course of the case studies, the data about individual patient care processes on one hand and about the organisation of work in patient care on the other were found to be intertwined in many ways. The combined data revealed another important aspect of specialist work: the aspect of logistics. Patient care logistics in hospital are balanced when demand and supply in patient care match. On the demand side of patient care this means the right planned patients show up at the right place at the right time and the acute patients should be expected any place and any time. On the supply side of patient care this means the right doctor shows up for the right patient at the right place at the right time when contacts were planned. It also means enough doctors are available for acute patients, the right patient information is available at the right place at the right time, and human and material capacity (beds, OR time, delivery rooms, nurses, food etc.) suffices for all patients.

Paragraphs 5.2, 5.3 and 5.4 respectively discuss the nature of work in patient care in medical, surgical and supporting specialities. The characteristics described here emerge from the iterative processing of data found in observations and conversations in the case studies of specialist practice (see paragraph 4.2.4).

Paragraph 5.5 discusses the results from the survey concerning the nature of specialist work in terms of working hours, distribution of time and specialists' preferences about the activities they perform.

Paragraph 5.6 presents the conclusions about the nature of specialist work in patient care and an overview of the results in table 5.8.

5.2 The nature of specialist work in patient care in medical specialities

5.2.1 Reasoning about individual patients

In the Dutch language, the medical specialities are called "contemplative specialities". This refers to the essence of practice in these disciplines: reason and inference. Different medical specialities vary in the emphasis on reasoning. Physicians in gastroenterology and cardiology for instance more than general internists need technical skills besides reasoning skills. Leaving these different accents aside, the act of reasoning defines the five-step model for medical specialities. Step 5 in its sense of inference is recognisable in every part of the individual process. Evaluation of individual patient care and deciding about further measures, are connected in a process of reasoning about the individual patient's parameters and about medical knowledge in general.

In the medical field inference often works by exclusion:

"Medicine, for example, tends to work by exclusion. If a case is unclear, doctors maintain a general supportive treatment while ruling out areas by using special diagnostic procedures or watching the outcomes of 'diagnostic' treatments provided beyond the general maintenance."
(Abbott 1988:49[1])

"Knowing the patient's story" (Tanenbaum 1994) is even more important here than in other specialities. That is why the medical specialist in the empirical prologue became angry when a resident suggested that the patient they were discussing might have "really nothing". Jumping to conclusions without having the story complete is virtually forbidden in the medical specialities.

An illustration from the fieldwork:

One of the residents discusses a patient's parameters with one of the specialists and mentions the patient's "liver functions". The specialist corrects him: "Please, don't speak about "liver functions". Only very few parameters really inform us about the functioning of the liver. We should talk of "enzymes". If you say "liver function" you demonstrate that you are not thinking about what you're saying. And that's just exactly what we should do in our speciality here: think about what we're saying and doing."

In short, specialist work in individual patient processes in medical disciplines is characterised by the act of reasoning. Step 5 is found in every other step, especially in its meaning of inference. This nature is reflected in the other aspects of work in patient care.

5.2.2 OPD and ward define times and places

An example of the weekly schedule will illustrate the essence of times and places in the medical specialities. This paragraph then characterises specialist work further by discussing times and places separately.

Weekly schedule

The basis for the week's schedule of activities in the medical speciality case studies looks like **table 5.1**.

Other activities may be scheduled, depending on the specific discipline and individual accents. General internal medicine for instance may have physicians who join rounds on the intensive care unit, or physicians who visit nursing homes for medical advice. A cardiologist's schedule may hold rounds on the cardiac care unit, angiographies and supervision of function tests (ECG, exercise tests). Classes and meetings will be scheduled more in the speciality group that teaches residents in specialist training.

1 Abbott probably refers to the medical profession in general. In the course of this thesis his observation is especially true for the medical (non-surgical) specialities.

Table 5.1: Weekly schedule medical specialities

		Monday	Tuesday	Wednesday	Thursday	Friday
Dr. A	morning	OPD	rounds + supervision	OPD	OPD + consultations	rounds + supervision
	afternoon	consultations	OPD	supervision + administration	-	OPD
Dr. B	morning	rounds + supervision	OPD + consultations	supervision + consultations	rounds + supervision	OPD
	afternoon	OPD	-	1/2 OPD + administration	OPD	supervision
Dr. C	morning	OPD	OPD	-	OPD	OPD + consultations
	afternoon	supervision	rounds + supervision	-	supervision + administration	
etc.						
		8 a.m.: morning meeting	8 a.m.: morning meeting	8 a.m.: morning meeting	8 a.m.: morning meeting	8 a.m.: morning meeting
					12: class for med students	
		4 p.m.: meeting with radiology	4 p.m.: meeting with radiology	4 p.m.: meeting with radiology	4 p.m.: multidisciplinary	4 p.m.: meeting with radiology

Administration =	for instance writing discharge letters, performing organisational activities
Consultations =	visiting patients on other wards for whom advice is requested by the attending physician
OPD =	meeting patients in the outpatient department
Rounds =	visiting patients on the own ward, together with resident and nurses
Supervision =	being available for casualty and for supervising the residents

Times

The morning meetings in medical specialities last longer than in surgical specialities, especially in peer groups who supervise residents in specialist training. Knowing the patient's story is partly a joint effort. Therefore just mentioning a patient's actual condition is not enough. Every patient that is discussed in a formal or informal meeting, is presented as a story, however short. Reasoning about the story and about further steps for this patient, on average takes more time than in other specialities.

Patients in need of care may show up any time. That's why specialists have to work shifts. At night they're not in the hospital. The resident on duty first examines the patients coming to casualty or needing care on the wards and phones the specialist on call if discussion about further management is needed. The specialist decides whether it's necessary to come in to see the patient. One of the specialists tells about working at night:

"At night we get phone calls. But surgeons have to go to the hospital more often than we do. It depends on the resident. I do get in here now and then. My own tutor used to say: 'When you don't understand the story or when you don't trust the resident, put on your pants and go.' That's a good motto."

Places

As seen in table 5.1 OPD and wards are central sites of specialist work. The volume of equipment found there depends on the speciality within the medical disciplines. A cardiac care unit houses more technical machinery than a ward for general medicine.

Every specialist in these disciplines has to be skilled in doing a physical examination, using his or her own observation, usually assisted by a stethoscope and some basic equipment for taking blood pressure and weight.

For many general internists this is the most important range of technical skill. For gastroenterologists and cardiologists more specialised skill is necessary, respectively for instance in performing endoscopical procedures and in performing angiography.

5.2.3 Persons: patient 'ownership' and joint reasoning

Physicians meet many different persons with whom work is done. The case studies showed patients, peers, other specialists and nurses are the most important persons for medical specialists.

Patients: reciprocal 'ownership'

From the observations of individual patient care and from the conversations with specialists emerges the special importance of patient contacts. Physicians in the medical specialities talk more often about the lives, qualities and faults of their patients than physicians in other specialities. On average, they know their patients better and longer than other physicians.

Patients treated by the medical specialities are more often chronic than in other disciplines. Medical specialists who stay working in one hospital grow old together with many of their patients. Because many diseases are chronic and related to several aspects of life, the medical specialists ask more questions about the patient's life in general (habits, work, housing, relatives, daily life). These aspects together give relationships with patients an important dimension in the medical specialities. The special dimension of specialist - patient relations is reflected in the reciprocal phenomenon of 'ownership': a patient has his or her doctor and vice versa. In daily language every physician talks about "his" or "her" patient, and every patient talks about "his" or "her" doctor. However, in the medical specialities the longer lasting relationships cause this ownership to be more visible and to bring more consequences to other aspects of work than in other disciplines.

In line with the importance of the specialist-patient relation and with the dominance of the act of reasoning is another feature. The specialists here reflect more than colleagues in other specialities about their style of communication. They are more specific about the structure in their conversations with patients. For instance some specialists insist on taking a history directly from the patient and interrupt daughters or other relatives who start telling how things are. They also discuss tips and tricks in communication more often than other specialists, for instance how to make your patient trust and follow your advice and how to prevent conflicts. An example:

"How the patient experiences our message is very important." a specialist tells a nurse and a resident. "For instance when I change medication and the new drug by any chance has a lower dose, then I tell the patient: 'I've found you a very good new drug. It is slightly more powerful, so in stead of X40 I now advise you to take Y20.' They always respond: 'That's really good doctor'."

The question of ownership also applies to the triangle of patient, specialist and general practitioner. Because medical problems affect various parts of daily life, patients seem to bring many health problems into the conversation with medical specialists. Specialists usually respond by explaining general problems should be discussed with the GP. Another item in this triangle is the dilemma of when to discharge a patient from OPD-care and refer him or her back to the general practitioner. Clear-cut arguments are hardly available. The arguments used are: patients' preferences, co-morbidity, stability of patient's response to treatment and the quality of the GP. More than in other specialities the specialists comment on the quality of some individual GP's or of the GP's in the district.

Another argument for discharge is the quantitative balance of the population: the number of new patients and the number of discharged patients should be about equal. Thus, all specialists have a more or less personal balance of the population they hold in care. They know that another specialist might reach another balance and discharge more patients back to the GP.

Because of the special and often long-lasting doctor-patient relationship, a change of specialists, for instance because of retirement, is difficult, both for patients and the new specialist. Young specialists want to build their own population and style of communication, and they are often more keen on discharging patients from OPD-care than their predecessors. They have to work hard to create these new balances. They explain they have to 'sell' a discharge to the patients, because many patients are used to a yearly visit to the specialist and feel lost if they are not allowed to come back, "unless with serious complaints". Therefore the 'selling' of a discharge requires motivation, which requires extra tests to obtain evidence for the safety of discharge. One of the younger specialists tells the waiting lists for function tests immediately increased when he started doing OPD-hours: he wanted to 'sell' a lot of discharges.

Peers: joint reasoning

As said before, when medical specialists meet within the own group, for instance in morning meetings or weekly rounds, on average this takes more time than comparable meetings in surgical specialities. The discussion per patient also takes longer because of its character: there's more elaborated reasoning in medical inference than in surgical inference. The medical specialists also seem to visit and page each other more often for in between discussions and mutual advice about patient care.

Work in the medical specialities is relatively lonely when it comes to direct co-operation with colleagues of the own discipline. Every specialist meets his or her own patients in OPD's and on wards and very few hands-on activities require more than one specialist.

Most specialists have certain patient rooms on the wards, see their own patients on the OPD's and communicate with their patients' relatives. It is difficult for medical specialists to step in each other's patient processes. If they do have to step in for each other - no one is available for 24 hours a day - the fact someone else is the actual 'owner' of the patient is always mentioned in some way.

The exclusivity of the patient-physician relationship causes a few specialists to wonder whether they should not organise a bit more circulation of patients between specialists. For "every physician has his blind spots." But they also say the patients would not like that.

They do discuss and know each other's patients. Especially the inpatients are known from shifts, morning meetings and shared rounds. When patient care is shared, for inpatients, the ownership also becomes a little shared. More than in other disciplines the specialists and residents ask each other the question: "By the way, how is Mrs. X doing?" This also connects to the importance of reasoning: specialists in these specialities need to know the whole story.

Other specialists

Within the processes of patient care, medical specialists seem to meet specialists of other specialities more often than surgical specialists. The largest category of these interactions is connected with shared involvement in the care for an individual patient. Many patients have co-morbidity and need the services of more than one speciality for separate problems. Sometimes other specialities are asked to assist in the act of inference about diagnosis or treatment. The specialists not only ask other specialists for consultations on their patients. They are asked as well and this brings them on the wards of all other specialities.

Formal communication between specialists about consultations is written on consultation forms. Specialists also visit and phone each other about advice. When relatively many patients are shared, multidisciplinary meetings are scheduled. For instance internal medicine and general surgery meet weekly, to discuss the inpatients for whom a combination of specialist care is needed. Sometimes the organisation of patient contacts is multidisciplinary, for instance a gynaecologist and an internist meeting pregnant women with diabetes during special OPD-hours.

Collecting information in the act of diagnosis (step 2), and reasoning about it in the act of inference (step 5), specialists also need colleagues in the supporting field to help them obtain and interpret data. They meet the supporting specialists ad hoc, by phone, or in scheduled meetings (radiology).

The question of ownership also creates a triangle of patient, specialist and other specialist. Problems of a medical character, especially new problems, are often not self-evidently connected with one medical speciality only. There are several candidates. These situations cause specialists of different medical specialities to discuss the proper 'owner' of new patients and problems.

Nurses

Nurses on the wards join physicians in pre-rounds discussions and in rounds, during which they ask for the medical interpretations of parameters, information on medical decision making and instructions for further treatment. The physicians want the nurses to provide information about the patient's bodily functions (parameters) and about the co-ordination of the care process. When a specialist happens to meet a nurse who is not thoroughly informed about the patients, the pre-rounds discussion usually causes frustration. A situation in a pre-rounds meeting:

The specialist has already asked the nurse about three patients whether necessary investigations, ordered earlier, have been organised. The nurse doesn't know and has to ask later. Just to be sure the tests will be organised soon, the specialist writes another form for each of these three patients. This might appear to have been unnecessary, when the procedures are indeed requested as expected. When for the fourth time the nurse doesn't know whether the request has been processed yet, the specialist gets annoyed: "Again you don't know! Now I have to write yet another form! This way you'll keep the bureaucratic paperwork going!"

Step 5, inference and co-ordination, is essential in individual patient processes in medical specialities. Specialists cannot manage these processes by themselves. For the inpatients they rely on ward nurses. When a nurse cannot provide the adequate data about the individual processes, specialists can get bad-tempered about it as it hinders their most essential act.

Physicians and nurses both take care of inpatients, but they have different focus points within their care. Because hands-on work is relatively rare, apart from physical examination, they don't share many technical procedures either.

The longer lasting processes for chronic patients make standardisation of various aspects of their care possible. This creates room for delegating specialist work to non physicians, for instance to specialised nurses on the OPD who see chronic patients suffering from diabetes (internal medicine) or heart failure (cardiology). The specialists supervise their OPD-work and they sometimes meet patients together. Most of the activities take place in separate rooms.

5.2.4 Logistics: organising patient contacts

Logistics combines individual patient processes with organisation of work in patient care over time. The case studies reveal this to be an important aspect in specialist work, hence it is discussed separately in these paragraphs about the nature of specialist work in patient care.

The various elements of logistics were introduced in paragraph 5.1.

Medical specialists seem to think about logistics largely in terms of organising patient contacts. Organising patient contacts means preparing, scheduling, planning and working on patient contacts in general. Specialists in the medical disciplines are more alert to this and talk more often about it than colleagues in other fields of medicine. When they talk about the rhythm of a working day for instance, they often explain how this rhythm relates to the patient contacts they have daily: they want to come in early to prepare the appointments with patients in OPD-hours, or they have to eat some biscuits in between because they don't want to eat in front of their patients.

The characteristics of specialist work in medical specialities are summed up at the end of this chapter in table 5.8.

5.3 The nature of specialist work in patient care in surgical specialities

5.3.1 Decision making about surgery on individual patients

Being trained and licensed to perform surgery defines being a specialist in one of the surgical disciplines. This is why decision making about surgery on individual patients is a central element of surgical inference.

Central questions in decision making concern the indications for surgery as a means of diagnosis or treatment, and the preparations if surgery is indeed indicated. If surgery is not indicated, specialists need to know whether the patient can be referred elsewhere or should stay under surgical control because surgery might be necessary in the near future.

Inference by exclusion, common in medical specialities, is especially possible when professionals get second chances. In surgical specialities the impact of surgery limits having second chances: trying out if medication works as a treatment (diagnostical treatment) is more acceptable than trying out if surgery works. Abbott (1988) also distinguishes inference by construction, which is found more often in surgical specialities, especially in the phase of decision making about surgery. Inference then follows rules and guidelines that combine considerations of probabilities, error and difficulty and that help construct the decision about surgery. By following these rules and guidelines both the patient and the physician are protected from unnecessary surgery. Once a patient has had surgery, the phase of recovery more resembles medical patient care processes.

In short, specialist work in individual patient processes in surgical disciplines is characterised by the act of surgery in diagnosis or treatment. Inference about diagnosis and treatment is characterised by decision making about surgery on the individual patient. These characteristics are reflected in the other aspects of work in patient care.

5.3.2 OR, OPD and ward define times and places

Weekly schedule

The basic weekly schedule for activities in the surgical case studies looks like **table 5.2**.

Different activities may be scheduled in different disciplines and for different individuals. A general surgeon for instance may be scheduled to take part in multidisciplinary rounds at the intensive care unit, or to supervise OPD-hours for patients with wounds. Gynaecologists supervise the delivery rooms and are scheduled to perform ultrasounds.

Table 5.2: Weekly schedule surgical specialities

		Monday	Tuesday	Wednesday	Thursday	Friday
Dr. A	morning	OPD	rounds + supervision	OPD	OR day care	rounds + supervision
	afternoon	OR	OPD	supervision + administration	-	OPD
Dr. B	morning	rounds + supervision	OR day care	supervision + administration	rounds + supervision	OPD
	afternoon	OPD	-	OR + administration	OPD	supervision
Dr. C	morning	OR	OPD	-	OPD	OR
	afternoon	supervision	rounds + supervision	-	supervision + administration	
etc.						
		7.45 a.m.: morning meeting	7.45 a.m.: morning meeting	7.45 a.m.: morning meeting	7.45 a.m.: morning meeting	7.45 a.m.: morning meeting
		8 a.m.: class for med students				
		3.30 p.m.: pre-OR presentation	3.30 p.m.: pre-OR presentation	3.30 p.m.: pre-OR presentation	3.30 p.m.: pre-OR presentation	3.30 p.m.: pre-OR presentation
		4 p.m.: meeting with radiology	4 p.m.: multidisciplinary meeting	4 p.m.: meeting with radiology	4 p.m.: multidisciplinary meeting	4 p.m.: afternoon meeting

Administration = for instance writing discharge letters, performing organisational activities
OPD = meeting patients in the outpatient department
OR = operating rooms
OR day care = operating rooms for smaller procedures; patient goes home the same day
Rounds = visiting patients on the own ward, together with resident and nurses
Supervision = being available for casualty and for supervising the residents, often combined with consultations

Times

Surgical physicians meeting each other have relatively short discussions on individual patients. The items that matter are more specific than in the medical specialities, which makes meetings, pre-rounds discussions and rounds shorter.

The OPD-observations in the case studies show the average length of an individual doctor-patient contact is the same in surgical as in medical specialities. Very short OPD-contacts (less than four minutes) are more likely to be observed in surgical specialities. Doctor-patient contacts in the operation room of course can take several hours.

The specialists are usually not in hospital at night, but when acute surgery is needed or might be needed, they have to go in to supervise the resident on call. This brings them to the hospital more often at night than medical specialists.

Places

Operating rooms are central sites of specialist work in surgical specialities. They provide technical surroundings with a lot of equipment and material. Every specialist in surgical disciplines is trained to operate on patients, using various instruments and machinery.

The specialists are users of the operating rooms and of the equipment. In the organisation structure of the hospital they do not formally own the operation department or the equipment.

5.3.3 Persons: focus on facts and joint decision making

Patients: focus on facts

The physicians in surgical specialities predominantly need to find facts in their contact with individual patients. Their remarks in and about individual contacts with patients mainly concern doubts and dilemmas in getting clear-cut diagnoses and decisions on treatment. They need facts to be able to complete decision making.

On average the surgical specialities have less chronic patients than the medical specialities. This makes individual physician-patient-contacts less long lasting than in the medical specialities.

Performing surgery on someone is a more radical kind of practice than prescribing drugs or regimens. This brings the item of informed consent more often explicitly into the doctor-patient contact than in medical specialities.

Reciprocal 'ownership' of doctors and patients is less tight than in medical specialities. The importance of logistics, discussed later, requires some flexibility: planning and organisation of surgery is easier when various specialists can operate on various individual patients. Ownership is more visible in relation to the act of surgery: the physician who operates on a patient will always visit the patient afterwards, regardless of other physicians supervising the ward. He or she will usually also be the one the patient meets at OPD-appointments.

Referral or discharge takes place when surgery is unlikely to be indicated anymore.

New physicians taking over OPD patient populations in surgical disciplines may have a difficult first period, because they have to get acquainted with the line of decision making their predecessors followed with each patient. If they want to change it, they have to explain that to the patient. These difficulties last a shorter time than in the medical specialities, because the average period of specialist care for a patient is shorter. Therefore the effort of making a population match the personal style and organisation of the physician is less obvious here.

Peers: joint decision making

The importance of decision making about surgery is reflected in the joint discussions on individual patients. Every decision about surgery on an individual patient is discussed and shortly evaluated before it actually takes place. One of the surgical groups in the case studies suffered from troubles in the mutual co-operation at the moment of the case study. Joint discussions were observed much less here than in the two other surgical groups. The follow-up contacts in this case study, after a change of specialists, show the present situation in this group is comparable to the other groups.

One of the surgical specialists explains the shared decision making:

"Practice in our speciality is suitable for evaluation and testing: you have to discuss indications for surgery before you operate on a patient. Those indications are obvious, visible. That's why we're used to putting our practice to the test. In other specialities the topics discussed are less obvious and hence less suitable for evaluation."

In line with the importance of decision making and decision evaluation is the attention for guidelines in surgical practice. In joint meetings the specialists often point out the use of directives and they remind each other and the residents to use them properly. They are used as an extra means for evaluation and testing.

Surgical work has more joint hands-on work than medical work. Most surgeons and gynaecologists (the ones observed in the case studies) perform surgery together now and then. All specialists in groups with residents in training are used to working close together with their young colleagues. During OPD-hours specialists work alone.

Other specialists

Specialists in surgical disciplines meet colleagues of other specialities slightly less often than specialists in medical disciplines. The first category of activities is, as in medical specialities, shared involvement in the care for individual patients. Surgical specialists are asked for consultations, for instance when advice is needed as to whether surgery is appropriate as a means of diagnosis or treatment. The surgical specialist in the empirical prologue had to assess this for a patient on a medical ward. Furthermore, they also ask colleagues for consultations, they join multidisciplinary meetings, multidisciplinary OPD-hours (for instance in oncology) or multidisciplinary surgery (for instance urology and gynaecology). They meet the supporting specialists ad hoc or in scheduled meetings.

The second category of activities is referred to as shared logistics. These are all activities in which the specialists streamline multidisciplinary individual patient care. The specialists in surgical disciplines seem to be more involved in these activities of streamlining and joint planning than their colleagues in medical specialities.

Nurses and other non physicians

The essential questions in surgical decision making are quite specific. This gives discussions with ward nurses a more matter-of-fact character than on the medical wards.

Delegation of tasks to specialised nurses at the OPD is possible in processes that allow some standardisation, for instance in the guidance of patients in oncology (specialised nurses in surgery) and during pregnancy (midwifes in gynaecology).

Physicians performing surgery are always assisted and accompanied by non-medical workers, for instance OR-assistants. The togetherness during hands-on activities on OR, the fact that everybody on OR looks exactly the same (green clothes and wearing masks and caps) and the closed character because of the sterility give OR's an exclusive atmosphere compared to other departments in hospital. Within the shared hands-on work, the tasks of non-medical assistants and physicians still are separate.

The importance of planning and logistics (see paragraph 5.3.4) give surgical physicians a special relationship with employees of the planning office. Especially in times of shortages the employees and the physicians share the difficulty of not being able to schedule every patient immediately. Prioritising patients is hard for everyone. The balance between planned patients and acute patients is quite easily disturbed when the capacity in demand decreases, for instance because of an understaffing in the OR. The demand of acute patients is hard to regulate, so the planned patients have to be put on longer waiting lists.

In these situations specialists and employees of the planning office together try to cope with the planning of patients.

5.3.4 Logistics: patient flows and availability of capacity

All specialists in the case studies were observed to spend a lot of time and attention on logistics in patient care. Compared to other specialities, surgical physicians spent the most time and attention on logistics.

The various elements of logistics were introduced in paragraph 5.1: right patient, right time, right place, right doctor, right information, adequate capacity. These separate issues all have to be taken care of, which seems to require continuous attention of the surgical specialists. To make matters more complex: in gynaecology 'the right time' for a patient also quite often depends on her menstrual cycle, because diagnostic tests have to be performed on certain days.

An operation is usually only one moment in an individual patient care process. If specialists cannot meet new patients to operate on, the act of surgery is threatened. Therefore the surgical specialists seem to think about logistics largely in terms of patient flows and capacity. On many moments and occasions they discuss the availability of physicians and capacity and the flow of acute and planned patients. They also look for better ways of organising:

"During the day one of us has to supervise the residents. Now it's often combined with OPD, which is rather inconvenient because all OPD-patients have to wait for you if you have to see an acute patient. We want new schedules in which one specialist supervises the residents for a whole week, without OPD-hours in that week. And we also want the part-timers to take a whole week then. Then they can work less in the other weeks. Maybe it's difficult for the part-timers, but when they know far in advance they'll manage."

Because of the attention for logistics, individual physicians in surgical specialities reflect on tips and tricks in logistics. For instance: making sure every OPD-patient is seen right on schedule prevents loss of time through patients complaining about waiting. Or: giving in to a difficult, time-consuming patient who wants to have an extra visit immediately might seem inadequate. However, it prevents the patient from showing up in the evening, when he or she will probably meet the resident first. Then such a patient becomes even more time-consuming.

In line with the focus on facts in the contacts with patients, physicians are alert to the arrangement and availability of patient information. In one of the surgical case studies the development of an electronic filing system for the wards was being prepared. Individual specialists are often keen on the completeness of files and on the routing of the files. Missing information can cause delay in decision making, which hampers a smooth patient process. An example:

One morning of OPD-hours is disturbed by the absence of X-ray pictures. Many patients here have an appointment for making an X-ray before coming to the OPD. They're supposed to bring the X-ray picture with them, so the physician has the latest information. But today radiology refuses to release the pictures from the department, allegedly because too many pictures get lost before they get a proper report from one of the radiologists. Phone calls from the specialist don't help. He has to ask several patients to make another appointment, because without X-rays he cannot decide on further treatment.

The characteristics of work in surgical specialities are shown in table 5.8 at the end of this chapter.

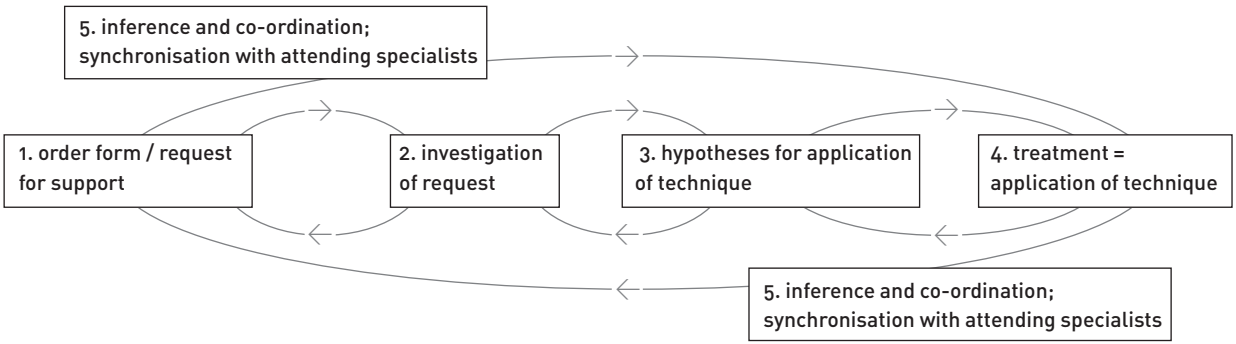
5.4 The nature of specialist work in patient care in supporting specialities

5.4.1 Connecting the acts of inference about individual patients

Physicians in the supporting specialities are never the first ones to meet the patient in hospital. They facilitate other specialists' steps, by applying their specialist knowledge and techniques to the individual patients other physicians bring them. This causes the supporting specialities to have double acts of inference that need to be connected. By definition they follow the primary processes of the specialists who request their services, in a supporting act of inference in which they offer services to the requesting disciplines. They also have their own act of inference in which they connect the requests for services with the application of their knowledge and skills.

Their work processes require an adjusted picture of the five-step model that puts the request for support in the first step (see **figure 5.2**).

Figure 5.2: The five-step model for specialist work in patient care in supporting specialities



Radiology and anaesthesiology, the supporting specialities analysed in the case studies, have different accents that are worth mentioning here.

In radiology supporting inference is laid down in reports about the images, which makes up a major and essential part of specialist work and specialist training. The own inference of radiology itself connects the request for imaging with the application of imaging techniques. Statistical considerations are important in radiology's own inference. False negative and false positive findings threaten the quality of radiological results. To prevent these, the request has to be carefully related to the radiological application. Radiological inference is largely by exclusion, starting with simple imaging and proceeding with more complex procedures when necessary. In its supporting inference, radiology sometimes provides ingredients for a decision by construction. For instance an X-ray showing air under the diaphragm constructs an indication for surgery.

Supporting inference is less dominant in anaesthesiology, although not absent. When a decision about surgery is uncertain, the anaesthesiologist will contribute to the surgical inference by providing information about the patient's fitness for anaesthesia. Another area for supporting inference is the ICU, where the co-ordinating anaesthesiologists advise and support the attending physicians about their acts of diagnosis and treatment.

Supporting inference on the ICU is often by exclusion, although patients in a precarious condition require inference by construction.

The own inference of anaesthesiology, connecting the request for anaesthesia with the application of anaesthesia, nowadays partly takes place in patient contacts in the outpatient department, at least for non acute patients. Inference about the application of anaesthesiological techniques is usually by construction.

New processes in supporting specialities are developing fast. Anaesthesiologists for instance are specialists in pain control and they can use their knowledge not only to support surgery but also to treat pain when it is a separate problem. Some anaesthesiologists in the case studies see patients during OPD-hours for pain management.

Radiologists are specialists in imaging and they can use their knowledge and equipment to combine imaging with treatment. Under X-ray imaging they insert gastrointestinal or vascular stents or drugs or other materials very precisely. These procedures introduce processes in which treatment is more important than supporting inference, but the process as such is not 'owned' by radiology. The request for the procedure always comes from another speciality.

5.4.2 Equipment defines times and places

Weekly schedule

The basis for the weekly schedule of activities in the supporting speciality case studies looks like **table 5.3**.

Other activities may be scheduled, depending on the specific discipline and individual accents. In anaesthesiology for instance one of the specialists co-ordinates patient care at the ICU. Alternately anaesthesiologists also have OPD-hours for pre-operative assessment or for pain management. Radiology has daily scheduled meetings with other specialities, and radiologists are alternately available for advice about procedures for acute patients.

Table 5.3: Weekly schedule supporting specialities

		Monday	Tuesday	Wednesday	Thursday	Friday
Dr. A	morning	room 1 + 2	room 1 + 2	room 3 + 4	-	OPD or procedures
	afternoon	room 1 + 2	OPD or procedures	room 1 + 2	-	
Dr. B	morning	room 3 + 4	-	room 1 + 2	room 1 + 2	room 3 + 4
	afternoon	room 3 + 4	-	room 3 + 4	OPD or procedures	room 3 + 4
Dr. C	morning	-	room 3 + 4	-	OPD or procedures	room 1 + 2
	afternoon	room 1 + 2	room 1 + 4	-	room 1 + 2	room 1 + 2
etc.						
		12.30 p.m.: class with residents		12.30 p.m.: class with residents		

OPD = meeting patients in the outpatient department (anaesthesiology: pre-operative OPD or pain management OPD) performing imaging in the outpatient department (radiology)
Procedures = procedures under X-ray imaging (radiology)
Room = operating room (anaesthesiology)
Room for CT, MRI, X-ray, Bucky etc. (radiology)

Times

Daily rhythm is different for anaesthesiologists and radiologists. Both groups supervise and perform procedures. In anaesthesiology, when a patient is stable, the anaesthesiology assistant usually stays with the patient and the anaesthesiologist can leave. He or she should be available close by, in case direct supervision is necessary. Availability is the main reason the anaesthesiologist is around the OR. The ICU and the OPD define work rhythm outside the OR, which gives various patterns of workload.

When the radiologist is not performing procedures he or she starts directing the individual patient processes, investigating requests, giving instruction on techniques, interpreting and discussing images, and reporting back to the requesting specialists.

Comparing both case studies, radiology seems to have a continuous pace of keeping the flow going, anaesthesiology seems to have more variety in moments of high and low pace.

Being on call is different for radiologists and anaesthesiologists. The latter always come in when anaesthesia is required on acute patients. The former have to come in for complex procedures. The routine imaging is taken care of by the assistants and (in the case study) the residents.

Places

Since the technical equipment specialists work with is concentrated, supporting physicians usually work in a limited number of rooms. For anaesthesiology these are operating rooms, ICU and OPD. For radiology all sites are concentrated in a radiology department, although radiologists now and then may be found performing procedures or discussing pictures elsewhere.

Because the specialists are usually close to the equipment they need, the colleagues of one discipline share the work areas and most colleagues are always close by.

Every specialist in supporting disciplines is trained to work various instruments and machinery. The specialists in supporting specialities more than other specialists seem to be the owners of the department and its equipment, although formally they are not. In the case studies this was more true for radiology and the radiology department than for anaesthesiology and its various working sites (OR, OPD, ICU).

5.4.3 Persons: short patient contacts and joint service

Patients: short and singular contacts

Leaving pain management in anaesthesiology out of consideration,[2] physicians in supporting specialities mainly have singular contacts with individual patients. The radiology assistants perform the simple imaging procedures in radiology and the radiologists don't even meet these patients at all. That's why a lot of the attention spent on individual patients is not spent on the patients personally but on communicating about them, for instance in discussions with their attending physicians. This is more true for radiology than for anaesthesiology.

In remarks about individual patient care specialists reflect on the momentary character of the contacts as a feature that makes the speciality attractive: you do have patient contacts, but only short ones, and they never get too difficult. Since specialists do not have an 'own' population, new specialists do not 'inherit' a patient population from predecessors either.

Supporting physicians don't own patients, patients are 'owned' by their attending physicians. Every patient in supporting specialities crosses boundaries between different specialist areas, which makes these boundaries an important item in specialist work. For instance when it comes to patient information. Patients sometimes ask anaesthesiologists information about surgical procedures. And sometimes the attending surgical physician has already discussed anaesthesiological techniques with the patients. In radiology, requesting specialists order specific images, while sometimes the radiologists think another kind of imaging might be better. In these situations the supporting specialists have to move along the borders between their own and other specialities. The patients are between specialities. An example of a situation in radiology:

One of the patients needing CT imaging has a port-a-cath (a little device placed surgically under the skin of the chest in order to give drugs into a large vein). His attending physician had told him he wouldn't need an IV for the CT contrast fluid, because of the port-a-cath. But contrast fluid needs to enter the body fast. And this can't be done with a port-a-cath, because of the reservoir. The radiologist explains the patient he really needs another IV.

Peers: joint service

The organisation of day to day work in patient care in the supporting specialities is intensively measured to the needs and organisation of requesting specialities. This leaves little room for individual variances in medical practice. Although the use of guidelines is little discussed in the supporting specialities, every individual physician works largely according to standards agreed upon by the speciality group. This makes the supporting specialists replace each other quite easily.

Joint hands-on work is limited, but mutual stepping-in during breaks or other short periods of absence is more common than in other specialities.

Other specialists

Supporting processes by definition are intertwined with the primary processes. This brings many contacts with specialists of other disciplines, either by working in the same room (anaesthesiology) or by many ad hoc and scheduled meetings (radiology). The two major categories of activities are similar to surgical specialities: shared involvement in individual patient care and shared logistics in the synchronisation of patient care with other specialities (also see the next paragraph about logistics).

2 The processes in pain management are comparable to medical processes. More than medical specialists the anaesthesiologists can perform treatment themselves (for instance blocking of peripheral nerves).

Assistants and other non physicians

The connection between request and application is routine for a large sample of all radiology cases. Routine decision making about technique and planning is standardised and performed by administrative employees. Routine treatment (the application of imaging techniques) is performed by the radiology assistants. The more complex procedures are reasoned about and performed by the radiologists themselves.

The anaesthesiologists do not delegate the inference about the connection between request and application. The major risk of wrong decisions about anaesthesia prevents this act of inference from becoming standardised. Treatment within anaesthesiology, applying anaesthesia, is largely standardised though, and partly delegated to anaesthesiology assistants. When unexpected events occur, immediate inference is necessary for diagnosis and adjusted treatment. The anaesthesiologists themselves are always available for these acute acts.

The delegated tasks make the co-operation with non physician workers most tight in the supporting specialities compared to the other ones. Radiology assistants and anaesthesiology assistants perform many of the hands-on activities, with the specialists available to supervise and intervene themselves at critical moments or for complex procedures.

5.4.4 Logistics: synchronisation with other specialities

Supporting physicians focus their logistics on the synchronisation with other specialities. When the ICU for instance has its daily meeting to discuss patients, radiology has to make sure the reports of the images are available.

In anaesthesiology the pre-operative OPD is a relatively new phenomenon in the Netherlands, partly related to the issue of logistics. In earlier times the anaesthesiologists met the patients needing anaesthesia on the wards, shortly before surgery. For two reasons, the meetings with patients planned for surgery are now taking place during OPD-hours. The first reason is logistics. Pre-operative assessment sometimes reveals unexpected problems that may complicate the anaesthesia. Problems found shortly before surgery forced the anaesthesiologists in the past to postpone the procedure. Besides, the number of patients being operated on in day care increased, which made the logistics for pre-operative assessments on the wards too complicated. On the OPD, possible problems can be analysed and proper measures can be taken. The second reason is legislation. By Dutch law, anaesthesiologists have their own contract with patients given anaesthesia. Informed consent for anaesthesia should be obtained by the anaesthesiologists themselves, not by the surgical physicians. This requires a meeting in which the anaesthesiologists discuss all aspects of their treatment with the patients.

The logistics of information also require attention; in the radiology case study a computerised system for the storage of images is available in one of the two hospitals (PACS = picture archiving and communication system). This makes the ever existing problem of lost X-rays largely disappear.

The characteristics of work in supporting specialities are shown at the end of this chapter in **table 5.8**.

5.5 Specialist work: results from the questionnaire

So far the results from observations and conversations in specialist practice have been discussed. The results of the questionnaire help form an overview of specialist work in general.[3]

To get acquainted with the respondents, a short introduction of some background characteristics will be presented first. Then, the working hours and the various activities performed in working hours will be discussed.

The respondents in the three speciality groups

On average the respondents are 49 years old. Female respondents are younger than the male respondents, 43 versus 50 years respectively.[4]

The surgical specialities have the lowest proportion of women, 10%, compared to 18% in the medical specialities and 20% in the supporting disciplines.

3 For methods, see chapter 4.

4 Differences in nominal data are identified by a $p < 0,05$ using Chi-square test or ANOVA.

The surgical specialities also have the smallest proportion of salaried specialists. Since women work salaried more often than men, 45% versus 18%, a connection might be expected. However, the difference is repeated within the populations of male and female respondents only. Within the male surgical population 9% of the specialists are salaried, versus 20% and 31% within the male medical and supporting specialities respectively. Within the female surgical population 22% of the specialists are salaried, versus 52% in both other groups.

Table 5.4 gives an overview of the respondents' characteristics discussed here.

Table 5.4: Respondents; age in years; sex and employment in percentages of respondents

	age	female	male	self-employed	salaried	combination
medical respondents	49	18	82	70	24	6
surgical respondents	49	10	90	86	9	4
supporting respondents	47	20	80	58	31	5
all respondents	49	15	85	73	20	5

n = 642 (39 missing values)

12 respondents, most of them in the supporting population, reported "other" for employment

Working hours

The working hours of specialists are hard to define, among other things because of work done at home or elsewhere and because of availability shifts and varying activities in evenings, nights and weekends. To get a picture of working hours, the survey first asked for working part-time or full-time and second for the weekly number of hours on average spent in hospital.

Almost 73% of the specialists report to work full-time, which keeps them in hospital for 50 hours per week on average. The 27% of the respondents working part-time report to work 33 hours weekly.

The different specialities statistically have equal proportions of part-timers. Women more often work part-time than men, respectively 68% and 20%. Salaried specialists work part-time more often than self-employed specialists, 42% versus 21%. This difference is repeated within the group of male respondents only, where 28% of the salaried specialists work part-time and 17% of the self-employed specialists.

The youngest group of respondents, 40 years and younger, holds the highest proportion of part-time working physicians, which is 44%. This seems to be related to the 40% proportion of female specialists in the youngest group rather than to age in itself, because the difference is not found within the group of male respondents.

The main results concerning working hours are reported in **table 5.5**.

Table 5.5: Working hours; full-time and part-time in percentages of respondents; hours in average number in hospital per week

	full-time	part-time	full-time hours	part-time hours
medical respondents	73	27	51	34
surgical respondents	77	23	51	33
supporting respondents	72	28	48	32
all respondents	73	27	50	33

n = 624 (57 missing values)

Activities within work

The questionnaire presented five different activities in specialist work: individual patient care, for instance work on wards, day care, OPD, OR; care related activities, for instance dictating letters, attending meetings about patient care; supervision and training, for instance supervising and training medical students and residents; classes and meetings; research and education, for instance reading literature, attending education, supervising or doing research;

organisation, for instance organisational meetings, committees, making schedules, management.

The specialists were asked to distribute their 100% time spent in hospital among these five items. They were also asked whether they were satisfied with the amount of time for each activity. **Table 5.6** shows the respondents' reactions.

Almost 80% of time in hospital is spent on individual patient care and care related activities. A little more than 10% is spent on supervision and training, and on research and education. A little less than 10% is spent on organisation.

On average the specialists are satisfied with the time they can spend on each activity. Many specialists would like to have some more time for supervision and training, and for research and education though. Respondents not being satisfied with the amount of time spent on care related activities and organisation are more likely to prefer a decrease of these activities than an increase.

Table 5.6: Activities; distribution of time in mean percentages; satisfaction with distribution in percentages of respondents

	% of time spent on this activity	this is the right amount of time for me	I'd rather spend more time on these activities	I'd rather spend less time on these activities	total
patient care	64,7	63,0	16,1	20,9	100
care related	14,1	61,5	8,5	30,0	100
supervision & training	5,7	51,8	45,2	3,0	100
research & education	6,1	41,0	57,0	2,0	100
organisation	9,4	59,4	12,6	28,0	100
	100				

n = 673 (8 missing values)

Men and women don't show different patterns of distribution of time or of wishes concerning time, and age doesn't affect the results either.[5]

Respondents in the three speciality groups have different patterns of activities. Surgical physicians spend more time on individual patient care and less on care related activities than medical and supporting physicians. About 40% of all groups would like to change the proportion of time spent on individual patient care. The physicians in medical specialities are more likely to prefer a decrease in individual patient care than surgical and supporting physicians. Specialists in medical and surgical disciplines express a bigger desire for a cutback in time spent on care related activities than the supporting specialities.

The amounts of time spent on supervision and training and the wishes concerning these activities do not show significant differences between the specialities. The time spent on research and education is not different either, but medical physicians more often would like to spend more time on this than surgical physicians.

The supporting physicians spend more time on organisation than the surgical physicians. No significant differences are found in the wishes concerning these activities.

Being self-employed or salaried by hospital also makes a difference. Self-employed physicians significantly spend more time on individual patient care and less on all other activities. The wishes concerning patient care are not different. A minority of salaried specialists, though relatively a larger group than in the self-employed population, expresses a desire for an increase of time for care related activities. Salaried physicians are the least satisfied with the amount of time available for research and education now. More often than self-employed physicians they would like to spend more time on this.

Self-employed physicians more often than salaried colleagues want to spend less time on organisational activities.

Almost all significant differences found between the three specialities are also found within the subgroup of self-employed specialists, not within the subgroup of salaried specialists. The same differences are recognisable, but not statistically significant. This might suggest specialists from different specialities tend to become more similar in a salaried position, at least regarding the distribution of their time and their preferences. However, the lower numbers of salaried specialists (n = 136 versus n = 489 for self-employed respondents) do not justify a conclusion about this suggestion.

Table 5.7 gives the results for different subgroups.

5 Differences in ordinal data are identified by a p < 0,05 using T-test or Bonferroni posthoc test for multiple comparison.

Table 5.7: Activities in different subgroups; distribution of time in mean percentages; satisfaction with distribution in percentages of respondents

	% of time spent on this activity	this is the right amount of time for me	I'd rather spend more time on these activities	I'd rather spend less time on these activities
patient care				
medical	62,2	62,5	10,7	26,8
surgical	68,4	62,4	20,3	17,3
supporting	62,7	63,4	18,3	18,3
self-employed	67,2	63,7	15,3	21,0
salaried	58,7	60,6	17,3	22,0
care related				
medical	15,6	52,9	8,6	38,5
surgical	12,2	64,1	6,5	29,4
supporting	14,9	69,9	11,5	18,6
self-employed	13,2	62,5	6,1	31,4
salaried	15,5	52,8	19,7	27,6
supervision & training				
medical	6,3	48,1	49,5	2,4
surgical	5,5	50,5	46,3	3,2
supporting	4,9	58,6	38,6	2,9
self-employed	5,0	51,9	45,7	2,4
salaried	7,2	50,4	46,2	3,4
research & education				
medical	6,5	35,0	64,1	0,9
surgical	5,7	48,7	49,6	1,8
supporting	6,2	41,2	56,8	2,0
self-employed	5,8	42,9	54,9	2,3
salaried	6,8	29,5	69,7	0,8

	% of time spent on this activity	this is the right amount of time for me	I'd rather spend more time on these activities	I'd rather spend less time on these activities
organisation				
medical	9,4	58,3	14,2	27,5
surgical	8,3	57,6	9,6	32,8
supporting	11,3	62,3	14,3	23,4
self-employed	8,7	59,0	11,1	29,9
salaried	11,8	58,4	18,4	23,2

n = 647 (34 missing values) for speciality

n = 625 for employment (9 missing values, 33 "combination"; 14 "else"; these groups are left out here because of the small numbers)

5.6 Conclusion: the nature of specialist work in patient care

This chapter needs to answer the research question about the nature of specialist work in patient care. The study took medical, surgical and supporting specialities as three different professional subgroups. So far this classification seems to be justified by the characteristics found in specialist work, which are different for the three identified categories of specialities.

Following Abbott's concepts (1988:40-52) the three speciality groups share the characteristic of having professional work in which the professional acts of diagnosis, inference and treatment can be recognised. The nature of work in the separate speciality categories is defined by the characteristics of individual patient care processes, by the characteristics of times, places and persons that matter in the work processes, and by the characteristics of logistics.

Medical specialities

The nature of work in individual patient care processes in medical specialities is characterised by an emphasis on reasoning in the act of inference. The specialists tend to create a coherent story in terms of medical knowledge and reasoning. Their work mainly takes place in OPD's and on wards. The importance of 'knowing the full story' during an often long lasting process results in reciprocal ownership of specialists and patients (a specialist has 'his' or 'her' patient and vice versa) and it makes medical specialists focus on communication with patients and think about logistics in terms of organising patient contacts.

Reasoning is essential in medical specialities, hence it is shared with peers, characterising discussions and meetings about patient care and the emphasis on good reasoning in medical education. It also connects with the finding in the survey that medical specialists, even more than other specialists, express a desire for more time for reading literature, attending education, and supervising or doing research.

Specialists in medical specialities work with nurses on wards, who are expected to provide the specialists with the information needed for specialist reasoning. Lack of information quite easily irritates the specialists, because it directly hampers specialist work.

They also work with specialised nurses, whom they supervise as they take over certain tasks in the individual patient processes, especially of chronic patients.

Surgical specialities

The act of surgery, in diagnosis or in treatment, is the essence of a surgical license, hence inference in surgical disciplines is characterised by decision making about

surgery on individual patients. The importance of surgery and decision making is reflected in the other aspects of work. Specialist-patient ownership is primarily connected to the act of surgery. The importance of decision making makes the surgical specialist focus directly on the essential facts in a patient contact. Specialists in surgical disciplines think about logistics in terms of patient flows and availability of capacity because surgery is threatened when flows stagnate or when capacity falls short.

Joint inference in meetings within the own speciality can be thorough and quick at the same time, because decision making follows specified rules and guidelines. In the survey, respondents in surgical disciplines report spending more time on individual patient care than other specialists. This might be connected with the characteristics discussed so far. The essence of being a surgical specialist is performing surgery on individual patients. However, an operation is usually only one moment in an individual care process. Specialists need to find new patients to operate on, or else the act of surgery is threatened. Simply stated, a specialist in the medical field only needs a few complex patients to perform his or her work in all professional aspects of inference and reasoning for a long time. A specialist in the surgical field constantly needs new patients to be able to perform his or her work in all professional aspects of decision making and surgery.

Supporting specialities

The supporting specialities have double acts of inference that need to be connected. They support the inference of other specialities and they have an own act of inference, linking requests for support to the application of techniques.

The characteristics of the other aspects of work are related to these characteristics of double inference processes. Patients are 'owned' by the requesting specialities that own the primary inference about them. This intertwining of primary processes and supporting processes causes supporting specialities to be used to being close to many other specialities. To prevent chaos in this network, supporting specialities need smooth co-operation within their own group of peers, which leaves relatively little room for individual interpretations of work and requires standard inference procedures and logistical synchronisation.

Physicians and non physicians work closely together in the supporting specialities. Inference about the non standardised connection between request and application belongs to the specialists; standardised connection and application belong to the non physicians.

Supporting respondents in the survey reported the highest proportion of time for organisational activities. 'Owning' the equipment, being close together in one department, working closely with residents, colleagues and non physicians seems to make organisation a larger part of specialist work.

Discussion, meetings and interaction with requesting physicians belong naturally to their work as well, which might explain why they have the lowest desire for a cutback in care related activities.

Accents and developments

The characteristics presented so far largely regard the 'pure' forms of medical, surgical and supporting specialities. Different specialities within each of these three groups have different accents and variants in the nature of specialist work. The separate cases in this study are taken as examples.

Internal medicine is the 'purest' of medical specialities within the case studies. Within internal medicine gastroenterology (a speciality in itself, but organised within the internal medicine partnership) and nefrology hold more technical aspects and reduce the dominance of inference. This also goes for cardiology, because of the technical procedures both in diagnosis (for instance angiography) and in treatment (for instance pacemaker insertion). Inference regarding these technical acts, also resembles surgical inference (decision making) a bit more than pure medical inference.

General surgery is the 'purest' of surgical specialities. Yet also within general surgery there are areas with recognisable medical accents. For instance the guidance and periodic control of patients who have had cancer and the after care of patients who have had surgery. Gynaecology holds even more areas with medical accents, for instance infertility medicine and endocrinology, oncology, and the guidance and periodic control of pregnant women. Within infertility medicine and endocrinology the connection between diagnosis and treatment often needs complex inference, in which inference by exclusion probably is more common than inference by construction.

Radiology is the 'purest' of the supporting specialities in the case studies because of its dominance on supporting the act of inference of other specialities. The development of its own procedures for treatment give the speciality surgical accents. Decision making about these procedures is now owned both by the attending physician and the radiologist, but the attending physician is the one who discusses the options with the patient and gets informed consent.

Anaesthesiology is a supporting speciality because most of its services are performed on behalf of requesting physicians. But its processes have medical and surgical accents. Monitoring the patient during anaesthesia for instance resembles a medical process with very short diagnosis - inference - treatment loops, because of the continuous measures and possibilities for adjusting treatment. Surgical accents are for instance found in decision making about giving anaesthesia and in the own treatments in pain management.

The characteristics that define the nature of specialist work in patient care are summed up in **table 5.8**.

Table 5.8: The nature of specialist work in patient care

	medical specialities	surgical specialities	supporting specialities
nature of individual patient care processes	emphasis on reasoning in the act of inference	emphasis on decision making in the act of inference	emphasis on connecting in the act of inference
			double inference (supporting inference and own inference)
	the patient's full story is important	the act of surgery defines being a surgical specialist	developing: ownership of processes and treatment
times and places	schedules: based on OPD, rounds and supervision	schedules: based on OR, OPD, rounds and supervision	schedules: based on machines, equipment and rooms
	meetings and discussion take time	meetings and discussion matter-of-factly	continuous pace in radiology; varied pace in anaesthesiology
	out of hours: resident in hospital; specialist on call; in hospital when supervision by phone is difficult	out of hours: resident in hospital; specialist on call; in hospital when surgery is or might be indicated	out of hours: resident in hospital (radiology); specialist on call; in hospital when complex procedures are indicated / when surgery is indicated (anaesthesiology)
	equipment: different accents on different sites	equipment: every physician is skilled to use various instruments and machinery	equipment: central in specialist work, every physician is skilled to use various machinery
persons: patients	special doctor-patient relationship	focus on facts	short, singular patient contacts
	mutual doctor-patient ownership	ownership connected to surgery	patients are owned by other specialities
	alert on communication with patient	informed consent	more discussion about patients than with them
	few clear-cut arguments for discharge to GP or continuation OPD-care	referral or discharge when surgery becomes unlikely	patients cross speciality boundaries
	new specialists have to rebuild the patient population	new specialists may have a short period of difficult contacts	new specialists don't 'inherit' patient population

	medical specialities	surgical specialities	supporting specialities
persons: peers	joint reasoning, detailed discussions and meetings about patient care	joint decision making, short discussions (guidelines)	joint service; little room for individual variance in practice
	few hands-on activities shared with specialist colleagues	used to share hands-on work with colleagues	colleagues are always close by
persons: other specialists	shared involvement individual patient care, meetings ad hoc (consultations, advice) or scheduled	shared involvement individual patient care; meetings ad hoc (consultations, advice) or scheduled	shared involvement individual patient care; meetings ad hoc (consultations, advice) or scheduled
	discussions about ownership of patient and/or problem	shared logistics in streamlining and planning multidisciplinary patient care	shared logistics in synchronising patient care
persons: non physicians	on wards: nurses are expected to support physicians in step 5 (inference and co-ordination)	specialised nurses at OPD; nurses on wards: matter-of-fact discussion	tasks shared with non-physician assistants
	different focus points in patient care	hands-on assistance on OR	different responsibilities
	in OPD's: specialised nurses who work under specialists' super-vision	special relation with planning office because of logistics	
logistics	focussed on organisation of patient contacts	focussed on patient flows and capacity	synchronisation with other specialities and alert on flow of information

References Chapter 5

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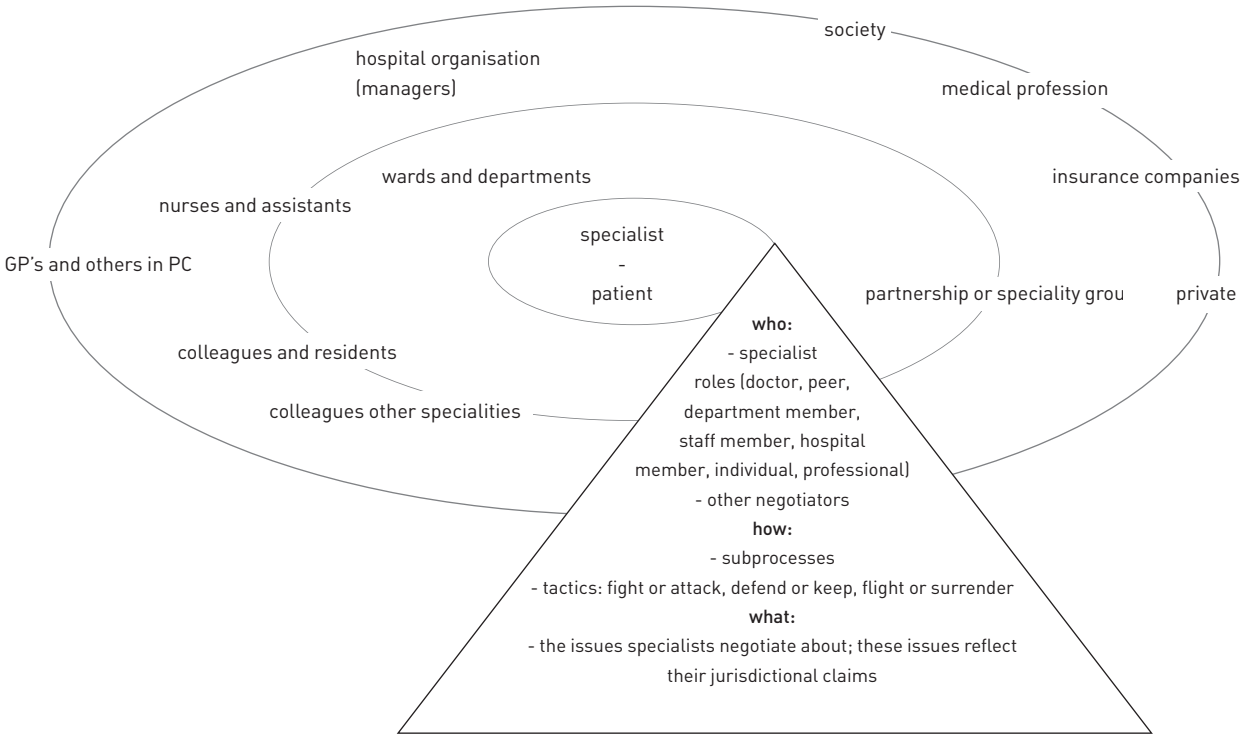
6 Negotiations in day to day patient care

6.1 Introduction

After studying the nature of specialist work in patient care (Chapter 5), the negotiations in day to day patient care were analysed. **Figure 6.1** brings back the second part of the research framework, which was used to analyse negotiations in specialists' work (paragraph 3.6.2).

Figure 6.1: The negotiation context of specialist work



In the negotiations that were observed in patient care, specialists in all case studies most often played the role of doctor. This role refers to seeing and treating patients or to being patients' representative. The role of department member was found to be the second one in daily negotiations. This is the role of being a member or representative of a department, co-operating with colleagues, residents, nurses and other workers on the wards and units of the speciality.

The negotiations in which specialists are involved as doctors generally concern patient care itself. The issues in these negotiations are defined by individual patient care processes, or by the use of specialist knowledge or skills. The negotiations in which specialists are involved as department-members generally concern the logistics of patient care.

Paragraphs 6.2, 6.3 and 6.4 will elaborate the negotiations for the three different speciality groups. The descriptions in these paragraphs emerged from the analysis of observations and conversations in the case studies (see paragraph 4.2.4 for the processing of data). Comparison of the data per speciality revealed the different patterns of specialists' negotiations and jurisdictional claims.

Paragraph 6.5 will outline the survey results concerning specialists' opinions about jurisdiction over patient care. The survey was mainly based on the research framework in paragraph 3.6.3, for studying the 'structural context' of negotiations.

Paragraph 6.6 takes all results together to conclude about the negotiations in day to day patient care.

6.2 Negotiations in day to day patient care in medical specialities

Following the research framework, this paragraph will discuss the negotiations that define the 'negotiated order' in day to day patient care in medical specialities by describing the negotiators, the characteristics of the negotiations, and the issues.

Negotiations about patient care itself are an important aspect of the negotiated order in day to day patient care in medical specialities. These are discussed in paragraph 6.2.1. Negotiations about logistics in medical disciplines will be elaborated in paragraph 6.2.2, after which the jurisdictional claims will be outlined in paragraph 6.2.3.

6.2.1 Entrance control at the pigeonhole for patients and problems

The most distinct negotiations in the medical specialities are connected with the inclusion or exclusion of patients and problems: do patients and their problems belong here or elsewhere? This is connected to what Mintzberg (1983:193) calls 'pigeonholing': clients and problems have to be categorised in terms of the functional specialists who serve them. The field of negotiations discussed in this paragraph is called 'entrance control', because medical specialists control the entrance of patients and problems into their pigeonhole.

The following paragraphs will respectively discuss entrance control for patients, and entrance control for problems.

Entrance control for patients

The question specialists here seem to keep asking themselves is whether the patient belongs to them, to another speciality, or to the general practitioner. Negotiations about this most often occur with new patients. In the first episode of an individual patient's process (the three diagnostic steps) the picture is not clear yet, and physical problems might stem from several causes. This makes inclusion or exclusion a part of the act of reasoning.

A fragment of the fieldwork illustrates the complexity of pigeonholing in medical specialities: a cardiologist explains why he is often the one who ends up treating problems that belong to other specialities:

"I often have to show up when several problems cause a somatic problem, while it's got nothing to do with cardiology. For instance, the other day a woman was sent here complaining about angina pectoris, which was caused by an

unnoticed loss of blood in the first place. Then I phoned the general internist and he said: 'Probably a bleeding ulcer. You treat her now, I'll check on her at the OPD.'
But then in fact I am treating an internists problem."

When the exclusion of a new patient is considered, negotiations about referral start. Specialists then negotiate with other specialists, who 'own' a pigeonhole (a speciality) that might be better suited to the patient's problems. Specialists may negotiate with the patient as well, for instance when they want to refer a new patient back to the general practitioner because they find no indication for any specialist pigeonhole.

Specialists may also negotiate the entrance of patients who are already known to them, especially when clinical admission is required. Quite often a known patient in medical specialities has co-morbidity. When deterioration of his or her health requires admission, several specialists are candidate attending physicians, because often the exact underlying mechanism is not clear yet. In these cases physicians try to keep patients at the entrance out of their pigeonhole, rather than allowing someone in who might turn out to belong elsewhere. This tendency gives rise to negotiations with other medical specialities, because all medical specialities are keen on proper pigeonholing. An example of two specialities negotiating an admission, both are trying to keep the patient out:

A patient has just been admitted from the casualty department onto the ICU. One of the specialists is visiting the ICU when a nurse tells him: "The [specialist of the other discipline] says this patient should be yours." "No, she should not," the specialist replies, "She has a [symptom], she is his, but apparently he doesn't feel like it." Later he phones the other specialist to discuss the patient. By pointing out diagnostic information on the X-ray, he tries to convince his colleague the ICU-patient doesn't belong to him. The other specialist wants to have another look before he decides on it.

Once patients are inside the specialists' pigeonhole, control is slightly less strict. Patients nevertheless are repeatedly tested on suitability for the pigeonhole. The lack of clear-cut indicators for discharge of ambulant patients (discussed in paragraph 5.2.3) gives rise to negotiations about putting a patient out of the pigeonhole. In these situations the general practitioner is a party indirectly involved, because the patient is referred back there. Specialists hardly ever phone the GP to discuss discharge from OPD-care. The patient is more often the negotiating party, especially when the specialist wants discharge and the patient would like to keep attending. The younger physicians seem slightly more aggressive in these negotiations than the older ones. They negotiate the discharge, for instance by 'selling' it and by finding evidence for the patient's eligibility for discharge through extra testing. One of the younger ones:

"I'm cleaning up the OPD population of my predecessors. I want to discharge 15% of the patients there. I met one OPD-patient who had had some procedure, 15 years ago! I only want patients back in here with real symptoms, not just because of periodical check-ups."

Entrance control for problems

Once a patient is inside the pigeonhole, he or she can bring many different problems into the consulting room. In the first place because co-morbidity simply causes many different problems and in the second place because patients sometimes want to ask all kinds of questions related to their health, but not necessarily related to the specific health problem they meet the specialist for. The general practitioner is indirectly involved in these negotiations, the patient is usually the negotiator. A specialist expresses his opinion about one of these problems brought to his consulting-room:

"The only intimacy that might be discussed here is sex. People are hardly shy about that. It's on television all the time. If they bring it up, I always say: 'See your general practitioner!' I'm not available for that."

Of course not every patient or problem gives rise to negotiations. Negotiations occur when specialists wonder whether the patient or problem is at the right pigeonhole address. In these situations negotiations are aimed at keeping control over the pigeonhole. Specialists take a stand in either allowing or refusing entrance to the patient or problem in question. Eager acceptance was not observed. Sometimes specialists seem to 'surrender'. In these situations the specialists allow a patient or problem in almost reluctantly, more or less because they have to. When OPD-patients object discharge, the older physicians seem to allow them to continue attending slightly more often than

the younger ones, referring to the special relationship they have with their patients, or the alleged bad quality of general practitioners around.

6.2.2 Negotiations about logistics

Negotiations about logistics concern either the supply-demand balance of patients and doctors or the logistics of information and quite often a combination of those (see paragraph 5.1 for an introduction to logistics). In the medical specialities supply-demand balances of patients and doctors require more attention than information logistics.

The following paragraphs respectively concern negotiations in ad hoc situations in which supply and demand are found to be out of balance, negotiations in logistical policy for patient care processes, and negotiations in logistics of information.

Ad hoc situations in the supply-demand balance

Work of the speciality group or department needs planning and organising, work of an individual physician too. Logistics is an issue showing up in negotiations about the distribution of individual time and attention and about the organising of the work in general.

Hospital capacity is another possible issue for negotiations, with the beds as the most important currency. Being 'full' is a bad thing for a hospital. An example:

One of the specialists sees a patient at the casualty department. The nurse there tells her no beds are available, should the patient need to be admitted. The specialist knows one bed will come available within an hour and agrees to claim that for this patient. "And then you should close casualty, because we're full!", she tells the nurse. "No!", the nurse replies, "We won't close casualty." The specialist leaves the department raising her hands and saying: "Why do you all look at me now? I can't help it! Now that's a management problem. They should tell me where to put my patients now!"

This example illustrates a way of surrendering: the specialist gives up, at least temporarily. More often specialists try to keep control over ad hoc situations by organising the problem one way or another, for instance by re-scheduling patients, by instructing others how to plan contacts or by getting things done themselves.

Logistical policy

Balancing logistics in general is an item in the organisation of work of the speciality group or of the department. The schedule is a basic structure for organising the workforce supply. Furthermore the administrative processes of patient planning know many tools for categorising patients, urgency and priority. But when capacities are scarce these general measures cannot solve the ad hoc logistical problems.

Patient logistics are also brought in by projects of other parties. Quite a lot of policy projects for the innovation of patient care concern logistics. The specialists don't always see the same potential improvement as the project-owners. One of the specialists tells about other kinds of co-operation with GP's, aimed at single visit consultations at the OPD:

"We are trying to make new deals with GP's. If they provide us with a fixed set of information we will try to do everything for the patient in one single visit: consult, X-ray, ultrasound etcetera. I don't really like it, the idea of seeing a patient only once. You can't get a complete picture of someone, you won't get to know someone. But then again, it's the fashion these days. We'd better take part, but organisationwise it is very complicated as well."

Specialists usually try to hold or defend their stakes in negotiations about logistical policy. They mainly do so by organising the processes themselves, either within the peer group or within the department.

Logistics of information

Information logistics bring slightly less negotiations into the medical specialities than patient care logistics. Nevertheless, patient processes are actually based on information processes. Seeing patients without having a picture of the past available seriously hampers the progress of patient care, especially because it hampers the act of reasoning. Thus, missing files are small disasters in hospitals.

On the wards of the medical specialities the information made available by nurses is more observed in negotiations than cases of missing files. The nurses are expected to know the ins and outs of the patient processes. When they don't, specialists instruct them, correct them or just show annoyance (see also Valk et al. 1997).

Patients are important suppliers of information as well. Many specialists try to teach all patients to write down the medication they're on and take the notes to the OPD-appointment. They sometimes worry about the information the patient gives them by heart and the information they get from the GP is often not complete.

6.2.3 Jurisdictional claims on content and contacts

Ownership is a reciprocal phenomenon between medical specialists and patients ('my doctor', 'my patient'), more visible in medical specialities than elsewhere (see paragraph 5.2.3). Apparently the moments of start and closure of this relationship give rise to negotiations. Underneath these dynamics of inclusion and exclusion seems to be a test of patient and problem suitability, which connects to a jurisdictional claim on exclusivity. Physicians in medical specialities protect their specialist jurisdiction by keeping the inside of their pigeonhole as much as possible connected with their specific domain of knowledge.

Since reasoning is the act that distinguishes them as medical professionals, they have to be careful with what they reason about. In the interest of their professional status they have to lay a claim on jurisdiction over the entrance of patients and problems into their pigeonhole, so they can control the content of their act of reasoning.

The negotiations about logistical issues do not reflect a jurisdictional claim on logistics as such, but on the standards for patient contacts. Specialists want jurisdiction over when a patient should be admitted or seen, organised in frequencies and at times that make sense in the medical process. Furthermore, the continuity of reasoning about individual processes should not be hampered by discontinuity of supply, and hence the information about proceedings must be available on demand. Thus, the negotiations for logistics reflect a jurisdictional claim on the standards for logistics, in the interest of the act of reasoning.

6.3 Negotiations in day to day patient care in surgical specialities

The negotiated order in day to day patient care in surgical specialities is, more than in medical specialities, defined by logistics. This field of negotiations is discussed in paragraph 6.3.1. Negotiations about patient care itself are outlined in paragraph 6.3.2, after which paragraph 6.3.3 is about the surgical specialists' jurisdictional claims.

6.3.1 Traffic control in patient care logistics

Logistics were often negotiated in all specialities. Most often, however, in the surgical specialities. Most of the negotiations are about patient and doctor logistics, in which specialists are keen on keeping the flow of patients going. They are spending a lot of time and attention on patient flows, almost as 'traffic controllers' in patient care. A smaller share concerns information logistics.

The following paragraphs discuss negotiations in ad hoc situations, negotiations in logistical policy, and negotiations in logistics of information.

Ad hoc situations in the supply-demand balance

Ad hoc issues in patient and doctor logistics occur when patients are too many and/or doctors or capacities are too few (the other way around was never seen in the surgical case studies). The complexity compared to the medical specialities lies in the variety of supply in dealing with planning and organisation of the logistics of patients and doctors: the OR and the ICU (for postoperative care after major surgery) provide capacity as well as wards and OPD's.

First, an example of some bargaining in patient and workforce planning:

At a morning meeting the specialists and residents discuss the fact one of the specialists has fallen ill and stays at home. The residents wonder who will supervise them now and they ask the specialist who worked last night if she can stay. "No, X will be here today". "But he's on OR today?", the residents ask. "Only this morning. He will finish all procedures in the morning."

Resident: "I don't think I will hold on today. I feel sick."

Specialist [looks at her]: "Yes, it shows." Then to another resident: "What will you do today? Maybe you can do the ward? Then she can go home after the morning meeting? What should be done at the ward today?"

Later she discusses the schedule with her specialist colleague: what can be rescheduled because of the sick colleague? Surgery planned together with another surgical

discipline should not be cancelled. The same goes for the oncology operations planned.

The specialists try to defend or hold their stakes in these negotiations by dealing actively when some bargaining in planning is necessary. The most observed tactic is planning and re-scheduling. Incidentally a specialist finds another creative solution:

One of the specialists wants an OPD-patient to consult another specialist. He instructs the OPD-assistant to make an appointment. She walks in later to tell the specialist that the appointment cannot take place within three months. She'd better get him an appointment at the OPD for urgent cases, but she's only allowed to make an appointment there when the specialist himself phones the other specialist to discuss the urgency.

The specialist: "You wait a few minutes now. Then you phone your colleague from the other OPD and then you tell her I discussed the matter with Dr. X and he agrees seeing the patient soon." Later he explains: "What else could I do? I know Dr. X is working alone today. Of course he would agree with me in planning this patient soon. You can't make a patient with a deteriorating condition wait for three months!"

Logistical policy

Individual specialists have developed individual theories about how to deal with negotiations about planning and organisation of patient care processes. One specialist for instance explains why he sometimes refrains from negotiating with difficult patients who demand to be seen immediately without obvious reasons:

"I'm prepared to accept the difficult and claiming patient squeezed in at my OPD-hours now and then. Rather an extra visit than refusing to see them, because then they might get here in the evening and they'll probably meet the resident. Bigger chance then they get more tests than they really need."

Some specialists have an extra role in co-ordinating logistics for the department. They spend time and energy getting the OR programs scheduled, together with employees of the planning office. Having control over the program at least prevents these specialists from negotiating about being planned badly:

The specialist who is planning for his department: "I like doing the planning. I always know exactly what's on the program. And let's be honest, I give myself a good OR program."

As department members the physicians negotiate the availability of capacity, the way they should handle OPD-logistics, and the financial consequences. In dealing with these issues several parties are met. Managers (or 'the hospital') are more often found to be negotiators here than in the medical specialities.

The physicians try to keep or defend control over logistics, both in ad hoc situations and in policy. They adopt special tasks in organising and planning and they perform a lot of planning and scheduling throughout day to day work. Sometimes with joy, like the specialist who liked doing the planning of operations, sometimes reluctantly:

"We took care of a smooth process for OPD-patients suffering from [diagnosis]. But that's all. Nothing else here goes without saying. If you want some extra investigation and you want it soon, you have to make a phone call yourself. But the colleague you then deal with always agrees, of course. So the extra conversation is completely useless."

The last example suggests routine negotiations have entered those patient processes in which waiting lists have created a relative scarcity of physicians.

Logistics of information

Having to negotiate flow of information causes irritation on the specialists' side. Ad hoc moments are usually about files or data not being available at the right time and place or not being available at all. Concerning policy matters in patient information, many specialists feel frustrated by rules and regulations and by the inconvenience of file formats (too much loose paperwork, too small, or too large). A larger policy issue are the plans for an electronic patient record. Specialists meet managers and computer experts in negotiations about the implementation. In one case study only was an actual electronic information system introduced.

The physicians grumble a lot about information logistics, often taking an attitude of flight or surrender in these situations, because they feel there's not much else to be done about missing files, or rules and regulations. They are trying to keep control in the introduction of an electronic patient record though, for instance by negotiating their demands with management.

6.3.2 Negotiations about patient care

The most important party met in negotiations about patient care itself are colleagues of the own speciality, questioning or at least discussing decision making about individual patients.

Every patient that needs surgery is discussed at least twice: before surgery when indications are being discussed and after surgery when the procedure is being evaluated. As pointed out in paragraph 5.3.3, joint decision making is essential. The quality of surgical decision making and surgical practice is watched sharply within the group, which gives the discussions the character of negotiations. When opinions within the group differ, the individual doctor who treats the patient settles the matter. When he or she then wants to perform a procedure not completely agreed on by the colleagues, though within the boundaries of proper practice, it's up to the individual physician and the patient to decide. An example:

Some physicians are discussing a procedure a colleague wants to do on a patient. They're in doubt about the use of the procedure. "Anyway. If he decides it must be done, he should do it himself."

In this case the authority of the individual physician is respected. Sometimes individual specialists are 'in each others way', more often than in medical specialities. For instance when they change each other's treatment, especially when this happens without further consultation. An example from the fieldwork:

The physician visits the patients he operated on. They are on a ward that is being supervised by another physician.
KK: "If you visit your own patients here, do you leave your colleague's treatment unchanged then?"
Sp.: "Not always. I have a different opinion on some things. Sometimes we're in each others way."
KK: "Do guidelines and instructions change that?"
Sp.: "A little. But individual differences will always remain. Not concerning the main features, only when it comes to details."

Colleagues from other disciplines are less often met, and when they come too close to surgical decision making they're hardly taken seriously:

One of the anaesthesiologists looks at the white board with the OR-program, together with one of the surgical specialists. The anaesthesiologist suggests a technical change of one procedures scheduled on the other specialists program. "If you perform it that way, that's usually faster." The surgical specialist denies immediately: "That's not necessarily faster at all."

Patients occur as a negotiating party as well. Incidentally OPD-patients in the surgical specialities more or less demand investigations for reassurance, especially patients who have had severe diseases in the past. Sometimes the specialists try to convince the patients that it's useless to make X-rays yearly. Sometimes they give up and order the X-rays:

A specialist tells a patient: "I've been lectured by the radiologist. He says there's no reason for making X-rays every year."
Pat.: "Well I never! I think the reason is pretty obvious! I think it's very important to make X-rays every year and if I'm not allowed to, I'll pay for them myself!"
Sp.: "That's not the point. The radiologist says it's been researched and medically speaking there's no need to check by X-ray every year. It doesn't get you anywhere."
Pat.: "Sure it gets me anywhere. I need to know if I'm alright. I need to keep an eye on it."

Television or other media are indirectly a party involved, bringing people to the consulting room asking for tests and treatments shown on television or written about. Usually the negotiating character is very limited, because the physician and the patient soon agree if the information really applies to the patient or not.

Sometimes the content and volume of surgical practice in itself is negotiated. A situation that was observed in a meeting of a peer group:

The peers discuss several areas of the speciality and consider expanding one area, not a focus point of the group yet.
Sp.1: "We could discuss whether the insurance company wants to finance this. Maybe they're interested."
Sp.2: "Yes, we could do that, the problem is found more often these days."
Sp.3: "I don't think so. The subject is boring and it doesn't pay anything."
Sp.4: "Okay, maybe it's not that interesting."

In general, specialists try to keep control over the negotiations in patient care. Occasionally they give in.

6.3.3 Jurisdictional claims on flows and decisions

The essence of surgical specialities is at stake in patient care logistics. Surgical specialists need to perform surgery to remain surgical specialists. If the act of surgery is threatened, the act that distinguishes them as professionals is threatened. Therefore the physicians need to play a very active role in logistics. To prevent traffic jams, physicians try to keep the flow of patients going by having special attention for traffic control. Their patient processes have more potential bottlenecks than the processes in other specialities, for instance the wards, the OR, and the ICU for postoperative care after major surgery. When one of the bottlenecks becomes obstructed, the flow of patients into the OR is threatened. This is why the surgical specialists have adopted many aspects of patient care logistics and why they are keen on the availability of capacity. Patient flows must be secure to guarantee surgery. More than in the medical specialities the specialists' negotiations about logistics reflect a jurisdictional claim on the logistics themselves, because of the direct connection with the heart of the surgical profession, surgery.

Patient flows are connected with information flows. The surgical specialists do not lay a jurisdictional claim on these flows themselves, but on the availability of information.

Surgical decision making in patient care is the second context for negotiations in surgical specialities. The specialists negotiate with peers about diagnosis, treatment, probabilities, and the connection of these aspects with the individual patient in question. The surgical act of inference is suitable for joint construction (paragraph 5.3.1), and the surgical methods in diagnosis and treatment are suitable for joint evaluation. Because of these characteristics, the surgical specialities have an older tradition of internal quality control, and are often the first disciplines for developing new quality systems. Individual specialists, nevertheless, claim jurisdiction over the final decision about procedures and treatment, as much in negotiations with their peers as in negotiations with their patients.

6.4 Negotiations in day to day patient care in supporting specialities

Patient care itself is the largest source of issues for negotiations in day to day work in the supporting specialities. Logistics come second.

Paragraph 6.4.1 discusses the negotiations in patient care. Paragraph 6.4.2 discusses logistics, and paragraph 6.4.3 outlines the jurisdictional claims underlying the negotiations in patient care.

6.4.1 Position control in relationships with other specialities

Specialists in supporting specialities watch their position in patient care, especially in their relationships with other specialities. As discussed in paragraph 5.4, supporting specialists do not 'own' patients or problems, they 'own' the equipment, techniques, knowledge, skills and the authority of applying these.

In the daily rhythm of medical and surgical specialities, physicians may tend to approach supporting specialities as a kind of 'takeaway service': when they need support, they want to be able to come and get it. Supporting specialists try to maintain their position by pointing out they do not deliver takeaway, they deliver 'made to measure'.

The following paragraphs will first discuss the differences between radiology and anaesthesiology, concerning 'position control'. Then the negotiations for a position in patient care will be discussed.

Radiology versus anaesthesiology

The highest number of negotiations in patient care is observed in the radiology case study. This is not because the issues discussed here are in their essence less important in anaesthesiology. The first explanation is the higher number of individual patients in radiology, causing more potential moments of negotiation. Second, anaesthesiology procedures are usually more radical than radiology procedures. This gives the anaesthesiologist a somewhat firmer own relationship with the patient, resulting for instance in OPD-hours for pre-operative assessment. Third, the requesting physicians in anaesthesiology are present at the moment the application takes place. They even usually ask anaesthesiology's permission to start their procedure. This is a repetitive acknowledgement of the expertise of

anaesthesiology. And finally, every specialist is trained in judging radiological images within his speciality, which makes radiology in the experience of requesting specialists less exclusive than anaesthesiology.

Negotiating a position in patient care

The 'takeaway approach' towards supporting specialists is illustrated by requests for procedures that are not necessary, especially in radiology. Although the specialists disapprove, they do not start negotiations on every occasion. An example:

The radiologist is dictating reports on tests. He reads the application form of one of the investigations: "This is a shame. We had already performed a [..test 1..]. Now they've made us do a [..test 2 ..]. But apparently these physicians don't understand the pictures of test 1. So they order some more. Nice wallpaper in the OR, but a waste of money and extra risk for the patient. Not much, but still."

KK: "Do you tell them so?"

Sp.: "No. Not yet. I'll be waiting for the next generation of [..speciality..], which will be here soon. Then we'll start hammering it."

The issue of position control shows up because support work is always on request of another speciality, except for the patients visiting the OPD-hours for pain management in anaesthesiology. Specialists negotiate and even fight to maintain their position in relationships with other specialities:

"Radiology in this hospital has acquired a firm position. This position needs protection. Therefore, I cannot be nice if this higher purpose is at stake: the radiology itself." [...] "Neither can I accept the urgent planning of imaging without us knowing. If I find out about that, I withdraw the application form. If I'm not informed, this application form cannot exist. Sooner or later someone always comes asking about the procedure. Mind you, it's nothing personal. I'd drink a cup of coffee with this colleague any time."

In short, specialists in supporting disciplines negotiate their position as 'owners' of support equipment and thus as decision makers about the use of this equipment. As explained earlier, these negotiations are less intense in anaesthesiology than in radiology. Surgical specialists, nevertheless, should not decide on the method of anaesthesia either. Having their own OPD-contacts with patients, anaesthesiologists furthermore can negotiate with the patient about the necessity of surgery when anaesthesiology might expect complex procedures. Of course these negotiations are only possible when surgery is not strictly necessary, for instance with stomach reductions for obese patients, or surgery on the jaw for reasons of function and looks.

Both specialities aim at least at keeping control over their position and tend to aim at fighting to improve their position. They keep pointing out their expertise and their right to decide on support patient care, either obviously or more covertly. They also tend to expand or at least strengthen their own practice. Radiology does so by an increasing number of procedures under imaging. Anaesthesiology does so by starting up relationships with patients at the OPD for pre-operative assessment and pain management and by involvement in intensive care medicine.

6.4.2 Negotiations about logistics

Supporting specialities by definition have to synchronise a huge part of their logistics with the logistics of other specialities. Yet the number of negotiations caused by issues of logistics or capacity is relatively equal to the number in the medical specialities and lower than the number in the surgical specialities. Apparently synchronisation of demand and supply processes is a self-evident feature of supporting specialities that doesn't cause many extra negotiations. The nature of the negotiations is different from the other specialities though. Information shows up more often in discussions than in the other specialities and negotiations about planning are more often of an ad hoc character than in the other disciplines.

The following paragraphs respectively will discuss ad hoc situations in which supply and demand are found to be out of balance, negotiations in logistical policy, and negotiations in logistics of information.

Ad hoc situations in the supply-demand balance

Ad hoc issues in patient and doctor planning in other specialities usually occur when patients are too many and/or doctors or capacities are too few. The other way around, having too many doctors and/or too few patients, is quite rare. If it is observed in other specialities, the

physicians don't see it as a problem. In the supporting specialities the physicians seem more eager to keep balanced either way. In moments of slack they look for work or re-schedule activities. Having relatively too many patients happens more often though, which forces specialists to bargain about planning and organisation. An example:

The anaesthesiologist co-ordinating ICU patient care today is discussing the OR program and the ICU capacity. One of the patients will have to go to ICU after surgery. But the ambulance brought an acute patient to the ICU. The anaesthesiologist tries to organise some transfers between the two locations. Nevertheless they end up having to cancel one of the patients scheduled for major surgery.

Specialists all try to defend or hold their stakes in ad hoc situations by taking initiative in bargaining and organising. This means they have to plan and re-schedule a lot by themselves. An example:

The anaesthesiologist wants one of the pre-operative OPD-patients to consult another specialist. He speeds away from his consulting-room leaving the patient at the counter with the OPD-assistant. When he gets back, he explains: "I've just fixed the patient an appointment myself. It's the only way of getting an appointment within a reasonable period."

Logistical policy

Logistic issues at a general level also concern the demand and supply balance of patients, doctors and capacity. For their assistance, the supporting specialists negotiate about capacity with hospital management, which is not always successful. An illustration from the fieldwork:

The OPD-hours for pre-operative assessment make patients visit the hospital once more. That's why the anaesthesiologists have agreed to prevent the development of extra waiting lists. This morning two employees who have never before assisted his OPD assist the anaesthesiologist. The anaesthesiologist tells them: "The schedule is very tight. So it's very important everything runs smooth, okay?"
Later he explains: "They can't help it, but we have different assistants all the time. That's because we're not taken seriously. These OPD-hours are tight and you have to get a lot of things done. Besides, it's an extra hospital visit for patients. So we feel patients cannot be in the waiting room for more than five minutes. But we really need good assistance to realise that."

The demand for supporting specialities depends on other specialities. On a daily basis the average demand is rather predictable. The supporting specialities always have to be alert on organisational and professional changes in the requesting specialities. The hospital merger in both case study hospitals for instance created shifts in procedures and patients between hospital locations. This forced supporting specialities to shift activities and schedules as well.

The parties met in negotiations about logistical policy are other specialities and the hospital with its managers. The latter especially when assistance or capacity is concerned, the former for synchronisation of processes. The specialists try to keep or defend control over logistics by making sure they organise their own processes by negotiating with other specialities and management about synchronisation and capacity.

Logistics of information: radiology pictures

Images are of course the main product of radiology. In one of the hospital locations the pictures are stored in a 'Picture Archiving and Communication System', a PACS. This guarantees availability at all times, unless something is wrong with the PACS of course. Radiology in the other location still has to print most pictures at film. Radiology owns the pictures and sends reports to the requesting physicians. But the requesting physicians often want to have a look at the pictures themselves or they don't want to wait for the report. Partly this need is filled by the radiologists who present the pictures in scheduled meetings, for some disciplines on a daily basis. Still, many residents and physicians walk the radiology floors looking for pictures and for radiologists to discuss them with. Sometimes visiting physicians take the pictures with them. When this happens without further notice, radiologists tend to take communication beyond negotiation:

A radiologist (specialist 1) walks into another radiologists' office: "Have you seen the pictures of Mr. X? I'm quite sure I had them on my desk a minute ago?"
Sp.2: "This resident from [speciality] came asking about them. I told him to see you...."
Sp.1: "He wouldn't...." At that moment the radiology resident in the room is paged and answers the phone. Specialist 1 soon understands from the conversation that it's the other resident, the one who indeed took the pictures. Specialist 1 orders: "Hang up that phone!", which the resident immediately does.

Sp.1: "I'll be at the ward for a moment..." and he leaves.
[...]
Specialist 2 explains the situation by telling an anecdote from another hospital, where one of the radiologists threw over a complete desk of another specialist for taking X-ray pictures away without asking. A row broke out of course, all kinds of professors became involved. "But really, taking pictures here without asking is like taking someone's work away. And then start phoning: 'Can you tell me what you see in the pictures of Mr. Y?' Anyway. It will all be over soon. In the new systems we'll be able to control the availability of information by authorising who can and who can't have access."
[...]
Later specialist 1 walks in again. Sp.2: "Is this resident still alive?"
Sp.1: "Let's put it this way. He's not going to be a specialist anymore. He has more or less become a patient himself..."

In anaesthesiology the importance of information logistics is one of the reasons for the anaesthesiology OPD. Since anaesthesiologists have their own process of patient care, negotiations about getting the right information on time are less often necessary.

6.4.3 Jurisdictional claims on professional position and synchronisation

The supporting specialists are happy to provide information and service, but not from a taken for granted position. In their relationships with requesting specialists and patients they will keep underlining their own expertise. Their jurisdictional claim is a claim on their own professional position. The supporting specialists may be dependent of the requesting specialists for getting work, but they lay a jurisdictional claim on an independent patient care process, including an own act of inference, and they need the requesting specialities to recognise them in this independent professionalism.

Supporting specialists negotiating logistics discuss information and ad hoc planning issues more often than other specialists. Both areas are essential in connecting their patient processes properly to the processes of the requesting specialities. Supporting specialists have to organise logistics smoothly to prevent traffic jams in their part of the process, giving requesting specialities reason to question their services. The importance of ownership of radiology images reflects the importance of radiology's position in the relationships with other specialities.

The jurisdictional claim in these negotiations regards the supporting specialists' authority to apply equipment, techniques and knowledge and their ability to make those decisions. This is another claim on independent professionalism.

6.5 Patient care: results from the questionnaire

So far in this chapter the negotiations taking place in patient care have been discussed.

The results of the survey give information about the 'structural context' of the negotiations in patient care. The opinions discussed in paragraph 6.5.1 concern professional primacy and autonomy, two aspects of the 'professional orientation' (see research framework in paragraph 3.6.3). Paragraph 6.5.2 outlines specialists' experiences in involvement in decision making about specialist care, which is an aspect of specialists' alignment with the hospital (also in paragraph 3.6.3).

6.5.1 Professional primacy and autonomy

Professional primacy reflects the principle that patient care and specialist work should provide the standard measures for decision making and organising in hospitals. Autonomy reflects the principle that patient care and specialist practice should be performed without interference or control by others. Collective autonomy means the profession decides on standards for clinical work. Individual autonomy means an individual specialist is free in deciding on the diagnosis and treatment for individual patients.

All statements were responded to on a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree). The results are shown in **tables 6.1** and **6.2**.

Most specialists endorse the principle of professional primacy, which means they feel that patient care and specialist practice should provide the standard measures for decision making and organisation. The results regarding autonomy seem to reflect most respondents do not desire

complete autonomy in the sense of complete absence of interference or control by others. They do support collective autonomy in the sense of the profession deciding on standards for clinical work (1c and 2a).

Table 6.1: Professional primacy, in percentages of respondents

	strongly disagree	disagree	don't disagree / don't agree	agree	strongly agree
2b Managers should create conditions for professional specialist practice.	0,3	0,3	0,3	38,2	60,9
1d Professional quality of individual patient care is being threatened by organisational considerations.	-	6,9	11,9	55,7	25,5
1e Professional quality of individual patient care is being threatened by financial considerations.	1,0	6,6	10,6	51,4	29,8
1g A physician with a focus point within the speciality should be entitled to have the last word about the organisation involved.	0,3	12,1	17,6	57,7	12,4
1f Because patient care is unpredictable specialists can hardly make regular arrangements in daily work.	2,7	35,8	21,5	31,5	8,5
Scale: professional primacy[1]	-	0,3	19,8	69,3	10,7

n = 678 (3 missing values); n = 657 (24 missing values) for scale; Cronbach's alpha 0,49

1 The responses to scales are constructed by totalling the responses to the underlying statements and then by rounding up or down to the numbers 1 - 5 of the Likert scale.

Table 6.2: Autonomy, in percentages of respondents

	strongly disagree	disagree	don't disagree / don't agree	agree	strongly agree
1c Quality of physician practice can only be controlled by the profession.	0,9	11,4	13,0	41,6	33,1
2a Managers should not interfere with physician practice.	0,7	10,4	11,6	37,8	39,4
3l Non-physician managers should be subordinate to specialists participating in management.	3,5	27,4	30,7	26,6	11,8
2c Managers should initiate developments actively, also when physician practice is concerned.[2]	4,4	20,6	30,2	36,4	8,3
1h Individual specialist functioning should be evaluated in periodic interviews.[3]	3,7	13,4	23,3	46,8	12,7
Scale: autonomy	0,6	10,0	53,1	33,6	2,6

n = 676 (5 missing values); n = 657 (24 missing values) for scale; Cronbach's alpha 0,56

Subgroups

Because of the relatively low alphas (< 0,7) the separate statements were studied to find differences between groups.[4] In professional primacy, men feel the threat of organisational considerations (1d) more often and more strongly than women, and they find more often that managers should create conditions for professional specialist practice (2b).

Men and women feel the same about collective autonomy (1c and 2a). Men more often agree with management subordination (3l). Female respondents more often endorse the idea of managers initiating developments in physician practice (2c) and periodic interviews with individual specialists (1h) than male respondents.

Comparing the three groups of specialities shows surgical physicians endorse professional primacy more often and stronger than supporting specialities, in its meaning of managers creating conditions for specialist practice (2b), having the last word about a certain focus point (1g), and physicians hardly being able to make regular arrangements because their working day in patient care has an unpredictable flow (1f).

Medical physicians support autonomy less often and less strongly than surgical and supporting physicians among the respondents. They oppose management interference (2a) less often than both other groups, they endorse management subordination (3l) less often than surgical specialists, and management initiative (2c) more often than supporting specialists.

2 The answers 1-5 on the Likert scale are processed in reverse order to the results in the autonomy-scale.

3 ibid.

4 Differences in ordinal data are identified by a $p < 0,05$ using T-test or Bonferroni posthoc test for multiple comparison.

Working self-employed or salaried makes a difference in the principle of professional primacy. Self-employed physicians find more often than salaried specialists that managers should create conditions for professional specialist practice (2b) and that patient care is being threatened by organisational considerations (1d).

Within the results concerning autonomy, the self-employed specialists only oppose periodic evaluation interviews (1h) more often than salaried specialists.

6.5.2 Involvement in decision making about specialist patient care

To find out specialists' involvement in decision making in the hospital, they were asked to report the level of present involvement and to point out the level of desired involvement. The difference between the desired level and the present level is a measure for desired change.

The survey items referring to decision making represented the organisation of specialist patient care and specialist training (discussed here), the organisation of wards and outpatient departments (discussed in paragraph 7.3.6), and hospital policy and the distribution of hospital means (also discussed in Chapter 7).

The levels for involvement given in the survey run from 1 to 4, in which 1 stands for 'no specialist involvement in decision making', 2 for 'specialists consulted before management takes a decision', 3 stands for 'specialists sharing decision making with management', and 4 means 'specialists take the decision'.

Table 6.3 shows the experienced level of involvement in decision making, and the percentages of respondents that are satisfied with the present level or desire more involvement ('less involvement desired' gives very small percentages, and is left out of the table).

Table 6.3: Decision making about the organisation of specialist patient care and specialist training, in percentages of respondents

Decision making about:	no specialist involvement	specialists consulted	specialists share decision making	specialists responsible	this level of involvement is fine	more involvement desired
6h training program of medical students	2,4	9,5	40,3	47,8	62,8	32,9
6i training program of residents	4,6	7,2	25,5	62,8	71,5	25,2
6j guidelines for diagnosis and treatment	-	2,8	16,1	81,1	82,7	13,9
6m a specialist's professional misconduct	5,1	28,8	54,5	11,6	51,0	47,3
6n co-operating projects with primary care	1,8	16,6	52,5	29,1	57,1	37,8
scale: the organisation of specialist patient care and specialist training						
present	1,0	6,7	51,6	40,7		
desired	-	0,4	26,5	73,1		

n = 655 (26 missing values) for 6h; n = 615 (66 missing values) for 6i, n = 677 (4 missing values) for 6j;
n = 664 (17 missing values) for 6m; n = 669 (12 missing values) for 6n;
n = 654 (27 missing values) for present scale; Cronbach's alpha 0,77
n = 652 (29 missing values) for desired scale; Cronbach's alpha 0,68

Table 6.3 shows the organisation of specialist care and specialist training largely belongs to the sphere of influence of specialists and the specialists want to continue or enhance this level of involvement.

Subgroups

Because of the acceptable alfas, the differences between subgroups will be discussed at scale level. The results for men and women are not significantly different. Respondents younger than 50 years of age report a higher level of involvement than older respondents.

Specialists in surgical disciplines experience less involvement in decision making about specialist care and specialist training than medical specialists.

Salaried specialists experience more involvement in decision making about the organisation of specialist care and specialist training than their self-employed colleagues.

No differences are found for desired levels of involvement.

Table 6.4: Different subgroups, in percentages of respondents

Decision making about:	no specialist involvement	specialists consulted	specialists share decision making	specialists responsible
the organisation of specialist patient care and specialist training				
present level, under 50	0,3	7,0	50,1	42,6
present level, over 50	0,9	7,5	52,8	38,8
present level, medical	-	6,4	46,4	47,2
present level, surgical	1,6	6,9	55,3	36,2
present level, supporting	-	8,6	54,3	37,0
present level, self-employed	0,8	7,0	53,4	38,8
present level, salaried	-	7,4	42,2	50,4

6.6 Conclusion: the negotiations and jurisdictional claims in patient care

This chapter answers the research question: "What is the nature of the negotiations in specialists' day to day work in patient care and what jurisdictional claims underlie these negotiations?"

When specialists work in the area of patient care, they play the role of doctor, which is directly connected with their relationship with individual patients, or they play the role of department member, when their patient care is directly related with the department context, for instance because residents or nurses are also involved.

The following paragraphs will discuss the main aspects in medical, surgical and supporting specialities respectively, after which an over all picture is given in the last paragraph and table.

Medical specialities

Since reasoning is the act that distinguishes medical specialists as professionals, they have to be very careful with what they reason about. This makes them 'picky' in allowing patients and problems into their practice. An important part of medical specialists' negotiated order in day to day patient care is defined by 'entrance control'. In the interest of their professional status they have to lay a jurisdictional claim on the exclusivity of their population of patients and problems, because they have to control the content of their act of reasoning. This jurisdictional claim makes medical specialists for example negotiate admissions with specialists of other medical disciplines, and it makes them negotiate problems and discharge with patients.

Doctor-patient meetings are important moments of evaluation in the act of reasoning. Paragraph 5.2.4 has already showed medical specialists therefore think about logistics in terms of the organisation of contacts. This is recognisable in day to day negotiations about logistics, because they concern the planning of contacts, the protection of process continuity and the availability of information. The negotiations about logistical issues do not reflect a jurisdictional claim on logistics as such, but on the standards for logistics: patient contacts should be organised in frequencies and at times that make sense in the medical process, the continuity of reasoning about individual processes should not be hampered by discontinuity of supply, hence the information about proceedings must be available on demand. The negotiations for logistics reflect a jurisdictional claim on the standards for logistics, in the interest of medical reasoning.

Medical specialists in the national survey support autonomy less often and less strongly than the other specialists, especially when it comes to the management-specialists relationship. Since medical specialists primarily work on wards and in OPD's (paragraph 5.2.2), they probably feel the need for management-specialists co-operation. This co-operation should be based on professional standards though, because the aspects of professional primacy are highly valued by the specialists.

Surgical specialities

Paragraph 5.3.4 has already revealed the need for the surgical specialists to keep the flow of patients going in logistics. The act of surgery distinguishes them as professionals. Since surgery is only one moment in a patient process, patient flows should not stagnate. An important part of their negotiated order in day to day patient care is defined by 'traffic control'. Surgical specialists have adopted many aspects of patient logistics and they are keen on the availability of capacity. In the interest of the act of surgery, they lay a jurisdictional claim on patient care logistics. This brings them into negotiations about daily planning among each other, with other specialists or with nurses, and in negotiations about capacity with managers or planning employees.

The organisation of surgical patient care is largely defined by logistics, hence by a smooth organisation of patient processes in hospital. This is probably why surgical specialists in the survey endorse the aspects of professional primacy more often and stronger than supporting respondents. In respect to autonomy, they are more often than medical specialists in favour of management subordination to specialist managers. This is in line with the jurisdictional claims observed in the case studies.

Decision making in patient care is the second aspect of the negotiated order in day to day surgical work. Surgical specialists negotiate with peers about diagnosis, treatment, probabilities, and the connection of these aspects with the individual patient in question. Usually joint decision making requires little negotiating. When opinions differ individual specialists claim jurisdiction over the final decision about procedures and treatment for the patients they treat. Also in negotiations with patients, specialists try to hold jurisdiction over decision making.

Supporting specialities

A large part of the negotiations that define the negotiated order in day to day patient care in the supporting specialities involve requesting specialists as negotiators. These negotiations are more frequent in radiology than in anaesthesiology, because of higher numbers of patients in radiology, more 'patient ownership' in anaesthesiology, the surgical recognition of anaesthesiological expertise at the OR, and because of all physicians having some basic radiological skills.

The theme here is 'position control', which refers to the position of the supporting specialities in their relation to requesting specialities. Requesting specialists are focused on their own patient care processes and they need the supporting specialities to provide information or circumstances that enable their processes to proceed. They tend to take the existence of the supporting field for granted, a kind of information and service 'takeaway'. The supporting specialists are happy to provide information and service, but not from a taken for granted position. In their relationships with requesting specialists and patients they will keep underlining their own expertise. They lay a jurisdictional claim on an independent patient care process, including an own act of inference, and they need the requesting specialities to recognise them in this independent professionalism.

Information logistics and ad hoc planning issues are more often the subject of negotiations in supporting specialities than in other specialists. In these negotiations specialists voice a claim on jurisdiction over their equipment, techniques and knowledge. Indirectly this claim is again a claim on independent professionalism.

The claim on jurisdiction over equipment also makes supporting respondents in the survey endorse autonomy more strongly and management initiative less strongly than medical respondents.

Overview

In hospitals "there is actual or potential competition among patients for available resources, notably the staff's time, attention, and skills, but also occasionally, if temporarily, scarce resources like equipment and drugs." (Strauss et al. 1985:154-5) This actual or potential competition is found in all specialities, making the negotiated order in day to day patient care a product of negotiations in patient care itself and of negotiations about the logistics of patient care. The impact of logistics was also found to occur in a study of 'loss of quality situations' in hospitals (Hutten et al. 2003). This study found specialists to report the largest category of 'loss of quality' in logistical problems, for instance admitting patients, transferring patients, getting a patient into surgery, and available time for patients.

The survey results show that specialists in all disciplines experience a rather high level of involvement in decision making about the organisation of specialist patient care and specialist training.

The negotiations and jurisdictional claims in patient care are summed up for the various specialities in **table 6.5**.

Table 6.5: Negotiations and jurisdictional claims in patient care

medical specialities	surgical specialities	supporting specialities
negotiations about patient care: entrance control	*negotiations about logistics: traffic control*	*negotiations about patient care: position control*
negotiations about patients and problems allowed into the pigeon hole	negotiations about patient flows, capacity and information availability	negotiations about the relationship with requesting specialists and the position in patient care processes
claim on jurisdiction over the entrance into the pigeonhole on behalf of the content of reasoning	claim on jurisdiction over patient care logistics to keep the act of surgery going; claim on availability of information	claim on jurisdiction over an independent patient care process
negotiations about logistics	*negotiations about patient care*	*negotiations about logistics*
negotiations about the planning of contacts, process continuity, availability of information	negotiations about decision making and evaluating in patient care	negotiations about getting and providing information, and (ad hoc) planning of patient care
claim on jurisdiction over the standards for logistics	claim on individual jurisdiction over final decision about procedures and treatment, especially when opinions differ	claim on jurisdiction over equipment, techniques and knowledge of the speciality

References Chapter 6

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7 Specialist roles defined by relationships in the hospital

7.1 Introduction

Paragraph 5.5 showed that patient care defines the largest part of specialists' time in the hospital, so it makes sense the first chapters in Part 2 of this thesis have focused on patient care. Day to day work, however, also brings negotiations that are not necessarily related to patient care. This chapter focuses on specialists working in relationships within the hospital, other than the relationships with patients. These relationships define four roles specialists can play: being a peer, being a department member, being a staff member, and being a hospital member.

So far, in chapters 5 and 6, the three categories of specialities have been discussed separately. The analyses this chapter is based on, however, revealed more similarities than differences between specialities. Therefore the paragraphs are focussed on the roles now, not on the separate specialities. Important differences between the specialities will of course be discussed.

Paragraphs 7.2, 7.3, 7.4, and 7.5 will respectively discuss the negotiations and jurisdictional claims from the perspectives of the four roles mentioned before: peer, department member, staff member, and hospital member.

Paragraph 7.6 elaborates one special role that is only played by a few specialists: the role of specialist manager.

Each of these five paragraphs opens with a short description of the day to day negotiated order from the perspective of the role in question. First, who are the negotiators and what nature do the negotiations have in general? Second, what issues are the negotiations about and what patterns will be discussed in more detail?

In every role two large categories of issues were found to define the negotiated order: the organisation of work, and relationships and positions. The details of these categories will be discussed in subparagraphs, after which the survey results that belong to the role in question will be presented, as well as the underlying jurisdictional claims.

Paragraph 7.7 presents this chapter's conclusions.

7.2 The role of peer

Dutch specialists started to organise their work in peer groups in the sixties of the 20th century. Solo practices of individual specialists are hardly found in hospitals anymore: less than 1% of the respondents in the survey work alone.

The role discussed in this paragraph is the role of being member or representative of the partnership (self-employed specialists) or speciality group (salaried specialists). Peers are thus defined as having the same speciality, sharing patient care and the business aspects of their practice.

In daily specialist life work is shared with many more participants than peers only. The pure peer-role therefore was relatively little visible in the observations (see appendix 2 for numbers). Specialist care nevertheless starts with having specialists around, and the peer group basically is the centre of specialist work. So, although the peer-role is quantitatively small, qualitatively it is important, and specialists often refer to the importance of the peer group.

In the case studies, specialists in medical disciplines were less often observed to be involved in negotiations from the peer-role than physicians in surgical and supporting specialities. This will be discussed in paragraph 7.2.5.

Negotiators and negotiations

Specialists in their peer-role mostly meet colleagues in negotiations, especially fellow members of the peer group and, since the observations took place in merger hospitals, the members of 'the other peer group': the partnership or speciality group of the same speciality in 'the other' hospital.

The second party specialists meet in the peer-role is the hospital organisation and its managers.

The specialists seem to deal with the negotiations in this role mainly by aiming at holding or defending jurisdiction. They do so by various tactics, for instance negotiating or forming coalitions, and by organising things themselves. Flight or surrender was observed as well.

Issues and patterns

The category of issues most often found when specialists play their peer-role is relationships and positions. The second category of issues is the organisation of work.

The category of relationships and positions has two subcategories. Paragraph 7.2.1 will discuss the inside component of the role (peer group member), which brings the double meaning of relationships in being a peer: being a 'pal', as far as possible, and being a 'business partner'. Paragraph 7.2.2 discusses the outside component of the role (peer group representative) in relationships with parties around the group.

Paragraph 7.2.3 deals with the category of the organisation of work, in which finances and output, or 'production' were found to be the issue most often negotiated.

Paragraph 7.2.4 addresses the survey results that reflect certain aspects of the peer-role, and paragraph 7.2.5 discusses the jurisdictional claims connected with the peer-role.

7.2.1 Pals and partners

This paragraph addresses negotiations in the inside relationships of a peer group. To be able to put peer-relationships in a functional perspective, the functions of a specialist in his or her role of peer will be discussed first. Then the negotiations brought by being pals and partners will be presented, after which the situation of conflicts will be addressed. Finally recruitment of new peers is discussed, since this process reflects the complexity of the role of peer.

Peer-role functions: sharing patient care and supervision

Specialists in the case studies stress the importance of good peer relationships, both professional and personal. They relate their peer-role in the first place to their work in patient care and in supervising and training residents. Peer communication and co-operation are necessary elements for having quality specialist care and supervision, 24 hours a day, seven days a week. The specialists 'prove' this necessity mainly by telling about the opposite situation, when peer relationships are bad, which almost every specialist in the case study at one time experienced in some way. Joint 'inference', continuity of patient care, and supervision were hampered then, which -indirectly, but inevitably- threatened the quality of individual specialist work.

The peer-role function of sharing patient care and supervision can be illustrated by discussing the problems of one of the case study peer groups that had a period of communication problems during the observations. The negotiated order of sharing work was damaged. The problems found here reflect problems other specialists had in their past.

The problems of the peer group in question were not kept secret from the researcher, and in the course of the case study period all different specialists gave their opinion. At first glance, observing specialist work at OPD's, patient care did not seem to be affected by the problems at all. Patients came in, discussed their problems, got specialist advice or treatment, and left again. The organisation was small scale in both hospital locations, with a few dedicated OPD-assistants who smoothly supported the patient processes. The processes even seemed to run easier than in the case studies of the larger scale hospital, not having these serious troubles in the peer group. The impact of the problems became more clear by observing more different processes and moments, on wards and in the operating rooms, and by having conversations with the specialists and with some nurses.

Moments of discussion and joint decision making, for instance, were hardly scheduled, neither within the speciality, nor in multidisciplinary groups. Morning meetings, in which the specialists and residents on call reported on patient care, were stopped for a period. On the wards, several procedures had to be done by different instructions, depending on the specialist who had ordered the procedure. The residents worked with the specialist on

call, but the specialists did not communicate with each other about their supervision. And finally, the peer-role was not played in terms of pals and partners, but in terms of positions, accusations and suspicion: the specialists seemed to keep a constant eye on each other, for instance by asking OPD-assistants or nurses on the wards for information about their colleagues' patient care, behaviour or remarks. Their individual stories about the problems were also told in terms of 'I' and 'them'. A few different specialists about this:

"It all started with a clash between Y and me. I still don't get the point of the clash, but Y can be quite emotional. He was annoyed, for instance because I sometimes came late at meetings. But after the clash we could talk things over, at my initiative. [..]
I sometimes clashed with this other colleague as well. But to him, I've always kept saying: "We're stuck with each other, we have to keep talking. We can not blow it." And we didn't blow it. But Y and Z, they're not talking with each other anymore. Nevertheless, I still try to get the whole group together now and then."

"Z is an individual. I don't want to speak ill of him, but I don't know how we can go on. I think he'll have a heart attack or something. He can get so angry.[..]
I still try to have some relationships with the nurses and OPD-assistants of our department. I gave a birthday party, and 20 people came over. Z gave a party too. No one was there."

"X is the only one I can get on with. I can tell him my opinion, for instance when I think he gave someone the wrong treatment. He won't like that, but he can handle it. The other ones are offended too easily, I can't tell them anything. But, as a colleague, I want to be able to discuss things. They're still of the authority based style of practice, I favour the evidence based way."

The problems mentioned here reflect the functions of the inside component of the peer-role. A specialist, being a member of a peer group, is responsible for taking part in the primary peer business, which is patient care: sharing inference in patient care, sharing '24/7' continuity of patient care, making clear rules and instructions for nurses and other personnel in patient care, and sharing the supervision of residents. These responsibilities reflect being 'partners in business'. Being 'pals', at least being able to 'get along', is not a responsibility in itself, it is a basic condition for the business responsibilities. If this condition is not met, the specialists are hampered in playing the peer-role, and this hampers the peer group's functions and threatens the quality and safety of patient care and supervision.

More advanced responsibilities of specialists in their peer-role are contributing to development or growth of the discipline, and acquiring or maintaining an organisational position as a group (see paragraph 7.2.2). These functions were only found in peer groups in which 'getting along' was positive and stable.

Negotiations: relational manners and a fair distribution of work and finances

Since 'getting along', or being pals in whatever minimal version, is a basic condition for the aspect of 'being partners in business', it might be expected to precede the business aspects. In practice however, these two aspects are difficult to separate, and most negotiations reflect both aspects.

Negotiations connected with the aspect of being pals mainly concern relational manners. These negotiations are often indirect, being worked out in the negotiations connected with being partners.

The issues in negotiations between business partners are the fair distribution of tasks and workload in the peer group, and the fair distribution of income, costs and output, or 'production'. The latter is openly on the agenda of many peer group meetings, especially partnerships, and it is an important issue in relationships with management, specialist staff and the hospital organisation. The specific subject most often mentioned, discussed and negotiated is the numerical output, the number of patients and/or procedures. This is also called 'production'.

Negotiations within the peer group are often preparations of negotiations with other parties about these numbers or about the capacity available for realising output. The negotiations within the peer group also address conflicting stakes in which finances somehow are involved. For instance, output numbers in patient care are more important for obtaining finances than activities in training residents. How should these activities be balanced and prioritised? Higher output numbers also improve or at least protect specialist fees in a partnership. But a higher output with the same number of specialists creates more workload.

As this should be distributed fairly, it may give some specialists problems in their role of doctor, because they have to see more patients in less time, or in their role of individual, because of the combination of work and a private life.

As an example of conflicting stakes in which finances are involved, one of the specialists tells about 'quality' as an issue on the agenda of the peer group:

"When our partnership discusses quality of patient care, for instance at our yearly day on partnership policy, everyone finds it important to do something about it. But if we really want to do something about it, we'd have to invest time and money. And then suddenly some of us think very economically again.... We find making money for ourselves important as well.."

Different groups have different ways of structuring these combined negotiations about being pals and partners. Some have openly agreed to be frank about mutual relationships, expectations and frustrations. Two specialists in supporting specialities are telling about this:

Sp1: "Our peers are important to us. And being able to get along."
KK: "And how do you make sure you get along? Is it automatic?"
Sp1 and Sp2 both shake heads.
Sp2: "Of course not! Don't you think the other ones annoy me now and then? And the other way around?"
Sp1: "We try conscientiously to consult each other. Our profession does not allow for differences. We take over each other's patient care, and we all need to follow the same procedure.
We've also agreed we'll never desert each other in public. And even if we don't agree with each other's treatment, we'll carry on without comment. We'll have the discussion about it within the group."

Other groups have a more covert structure for these negotiations:

Sp: "The good atmosphere of our group is important to me."
KK: "And how do you make sure you keep it? Is it automatic?"
Sp: "No, it's not self-evident. I think respect is the most important thing. We respect each other."
KK: "Do you talk about it? About respecting each other?"
Sp: "No, we feel it. We're open with each other."

Regardless of a structure for negotiations about these aspects, irritations, smaller or larger fights, gossiping and grumbling, are present in every peer group. Sometimes longer lasting conflicts occur.

Conflicts

When the structures for negotiations fail to support the negotiated order in mutual relationships, peer group conflicts sooner or later become evident. Most specialists have had periods in which peer relationships were bad. The stories they tell about these periods reveal two variants. The first variant is when one of the specialists is a 'rotten apple', not capable of functioning in a peer group. The second variant is when the group as such is temporarily not capable of smooth functioning. The two variants of conflicts can be mixed too, with one or two 'rotten apples' surrounded by a group that is no longer functioning.

Discussions and interviews with the specialists in the case studies show that, even when conflicts are evident, it seems hard to openly acknowledge their existence. And even when they are acknowledged, it seems hard to find a solution, and specialists feel forced to cope indirectly. For instance when the quality of patient care is at stake, specialists seem to adopt extra tasks in checking on patients themselves, to prevent "unpleasant surprises". One of the specialists tells about a difficult period in his past, during which he was not communicating with one of his peers (a 'rotten apple'):

"It was a horrible period. The biggest problem was, we didn't discuss patients anymore. So my other colleague, the one I was still communicating with, and I always made sure we knew absolutely exactly what inpatients we had on the wards. We wanted to prevent unpleasant surprises. We had to be on top of everything ourselves."

Solving longer lasting conflicts is difficult and takes a lot of time. Quite often severe problems in patient care are necessary to speed things up. The solution for a 'rotten apple', after attempts of correction, is the removal of this specialist, despite his or her fighting removal. Negotiations in these situations often end up in lawsuits. Solutions for bad group functioning vary. Ignoring the problems and avoiding negotiations is possible, for instance awaiting the departure of some "oldies". These are variants of flight or surrender.

Active negotiation about the problems is another option, with or without the help of management or external mediators (see also Visser 2000). Sometimes the departure of one or more specialists is necessary as well, to restore the balance of relationships.

Recruitment

Several specialists mention careful recruitment of new peers as a method to prevent problems with peer-relationships. They sometimes add that recruitment is a complex process and that individual specialists may fear being threatened by bright new colleagues. Therefore recruitment not self-evidently gives the best candidate. One of the specialists says:

"If it's about finding new colleagues, you have to be aware that it's easier to get rid of your wife than to get rid of a peer. Still, many people favour candidates being slightly less good than they are themselves, in stead of better. We have recently chosen a better one though, mind you."

And another specialist:

"A group of already weak specialists will recruit an even weaker one, because they don't want to be threatened by a new colleague."

Recruitment of a new peer thus is a method to protect the negotiated order and prevent conflicts, but at the same time it is another field of potential negotiations between peers. Some considerations, for instance qualifications in patient care, will be discussed openly in a recruitment process. Fear of a bright young peer who might threaten the position of the others, will probably not be admitted easily.

7.2.2 Working the relationship network

This paragraph discusses the role of peer from the perspective of relationships with outside persons and parties. First the importance of positioning will be explained, after which another subparagraph discusses the negotiations with 'the other' peer group in merger processes. Then negotiations with other parties in the hospital will be presented, and lastly negotiations with the outer world will be discussed.

Positioning the peer group

Peer groups work in a network of other parties. The issue emerging most often from the analyses of the peer-role in its outside component is positioning the group in its relationships with parties around it. Much attention is given to defining or expanding the group's position in these relationships. Three categories of parties are found in this. The first one is 'the other' peer group in the merger of the hospitals. The second category are parties within the hospital organisation, for instance management, other peer groups, and the specialist staff. The third one is the specialist outer world, mainly being speciality groups in other hospitals.

In these processes, in which the role of being peer is connected to representing the peer group, the role is mainly defined by shared group interests and structures, with some personal and individual accents shining through.

'The other' peer group in the merger

'The other' peer group exists within all seven case studies, resulting in 14 peer groups with members mentioning 'the other' group. All groups merged recently before the case study or were in the middle of the merger. Since being peers in one partnership or speciality group is more than just being colleagues, as discussed in the paragraph 7.2.1, it makes sense a merger with another peer group causes negotiations related to the peer-role. Specialists in their role of representing the peer group seem to watch the way 'the other' peer group structures their negotiations in being pals and partners.

With respect to being pals, specialists know being a good group of colleagues is difficult anyhow. Becoming a group about twice as big can hardly be a smooth process from the start. Most specialists, once they've accepted the merger, work hard to deal with this. For instance they get external advice and mediation, try to be patient and positive with each other, take time for meetings, and organise trips together. The existing negotiated order nevertheless is gone, and it takes a period of several kinds of negotiations and tactics to create a new one. One of the specialists tells about the first acquaintance with the peer group of the other hospital, after the merger was announced by hospital management:

"They gave us the feeling we were on a job interview. They were here in our hospital, and they asked: 'So, what do you do around here? What have you got to offer us?' [raises his

eyebrows and shrugs] 'Well, ourselves..?', we said, ' We're good physicians, we have energy, we're young.' But apparently that wasn't good enough. We were sitting together, after they'd gone, looking at each other: 'No, this won't work...'. "

With respect to being partners in business, the specialists in their peer role watch the way 'the other group' structures these negotiations as well. For instance, are they equally eager to prioritise a regionally important position? How do they feel about training residents? What will be the balance in mutual adaptation to each other's standards, rules, guidelines, manners and atmosphere? One of the specialists jokes about what the balance will be, as far as he's concerned:

"It's going to be a challenge to work with this bigger group. They will have to adapt alright!
O, o, aren't I terrible?"

This attention for positions in mutual relationships exists for a long time before and after a merger, and it is worked out in discussions and negotiations between the merging peer groups. The actual issues in these negotiations in the first place concern the organisation of patient care. In two of the case studies the merger was combined with relocating patient care in the two hospital buildings. This forced specialists in their peer-role to negotiate with 'the other group', with department managers and with hospital managers about patient care in a new situation. In these peer groups much time and effort was spent on harmonising guidelines and daily routines.

When locations of patient care are unchanged, the merged organisation of patient care can grow a bit more gradually. Specialists then start by sharing shifts, or by working each other's wards and departments. Whether developing abruptly or gradually, a merger is a source of patient care issues for specialists in their peer-role.

Another source of merger related negotiations is everything that has to be distributed among the members of the new peer group: work, income, costs and output. For members of a partnership these financial aspects are more important than for an employed speciality group. Financial considerations bring negotiations between (new) peers about priorities. A specialist may favour gradual development of co-operation between locations, to prevent a sudden change of the negotiated order in the 'own' group. But gradual development may hamper the output in patient care, which may be a priority from the perspective of the peer-role as well. One of the specialists explains:

"We'd like to develop the co-operation between the two groups and hospital locations gradually. But we can't. We'd lose too much production if we started up gradually."

Merging patient care in the interest of 'production' is especially necessary in the supporting specialities, because of their dependence of requesting specialities. One of the supporting specialists in the case studies:

"We needed to merge too, urgently. Because of our production. The requesting physicians are merging and shifting their logistics. Which caused an unequal distribution of the output in our speciality."

The specialist income is an issue when both peer groups have very different levels of income. Then it takes a lot of negotiations between the peer groups and hospital management and a lot of external advice before new arrangements are taken care of.

All peer groups have had some interference from parties outside in the periods of their merger. The board of directors and other managers are always involved in creating conditions for the new situation. Sometimes external advisors or mediators support the peers to get the groups together. The specialists' staff is of course involved in the hospital merger in general and when conflicts in one speciality get out of hand they will specifically deal with it. When a merger causes a long lasting period of negotiations, even the scientific association of the speciality may give its opinion. Besides, the profession plays a role in confirming new positions after the merger has taken plays. For instance in the 'visitatie system' (see paragraph 2.5.1) the new peer group is tested on its qualifications for the teaching status.

Parties within the hospital

The hospital context offers a field in which specialists pay attention to the relative position of their peer group compared to other parties. Various other parties are often involved at the same time, creating relationships that are at least triangular, usually even more complex. Specific subjects are in question in actual negotiations for positioning in hospital. These almost always involve finances, output and

capacity numbers (beds, OR-hours, et cetera) and the way these are distributed in hospital. The following specialist refers to the triangular relationship between his peer group, the specialist staff and the hospital management:

"The specialist staff is discussing the function of 'hospital physicians'. These junior physicians have different functions from residents because they have a specific focus of attention. Our partnership probably wants to make this a permanent function, with the partnership responsible for supervision. The hospital is also considering making it a regular function and take it into the financial system. But the specialist staff and hospital management are still discussing the financial arrangements. We probably want to continue with this function anyhow. So, we'll join the discussion, but we will also move on and hire someone, taking the risk of this venture ourselves for the time being."

The relative position of the peer group in the relationship network of parties in the hospital seems to be an important issue in this kind of negotiations. Specialists often mention the features of the various relationships in comparing terms. For instance: "We have easier access to the board of directors than our colleagues in the other hospital", or: "We are not friends with this other partnership at the moment, 'cause they blame us for annexing this new training program." The outcome of negotiations is quite often formulated in comparing terms as well.

Most peer groups in the case studies aim at keeping or defending their position in the hospital network of relationships. They watch changing relationships, form coalitions, negotiate or they deliberately break away and act on their own. On the inside of the peer group, different specialists of course play this role differently, depending on their personal preferences and tasks or sub-roles the peers assigned each other. A specialist manager will especially have eye for the department context and for the managerial aspects of the position. Specialists who have certain focus points within patient care will try to protect the position of that field of patient care.

The peer group that had co-operation problems did not act as a group in its context anymore. The individual specialists still tried to position themselves in hospital, but the problems mainly made them a group to be dealt with by hospital, not the other way around. After the case study period this group made a new start acquiring position again. For instance, they published a report on their professional and organisational structure and used this for a presentation in the specialist staff, and for negotiating capacity with management and other speciality groups.

The outer world

The third category of parties in the issue of positioning the peer group is the outer world, in particular the outer world of providers of patient care in the district: general practitioners, peer groups of the same speciality in other hospitals, and a single commercial organisation. These relationships were especially found in four peer groups being involved in establishing co-operations beyond the borders of the hospital. The four initiatives found in the case studies concern establishing a 'transmural centre' for treatment of a certain chronic population (two peer groups in the medical specialities), establishing a regional partnership by merging with a partnership from another hospital (a peer group in the surgical specialities), and establishing a diagnostic centre (a peer group in the supporting specialities). The regional position of the peer group was an item in decision making about these plans.

In this field of negotiations, different specialists again play this aspect of the peer-role in different ways. Every peer group has two or three specialists who participate in the actual negotiations with hospital management and outside parties. These specialists prepare formal meetings in the context of the peer group as a whole. Incidentally formal meetings take place with all members of the peer group and all outside parties involved.

Formal negotiations are important moments in the negotiation processes with outside parties. Other tactics take place as well, and seem to create the conditions for the formal meetings. In these tactics the specialists find out about 'hidden agendas', about interests that are not openly discussed, or about relational manners of the parties they are dealing with. For instance, one of the specialists tells about the negotiations with an outside partnership:

"We soon found out that this other partnership could not be trusted completely. We had dinner with them, and later it got back to us that they had started gossiping about us after that dinner, telling stories, that we had problems in our co-operation. We still continue our meetings with them now, but we do not trust them completely anymore."

Specialists telling about relationships with parties outside the hospital usually refer to their peer group as 'us' and 'we'. This illustrates the representing character of this side of the peer-role.

7.2.3 The organisation of work: finances and output

Paragraph 7.2.1 and 7.2.2 addressed various aspects of negotiating relationships. This paragraph discusses the second category of negotiations that define the negotiated order from the perspective of the peer role: the organisation of work.

Finances and output are pivotal in this respect. The following paragraph explains why output is income, after which the negotiations about these issues will be discussed.

Output is income

The importance of finances, fees, costs and output has already revealed itself in other issues discussed so far. This area matters more to partnerships than to salaried groups, because partnerships share their income and salaried groups get their fee individually from the hospital. Both kinds of peer groups nevertheless are eager to protect their output. Specialists' core business is patient care, and the volume of patient care is still related to income, although more indirect than it used to be, since the lump sum remuneration replaced the fee-for-service system (see paragraph 2.4). Despite the pay on the nail principle (see paragraph 2.5.2) for some services, the rule of 'budget is budget' was more important in the case study period. In this system, meeting agreements about output volume is necessary to prevent future budgetary cutbacks. Exceeding agreements about output volume should be prevented, because the budget is limited.

In short, output is important, and the specific issue most often in question in negotiations on this field are financial arrangements or output itself.

Negotiations about financial arrangements and output

When financial arrangements or output are the specific issue in negotiations, specialists representing their peer group most often meet 'the hospital' as the other negotiator, which means they meet managers and employees of the financial staff. The latter are often involved in negotiations about facts. Peer groups and financial departments often both keep track of the output and if their numbers are different, which is often the case, negotiations take place about the accuracy of the recording systems. Managers become involved in negotiations when decisions have to be made about the correct numbers. They are also the party to meet for discussing financial conditions in general, for instance the distribution of hospital capacities for making output (beds, OPD-hours, OR-time).

Dealing with finances and output requires a lot of negotiating, fighting and arguing, because the interests of all parties involved are quite often opposite and conflicting. As explained in the former paragraph, specialists' core business is patient care, and its volume is still, although indirectly, related to income. For hospital management, output is important too, but efficiency needs to be watched as well, which means the hospital cannot always provide the peer groups with the personnel and budget the specialists would like. One of the specialists puts it this way:

"Specialists' and hospitals' interests just are not the same. Even different specialities have different interests. But in general, specialists want to do as much patient care as possible and they want to make as much money as possible. Hospitals want to do as little as possible, and keep money in the pocket."

In the period of the case studies, a general shortage of nurses and OR-assistants caused many vacancies, forcing managers to 'close' beds and operating rooms. One of the specialists in a surgical speciality tells about the OR-capacity:

"We are scheduled in two operating rooms per day, which gives us 16 hours of surgery a day. About 30% of that time, about five hours, we need for acute patients from casualty, or inpatients. The remaining 70% is for planned procedures. But now we have shortage of OR personnel. And we have to decrease OR-hours. We can use one room, and only on Wednesday we have two rooms. But on average we still need five hours a day for acute patients. So we can hardly plan any procedures anymore! Which is not good in the financial system. We'll have a meeting on that with the board of directors tonight."

The importance of the financial arrangements, and the multitude of interests means peer groups have to make sure they have knowledge and skills for dealing with the issue. Most groups have one or two peers who are especially keen on financial techniques and output calculations. They also ask external financial advice when important decisions have to be made, for instance about co-operating with a commercial organisation or about a partnership merger. Almost every specialist has a regular financial advisor to assist in fixing personal arrangements and in group meetings they sometimes share this advice.

In the processes concerning the issue of finances and output actual negotiating is the most important way of dealing with the situations.

7.2.4 The role of peer: results from the questionnaire

The survey themes (see paragraph 4.3.1) came from the research framework for studying the 'structural context' of negotiations (paragraph 3.6.3). This paragraph addresses the survey results that are related to the role of peer.

First, specialists' opinions about mutual peer relationships will be presented here in terms of 'egalitarianism'. Next, specialists' feelings towards their peer group will be discussed, after which specialists' opinions about the position of the peer group in hospital will be addressed. The last subparagraph of this paragraph focuses on respondents with a special kind of peer-role, the chiefs of peer groups.

Egalitarianism

Traditionally relationships within groups of professionals are characterised by a dislike of hierarchy (for instance Van der Wee 2000:78). This is the principle of egalitarianism, reflecting the value of every member of a group of peers having an equal say in decision making. People supporting hierarchy are less likely to support egalitarianism.

The specialists in the survey endorse the statement that all members of a peer group need to have an equal right of say in decision making. Hierarchy, however, is not completely 'off limits', because about 40% of the respondents feel it is necessary to determine who is 'boss' within a peer group. A little over 40% of them think this is not necessary. The results are given in **table 7.1**.

Table 7.1: Egalitarianism, in percentages of respondents

	strongly disagree	disagree	don't disagree / don't agree	agree	strongly agree
1a All specialists in one group need to have an equal right of say.	0,7	7,8	6,5	31,9	53,1
1b It is necessary to determine who is 'boss' within a group of specialists.[1]	14,2	30,3	16,5	27,2	11,9
Scale: egalitarianism	0,5	7,8	24,8	35,6	31,4

n = 678 (3 missing values) for 1a and 674 (7 missing values) for 1b; n = 657 (24 missing values) for scale; Cronbach's alpha 0,83

1 The answers 1-5 on the Likert scale are processed in reverse order in the results on the Egalitarianism-scale

Men and women don't have different opinions on egalitarianism. The oldest group of specialists, 55 years or older, endorse hierarchy (determine who is 'boss') more often than the youngest group of 40 years or younger.[2]

The physicians in the three different speciality groups do not have different opinions.

Salaried specialists endorse hierarchy more often than self-employed specialists.

Feelings towards the peer group

Another phenomenon in professional group life is commitment to peers. That is why the survey also asked about the feelings towards the peer group.

About 10% of the specialists do not feel at home in his or her peer group, the majority does. The majority of the respondents, about 80%, also think his or her peer group functions all right. **Table 7.2** shows the results.

Different subgroups of respondents do not show any different results.

Table 7.2: Feelings towards own group, in percentages of respondents

	strongly disagree	disagree	don't disagree / don't agree	agree	strongly agree
4c I feel at home in this partnership or speciality group.	1,0	2,9	6,0	45,4	44,5
4d I think this partnership or speciality group functions all right.	2,1	5,9	14,0	52,9	25,1
Scale: positive feelings own group	0,6	3,5	7,5	45,3	43,1

n = 678 (3 missing values) for 4c and 4d; n = 655 (26 missing values) for scale; Cronbach's alpha 0,83

Position of the peer group in hospital

In the past, the collective organisations of specialists seem to have been developed partly to compensate the lack of formal relationships between specialists and the hospital organisation (see Chapter 2). How about the other way around? Do specialists expect the peer group to lose importance when formal relationships grow stronger in the context of management participation? This was asked in the survey (see **table 7.3**).

2 Differences in ordinal data are identified by a $p < 0,05$ using T-test or Bonferroni posthoc test for multiple comparison.

Table 7.3: Position of partnerships or speciality groups, in percentages of respondents

	strongly disagree	disagree	don't disagree / don't agree	agree	strongly agree
3m The importance of partnerships and speciality groups as organisational forms will decrease when specialists get a stronger position in the hospital organisation.	12,4	42,6	18,4	24,6	1,9

n = 678 (3 missing values)

Most specialists do not expect their peer groups to lose importance. Almost one out of every four specialists does think the stronger formal position will replace the collective organisation. Different groups of respondents do not have different expectations.

Chief, head or chair of partnerships and speciality groups

The survey also asked for secondary functions, among which the chief (or head or chair) of the peer group. Almost 24% of the respondents is chief of his or her peer group,[3] and another 24% reports to have had this function in the past. A small group (3%) reports present and past experience.

About 25% of the remaining population, without present or past experience, thinks about this function for the future (this is 14% of the total population). About 40% of all respondents does not have past or present experience as chief and does not report to be interested either (see **table 7.4**).

Women chair their peer group statistically less often than men (15% of female respondents and 26% of male respondents reports to be chief). As might be expected, the number of respondents with chief experience increases with age.

Other differences between subgroups (specialities, salaried or self-employed) are not significant.[4]

Table 7.4: Chief of the peer group, in percentages of respondents

	percentage
chief now (not in the past)	21
chief now and in the past	3
chief in the past (not now)	21
thinking about becoming chief in the future	14
no experience, not thinking about it	41
total	100

n = 657 (24 missing values)

Being chief of the peer group gives the peer-role other accents than just being member of the peer group. Chiefs spend more time on organisational tasks, 12% of the time in hospital in stead of 9% for their colleagues. This time is taken in little pieces of the other activities, not rendering significant differences. Hours in hospital per week are not different for the chiefs.

In some ways the present chiefs differ from the rest of the population. They endorse the principle of egalitarianism less often than the other specialists, their feelings towards hospital (discussed in paragraph 7.5.3) are more positive, and they support specialist management (discussed in paragraph 7.6.4) more often.

7.2.5 Jurisdictional claims related to the role of peer

Various jurisdictional claims seem to underlie the negotiations discussed in former paragraphs. The inside component of the role of peer is related to an individual jurisdictional claim, while the outside component is related to shared jurisdictional claims. Some differences between the three groups of specialities seem to be connected with jurisdictional claims in patient care.

Individual jurisdictional claim

The inside component of the peer-role makes specialists members of the peer group, being each other's pals and business partners. The responsibilities involved give rise to potential and actual negotiations within the peer group. As explained, the actual issues are about relational manners, and the priorities in or distribution of work and money. Under this surface of actual issues emerges a deeper negotiation level: every individual peer wants his or her interests to be served and his or her individual style and needs to be accepted and respected by the peers. The role of individual, from which specialists care for personal and private interests and needs, touches the peer-role here. This will also be discussed in Chapter 8, when the role of individual is in question.

The jurisdictional claims underlying negotiations in being pals and partners thus seem to reflect the individual specialists' desire for personal jurisdiction over the content and the organisation of their practice. Jurisdiction in this aspect cannot be personal and has to be shared, because individual specialists need the group. Without it, they cannot guarantee quality specialist care and supervision, 24 hours a day, seven days a week. Within it, the group by definition touches individual borders of jurisdiction.

The individual jurisdictional claim is reflected in survey results concerning egalitarianism. Specialists in general favour equal say for every individual in group decision making. Individual respondents who may experience some hierarchical elements in their own position, such as the oldest group of specialists and the chiefs of peer groups, endorse egalitarianism less often. This suggests they seek room for establishing their individual jurisdiction within the group.

The individual jurisdictional claim may cause specialists to annoy each other in a peer group. The survey results, however, show most specialists express positive feelings towards their own group.

Shared jurisdictional claims

Specialists quite often refer to their practice as a shop that they own together with their peers (this is also mentioned in literature, for instance Scholten and Van der Grinten 1998, Tap and Schut 1988). It's a nice shop or, even more important, it's 'our own shop'.

The last remark is especially made when specialists explain that it is becoming harder to keep 'your own shop' nowadays. In times gone by the specialists apparently owned their shop more obviously. One of the specialists explains this:

"In the past things were better. The specialist was in charge. He kept his own shop. And everybody just had to do what he told them to."
KK: "You haven't experienced that yourself, have you?"
Sp.: "No.... I think it was a kind of situation you see now in private clinics: small scale, clearly arranged."

3 Based on the assumption that each peer group has one chief, and based on the amount of members per peer group (asked in the survey), a percentage of 22% present chiefs may be expected. Probably smaller peer groups often do not have a formal chief or head, so the percentage of 24 suggests a slight overrepresentation of present peer group chiefs in the population of respondents.

4 Differences in nominal data are identified by a $p < 0,05$ using Chi-square test or ANOVA.

KK: "Do you know colleagues working there?"
Sp.: "Yes, and they're also immediately the director then."
KK: "Would you like that too?"
Sp.: "Maybe."

The feeling of being fellow-owners of a shop underlies the negotiations discussed in this paragraph. Members of a peer group share a jurisdictional claim on the professional, financial and organisational aspects of their work. They make this claim in relationships with other parties, and negotiations about finances and output are manifestations of the claim.

Specialists in general expect the importance of their shop to continue, since most respondents in the survey expect peer groups not to be replaced by formal relationships in the hospital.

Different categories of specialities

Comparing the quotations found in the case studies shows that specialists who play the role of peer in medical disciplines have the lowest number of negotiations. The numbers of negotiations from the peer-role perspective are about equal in the surgical and supporting specialities.

The peer group apparently is more often connected with negotiations in surgical and supporting specialists than in medical specialities. This probably makes sense when the jurisdictional claims from the perspective of the peer-role are connected with creating conditions for the jurisdictional claims in patient care. Entrance control for patients and problems, central in medical specialities, brings negotiations within the process of patient care itself. Negotiating the group's position in the hospital network will hardly affect this kind of negotiations. The main jurisdictional claims in patient care of surgical and supporting specialities, respectively traffic control and position control, bring more relationships with parties surrounding the peer groups. These relationships cause shared interests to be more obvious than in the medical specialities and to strengthen the importance of joint acting as co-owners of a shop.

7.3 The role of department member

A peer group without a department makes no sense in specialist work. The wards and units and floors provide the specialists with everything they need to work, shaping the actual specialist workplace. The department, in this context, is not defined in the strict sense of a certain part of the organisational structure. When specialists play their role of department member, they are a member or representative of one or several of the wards or units where patient care in the speciality takes place. In the department-role, specialists co-operate with colleagues, residents, nurses and other personnel on the wards or units of the speciality.

The peer group may be the centre of the specialist organisation, the role of member of a department quantitatively brings more negotiations in daily life. Many of the negotiations specialists participate in from the department-role concern patient care and are discussed in Chapter 6. But even more quotations in the data reflect specialists acting from their department-role in organisational relationships.

The specialists in their regular department-role do not have formal relationships with individual employees. The specialist managers, present in four case studies, have a special accent in their role of department member, because they do have hierarchical authority, shared with the 'organisational manager'. The specialist managers will be discussed separately in paragraph 7.6. The current paragraph addresses the regular specialist in his or her department-role.

Negotiators and negotiations

Specialists negotiating in their department-role meet three categories of negotiators. They meet colleague specialists, especially from other departments and peer groups, they meet the hospital workforce, especially nurses, assistants and other personnel in patient care, and they meet the hospital organisation, especially its managers.

In the course of the negotiation processes, specialists seem to aim at holding or defending their stake. They take care of the issues by organising them in one way or another, or by actual interactions, such as negotiations. The more passive methods, flight or surrender, are also observed in negotiations.

Issues and patterns

The first field of negotiations is the organisation of work. This field is divided into three elements. First, on the level of creating conditions, the specialists pay attention to the organisational structure of the department, and to their position and role in it, which will be discussed in paragraph 7.3.1. Second, they have to get things actually working. This gives rise to negotiations about work itself, which will be presented in paragraph 7.3.2.

Third, the department is the context in which working space, materials and equipment are made available to specialists. Paragraph 7.3.3 addresses these issues.

The second field of negotiations is relationships and positions. Paragraph 7.3.4 addresses the inside component of being a department member. Paragraph 7.3.5 discusses the outside component of representing the department in relationships outside the department.

The issue of logistics is found often as well in the perspective of the department-role. This will not be discussed in detail in this chapter, since it is primarily connected to patient care. Therefore chapters 5 and 6 already contained several paragraphs on logistics.

The questionnaire results that are related to the role of department member are presented in paragraph 7.3.6, after which the underlying jurisdictional claims are outlined in paragraph 7.3.7.

7.3.1 Department structures

The department structures are different for both hospitals in the case studies. One of the two hospitals introduced a new organisational structure in the case study period, making each peer group part of a 'function group', lead by a duo of a specialist manager and an organisational manager. A function group contains all units and departments, including outpatient departments, belonging to one or several specialities. Ward and unit co-ordinators lead the personnel working these units and departments. Compared to the former structure, power decentralised from the top to the function groups (see also paragraph 7.5.1).

The other hospital wanted to introduce a similar structure, but with specialist managers only on the level of divisions. During the period of the case studies however, decision making about this structure was delayed because of other items on the agenda and because of the directors and the specialist staff having different opinions about it. Only at the very end of the case study period were some pilots for management participation about to start, in the event having specialists function as specialist manager at the level of 'organisational departments', not at the division level as was previously planned.

Regardless of these differences in the two hospitals, all specialists in the case studies gave their opinion about the way wards and units are structured or should be structured, and about the level of management participation specialists should or should not have. These opinions reflect the negotiated order of the specialist's position and role in the hospital organisation, especially in the actual workplace of the department.

Most specialists want their group to have a leading or at least a decision making role in the context of the wards and units of the department. In other words, they favour management participation at the level of the department. This role does not necessarily have to be played by themselves, but it should be played by at least one of the peers, preferably from the own speciality.

The specialists connect this need for management participation usually to one of the following three motivations. First, the intertwining of organisational processes, specialist practice, and patient care processes is most often referred to, with the organisational processes described as ancillary to patient care and specialist practice. Only a specialist can understand patient care:

"Doctors have to be involved in management. Only they understand how people get ill, and get well again. Nurses don't understand these processes either.[..] Specialist patient care and the organisation of specialist patient care cannot be separated."

The second category of reasons for a formal specialist role in decision making relates policy making of the department with aspects of patient care: specialists need to participate in choices for department priorities in the near future, because these choices have to be related to developments in the speciality. Third, specialists fear losing their position in organisation and society if they do not join management.

In this respect, specialists seem to find the motivations for the desired role in department decision making and management in their role of doctor, by referring to patient care, in their role of peer, by referring to priorities in the speciality, and in their role of professional, by referring to their position in society.

Most specialists, in both hospitals, express a desire for a small scale department structure of managerial control. The board of directors is "too far away" to be in charge of departments, so the departments should be in charge of themselves, as far as possible. The following quotations reflect specialists' ideas about the traditional hospital structure and about the lack of specialists participation in management. The first quotation comes from a case study situation before the introduction of specialist management participation, the second comes from the hospital in which the introduction of management participation was postponed:

"Now for instance, if we want something to change at the OPD, we first need A [manager OPD]. We don't know exactly what he's doing, he's probably drowning in bureaucracy. Anyway, he's usually not doing enough for us. So probably we'd have to ask B [division manager], and if it's difficult we also need to talk with C [nursing director]. Often C will have to ask D [medical director], and maybe in the end E [economical director] will have to take a decision. If we want something with one of our wards, same story, all over again. In the new structure, we'll have a concentration around our own speciality, with our own organisational manager. So we hope the new organisational structure will give us more grip on our own organisation."

"Our OPD has a separate head, who is someone else than the one who manages the inpatient wards. So, the principle about having our organisation directed at the level of care processes is not really being followed here. And we specialists still don't participate.
We know that some patients who get here to have a certain procedure, might be admitted on the day of surgery, in stead of the day before. But at the level of the organisation, this connection is not being made. And I don't feel like taking initiative."

Thus, specialists in the case studies want to concentrate control on the level of the department. They do not completely deny a need of supervision and control over the department, but this should not be shaped in a layered hierarchy that takes the board of directors further away from the department. Both hospitals, however, have a structure in which some sort of 'division managers' hold middle management functions between the board of directors and the departments (departments in the organisational sense). These functions are quite often grumbled at by the specialists:

"The division manager is more of a burden than a support. We'll co-operate if necessary. But if it's possible, we'll pass that layer and talk with the directors."

The preferences discussed here affect the negotiations specialists are involved in as department members. These negotiations address the organisational role and position of specialists, the structure of the department and hospital organisation, and priorities in department policy and management. Within these negotiations specialists meet the organisational managers of the department, their managing peers, and their peers in general.

When, despite negotiations, decisions have been taken against the specialists' desire, or when existing structures do not match their preferences discussed here, specialists express their feeling by grumbling or by trying to ignore or pass the existing structures (for instance by going to the board of directors rather than to the division manager).

7.3.2 Work itself

The department structure, discussed in paragraph 7.3.1, provides the context for actual specialist work. Within this context, work itself has to be taken care of. Specialists negotiate logistics, workforce capacity, the organisation of day to day work, and various other issues.

First of all, the issue of logistics in patient care (getting the right physician, the right patient and the right information together at the right time and the right place) is found most often to be the subject in negotiations about work in the context of the department. This was already discussed in chapters 5 and 6.

The hospital workforce capacity ('no beds' usually means 'not enough nurses to take care of more inpatients') and the physician workforce capacity (the workload per physician, the difficulties in recruiting residents) are related to logistics and make a second category of subjects in negotiations about 'getting things done'. Concerning the workforce capacity, specialists blame hospital management for not doing enough to make working in hospital more interesting. In the issue of the physician workforce, specialists negotiate with residents and with each other about the ways to deal with the balances in workload and physician workforce. In times of scarce capacities, specialists have to choose

between working harder themselves to protect the volume of patient care, and indirectly the volume of income, or not working harder themselves, and jeopardising the volume of patient care, and indirectly of income. This choice links the role of department member with the role of peer, because the peers' priorities in the distribution of work and money affect their priorities in dealing with capacity and scarcity.

A third category of subjects in negotiations is the daily organisation of specialist work. Interruptions are the specific item that is most often mentioned in this respect: how could interruptions of specialists' daily work be avoided? Pager calls, telephone calls, people dropping by, all these moments usually demand a specialist's attention when he or she is already attending to something or someone else. The issue is, most of the time, a problem from the perspective of the role of doctor, because patient care is being interrupted. Solutions are looked for from the perspective of the role of department member, because work processes are largely designed in the context of the department. The search for ways to diminish interruptions bring negotiations about the distribution of responsibilities, about the scheduling of work, and about technical measures.

An example of specific dilemma's when specialists negotiate the distribution of responsibilities: should specialists be the first ones to answer phone calls from general practitioners or can residents deal with general practitioners as well? In the interest of diminishing interruptions, specialists want the residents to take care of external phone calls. But in the interest of collegial relationships with general practitioners, they feel they should take the calls themselves. Maybe OPD-assistants could answer pager calls during OPD-hours, but then the OPD-assistants might well be too busy answering the pagers for specialists working the OPD at the same time.

Negotiations about the scheduling of work give examples of supervision scheduling. Should this be combined with OPD-hours, or should the supervising specialist not be scheduled in direct patient care? In the interest of decreasing the number of interruptions, supervision should not be combined with other activities in patient care, because supervision by definition brings interruptions. But in the interest of logistics and output, it is a waste of specialist capacity when supervision is quiet.

And finally an example of technical measures: one of the specialists asked for a voicemail construction on the pager during OPD-hours, but unfortunately the technical department declared this construction "technically impossible". Further searches for technical solutions were stopped because of the (alleged) technical limitations.

Various other issues occur in negotiations specialists face from the perspective of their role as department member, concerning the organisation of work itself. For example: what is quality of patient care, and how should it be maintained and measured; what support can we ask and expect from other departments or from other peer groups? To illustrate the last example:

A specialist in a medical discipline has just finished a procedure for which he co-operated with an assistant from a supporting department. The assistant tells the specialist that her superior regrets the fact she has to be "lent out" to assist these procedures. The specialist discusses her important role and the fact her assistance cannot be missed in these procedures. If her department keeps on nagging about it, he'll have to discuss it once more.

7.3.3 Space to work in, materials and equipment to work with

The wards and units of the department provide the context in which working space, materials and equipment are made available to specialists. This paragraph first explains the value of space, materials and equipment. Then it discusses negotiations for space, after which negotiations for materials and equipment are outlined.

Practical and symbolic value

The department provides the capacity specialists need for day to day work. Nurses, assistants and other personnel are the 'human resources'. Work space, materials and equipment are other forms of capacity. Besides the practical aspect - space, materials and equipment enable specialists to work - the issue has symbolic meaning, because space, materials and equipment reflect the importance of the speciality and the speciality group in its organisational context. Having better rooms or newer equipment than other groups is considered a sign of having higher value.

Since space, materials and equipment are almost inseparably connected with wards or units of the department, these issues are discussed in the perspective of

the department. The specialists, however, play the role of department member in this respect largely from the perspective of their role of peer. They discuss department related space and gear, but they represent their peer groups' interests rather than the interests of the department as a whole.

Space to work in

Hospitals are big buildings. Yet space is an issue. Four explanations emerge from the observations and conversations. First, the intense intertwining of processes in patient care and in hospital work in general makes it difficult to structure space. An example of how rules and arrangements in patient care affect housing in hospital, is offered by both gynaecology groups in the case studies. They had to relocate patient care because of the scarce availability of paediatricians. Caesarean sections are only allowed with a paediatrician around. With paediatricians being scarce, this rule could not be followed in two hospital buildings any longer, forcing gynaecology at least to concentrate obstetrics in one building only. Second, many rooms seem to be designed for one purpose or for one kind of equipment only, which makes it difficult to use space efficiently. Third, space is potential capacity for output, which makes it valuable. And fourth, as already mentioned, space reflects the importance of its users, adding to its value in positioning.

These aspects make space scarce, or at least make space feel scarce and hence something to negotiate for.

The party most often mentioned in negotiations for space are other specialities or peer groups and departments. The specialists mention them as parties when space is structured and allocated, for instance in preparations for a new hospital building or in preparations for relocating. One of the specialists tells about the new hospital building:

"And then we have to deal with the merger and the new building. Lots of people talking rubbish. They want to mess with our beds and floors, some secret groups seem to exist. We should incorporate our floors with this other speciality. No way, of course not. This other speciality has got a very different patient population!"

Although the other specialities are the parties most often mentioned, they are not the party most often met directly, because decision making about space is formalised in a structure of hospital committees or working groups, chaired by management. These committees advise the board of directors who take the final decisions. This hospital structure and its members - managers and specialists - is the party specialists actually meet on the issue. Managers are met first for decision making and second for enabling the practical use of space. A third party involved in negotiations for space are colleagues, either within the department and peer group, or outside, especially in ad hoc situations in which two or more persons want to use space at the same time. An example of this aspect, that also illustrates the symbolic value of space for relationships:

One of the specialists walks around with a small group of students, looking for a room for their weekly class. They walk into the specialist coffee room; three specialists are sitting there. "Do you mind us sitting in a corner here, for our class?", the specialist, relatively new in hospital, asks. One of the three specialists mumbles something without looking at her, none of them clearly agrees. The specialist hesitates, then turns around, saying: "C'mon guys, we're out of here." They find another room and the specialist tells the students the names of the 'jerks' they've just met. Later, after class, she walks by the coffee room again. The three specialists are just walking out. "We were real friendly just now, weren't we?", the mumbling one, now smiling, asks the specialist. She smiles back at him: "Well indeed, what was that all about?"
"We had to create some clarity concerning hierarchy around here."
"Why, to me?", the specialist asks. "No, no, to the students. It must be crystal clear the specialist coffee room is sacred and only meant to be used by specialists. That's the way things work around here..."

Usually one of the specialists of the peer group takes care of the formal negotiations in decision making about space. He or she prepares for these negotiations by discussing arguments with colleagues. Apart from the formal meetings the specialists lobby and try to find allies by dropping in on managers or by discussing their interests with other specialists. Ad hoc struggles for space are usually also dealt with in negotiations, on a smaller scale.

Because of the variety of specific items involved in the use of space, the outcome of negotiations and decision making varies. To illustrate this, the arrangements for personal working rooms of individual specialists are shown in **table 7.5**.

Table 7.5: characteristics of individual working space in the seven case studies

speciality	working rooms individual specialists	
medical 1	in both hospital locations: - individual working rooms - apart from OPD-rooms - several specialists on several floors, some close to the ward, some not	
medical 2	hospital location 1: - each specialist has an OPD-room that is also the individual working room, including PC - all specialists next to each other in one corridor, sharing one OPD-counter	hospital location 2: - shared working room - own desk and PC for every specialist - apart from wards and OPD-rooms
surgical 1	hospital location 1: - shared working room - own desk and PC for every specialist - apart from wards and OPD-rooms	hospital location 2: - shared working room - shared desk and PC (temporary) - apart from wards, close to OPD-rooms
surgical 2	hospital location 1: - shared working room - own desk and PC for every specialist - apart from wards and OPD-rooms	hospital location 2: - shared working room - own desk and PC for every specialist - apart from OPD-rooms - close to ward
surgical 3	hospital location 1: - individual working rooms, including PC, on the ward, apart from OPD-rooms - all specialists next to each other in one corridor	hospital location 2: - each specialist has an OPD-room that is also the individual working room, including PC - specialists next to each other in one corridor, sharing one OPD-counter
supporting 1	hospital location 1: - individual working rooms on the department - PC in every room	hospital location 2: - individual working rooms for one half of the speciality group, one shared working room for the other half - own desk and PC for every specialist
supporting 2	hospital location 1: - shared working room apart from the department, own desk and PC for every specialist - small shared working room on department too	hospital location 2: - each specialist has an OPD-room that is also the individual working room, including PC - small shared working room on department too

Results of negotiations and decision making processes, whether structural or more temporary, do not always satisfy the specialists involved. Renewing negotiations is difficult then, because decisions have already been made. So spatial issues relatively frequently provoke a kind of flight or surrender, for instance in specialists grumbling about the situation. Smaller, practical spatial inconveniences are often just taken care of though, sometimes causing amateurish decorating details in the rooms: layers of bubbled plastic on a head-height sharp corner of a shelf, or bandages stuffed under a communicating door to keep the noises of the neighbours out. To illustrate the latter:

In one of the OPD-rooms one can easily hear the person speaking in the room next door. The specialist explains: "This whole OPD-floor is absolutely not sound-proof. It was built way too cheap. The skirting-boards fell of the walls quite soon. The noise is the worst. All day long you hear 'wawawa' from the other side. What if our directors could hear each others conversations? That would never happen! That really disturbs me, them not knowing what's going on here in the workplace." To keep out the noise some bandages are stuffed under the communicating door that is not in use.

Materials and equipment to work with

The sorts of materials and equipment used of course differ for the different specialities, which is already discussed in paragraphs 5.2.2, 5.3.2, and 5.4.2. All specialists use some things to work with, at least a personal computer.

Proper availability of materials and equipment - the right sort in the right amount at the right time - requires its own kind of logistics. Materials and equipment being issues of negotiation are comparable with work space. Materials and equipment are basic necessities for basic working. New and special materials and equipment make working more fun and getting or having these reflects status. Having real special equipment may enable a peer group to distinguish itself regionally, which makes equipment part of mechanisms in regional positioning. For instance:

One of the specialist tells a resident about the instrument he is about to use: "It costs about € 80.000, without the smaller equipment also needed. That's a lot more than you usually need for a car! We're the only hospital in the district with this instrument."

Decision making about the allocation of the hospital budget available for materials and equipment is comparable to decision making about space. It is structured in a system of committees advising the board of directors about the yearly budget.

Acquiring equipment and materials makes specialists negotiate with management. First because the department managers are the ones formally applying for the yearly equipment budget. Second because they decide on expenditure, which makes specialists negotiate the ad hoc purchase of instruments with them.

Other peer groups and departments are less often observed in negotiations for equipment than in negotiations for space: two speciality groups might want to have the same room, wanting the same machine happens less often. They all might want as much equipment budget as possible. That struggle is taken care of in the hospital decision making structure that prevents direct negotiations between peer groups and departments. This makes 'the system' the party to negotiate with. Formal moments are attended by one or several specialists. Apart from these moments the specialists try to promote their interests to managers and other decision makers. Materials and equipment are relatively often on the agenda of meetings of peer groups and the specialists then discuss the way they want further negotiations to take place. An example from a partnership meeting:

The partnership discusses the decision making about getting a system for electronic patient recording. One of the peers will meet one of the directors soon and he should negotiate for availability of this system in OPD-rooms as well as on wards. They also agree that one of the other specialists is going to find out about the rules for acquiring extra budget for innovations and a third specialist will attend a conference about information and communication technology in hospitals.

Once the budget is available, the equipment and materials have to be obtained and used. Here another party enters: employees of staff departments for purchasing and for technical support, and external employees from the suppliers of equipment and materials.

The importance of equipment and materials makes this party important and in the perspective of specialists annoying at the same time, because these employees 'own' parts of the logistics for materials and equipment. Every

specialist meets these employees in negotiations now and then, and quite often experiences these meetings as frustrating: the specialist wanting the employees to deliver services sooner or better and the employees saying 'sooner' or 'better' is not possible. The availability of regular materials and equipment is usually standard and in general connected to rooms and departments. If specialists want something specific to be available, they often have to take care of that themselves in negotiations with the employees controlling or purchasing the materials and equipment. An example:

After being paged one of the specialists explains what the conversation was about: "We want to purchase this machine and we're granted the budget. We know this supplier we'd like to co-operate with, but the purchasing department is the one deciding on that. And they are real slow, which gave us a delay of four months. They purchased from another supplier. After that we had to wait another two months for instructions and manuals. So we said: 'Please, let's just get this supplier we know to instruct us. It may cost extra, but that's because you should have followed our opinion in the first place.' And now this purchasing manager finally tells us we can make our own arrangements with this other supplier."

Another example, illustrating the sometimes frustrating outcome of negotiations for and technical adjustments of equipment:

A specialist explains to her peers and residents that the safety construction of one of the machines they regularly use on the OR must be deliberately put out of order to be able to use the machine. The technical department hung up a warning light connected to this machine, and now it only functions when the warning light is on. The employees, however, have not yet taken care of the actual connection between light and machine, so the machine cannot be switched on. The specialist tells she wrote the procedure for disabling the safety construction in the instructions with the machine. Then she says: "The technical connection will be made as well yet, but they have to break a wall for that. Aren't they extremely stupid? For years we've been going on and on about this warning light and now they forget to connect the construction. And besides that, they just walked into the OR when the patient was still awake! Asking if everything was alright with the machine! So I had to tell them to wait outside, at least until the patient was asleep."

In dealing with issues of materials and equipment, specialists try to hold or defend their stakes by negotiating and organising to get things done. These mechanisms are not always appropriate. Sometimes decision processes or logistics result in outcomes not favoured by specialists. Specialists have to surrender then, sometimes accepting, sometimes grumbling:

The department manager drops by on the specialists to tell them the application for a new machine is not granted. One of the specialists: "But the machines depreciate real fast these days! Now we're forced to confront the community with outdated equipment!"

The different kinds of equipment bring different accents to the negotiating processes of the three categories of specialities. The supporting specialities require more machines and capital goods than the other ones. The surgical specialities need comparatively more instruments and disposables and the medical specialities on average have to negotiate more often about the materials their individual patients need, for instance pacemakers and expensive medication.

7.3.4 Being a 'fellow member' at the department

Paragraphs 7.3.1, 7.3.2, and 7.3.3 concerned the negotiation field of the organisation of work. The second field of negotiations related to the role of department member is the field of relationships and positions, not in the formal structural sense discussed in paragraph 7.3.1, but in the relationships specialists have with other parties within and outside the department.

The first kind of position, discussed here, affects the inside component of the role of department member: specialists in their department-role versus the other members of the department. In the definition of the department-role the other department members mentioned are: colleagues, residents, nurses and other workers on the wards and units. This definition includes all personnel on all wards and units the specialists work on. Therefore, as mentioned before, it does not completely correspond with the usual organisational limits of departments. The definition used here for instance deliberately incorporates the OR into the department of surgical specialities, while in real life the OR is usually a department by itself.

When specialists negotiate their position in relationships on wards and units, the other department members observed most often are nurses and other employees in patient care, for instance OPD-assistants and anaesthesiology and radiology assistants. The specialists do not have any formal organisational relationship with these fellow members of the department. The lack of formal positioning seems partly compensated for by functional differences in tasks and responsibilities in patient care.

In specialist patient care physicians are the directors of inference and the owners of decision making. They need nurses and assistants to be their ears and eyes for measuring and monitoring patients, to be their hands for assisting or for performing delegated tasks, and to be their substitutes for organising aspects of patient care or for taking over delegated work. Of course nurses and assistants have important areas of knowledge, tasks, skills and responsibilities of their own, separate from or complementary to the areas of specialists (Hoefnagels 1997). But from the perspective of specialist work, these areas are ancillary. This makes nurses and assistants important companions in patient care, often even appreciated participants in inference, but hardly ever co-owners. With hierarchical structures being absent, negotiations seem to be necessary for defining the position of specialists in their role of department member.

The department-role, in this aspect, is something young specialists still have to learn to play. On one of the case study days a young specialist asked an OPD-assistant to find a missing patient's file. Later she explained sharing work with assistants and other personnel is something one must learn:

"In earlier days, when I just started working here, I would have started looking for a file myself. In those days I came here at 7 a.m. and I left at 9 p.m. I prepared all my work myself, because I felt responsible. Now I ask others a lot more often to do things for me, for instance the OPD-assistants. I've learned to do that, especially because I saw my peers working quite different with the assistants than me."

The following paragraphs explain how the specialists manifest and maintain the negotiated order in their position as department members. First their not being employers is discussed. Next, their balance in being 'pals' or 'production pushers' is outlined, after which the covert negotiations in relational manners are addressed. Finally two groups of fellow department members are discussed separately: the secretaries and the residents.

'Semi-employers'

Most specialists talking about their role at the department say they don't feel responsible for nurses and assistants in a way an employer would feel responsible: taking care of terms of employment, being responsible for hire and fire. They do realise, however, they are an important element in the environment of nurses and assistants and they usually want them to feel good about that. They do feel responsible for contributing to a good atmosphere on wards and units. Because of this, most specialists participate in get-togethers, parties or trips of units, wards or departments. Some peer groups organise these activities for employees periodically themselves and pay for them too. All peer groups give the people they work with presents at birthdays and jubilees.

By doing this they place their collective role of department member in some sort of employer perspective, because the activities don't take place the other way around this way.

One of the specialists tells within the peer group, he has to keep track of the jubilees:

"We were not used to have a real system for these presents. And then you have people asking each other why one got more money than the other. Now, we've made a system with fixed amounts of money."

'Pals' or 'production pushers'

From the interest of their role of peer, specialists care for output and efficiency: doing as much patient care as possible with the personnel available. This may collide with the intention specialists often have as department members: contributing to a positive atmosphere.

Despite their output interests, specialists feel they should protect nurses or assistants, especially in periods of scarcity or other personnel difficulties. At least they intend not to build up too much pressure and to show some extra interest in their well-being. Serious worries about output connected with lack of personnel capacity seem to be negotiated with management rather than with the employees themselves.

Specialists seem to try to respect employees' wishes regarding the organisation of their work, although they sometimes see ways of working more efficiently. For

example, in one of the case studies, a specialist in a supporting speciality finds out the assistants used the wrong machine adjustments for a certain procedure. He's upset:

"Terrible. If we didn't have a staff shortage, I'd smack 'em! I would really like them to use standard adjustments for this procedure. That way these mistakes wouldn't happen. But our assistants wouldn't like that. They don't want themselves to become 'the persons who press the buttons'. But now they press the wrong buttons! There was a letter hanging on that machine at first. Some sort of message of one of the co-ordinators, saying: 'If you don't know what you're doing exactly, don't start this procedure.' But the letter is gone..."

In short, specialists in their department-role seem to favour being pals on the department over pushing for production. If, from the perspective of their peer-role, they feel the need for pushing for production, they will negotiate this with management rather than with the employees.

Relational manners

The days of nurses standing up and leaving the office when a specialist walked in are definitely over. But this doesn't mean specialists and nurses or assistants quietly share one social stratum on the department now. Their manners, their style of addressing each other and the jokes they make often reflect negotiations for or manifestations of positions. The specialists are more often the active communicating party and nurses or assistants the responding party. Specialists are the ones asking, instructing, questioning, commanding and so on. In the department context, they are also more often the ones making compliments, jokes or remarks towards nurses or assistants. The other way around, nurses and assistants taking initiative, of course happens as well. It seems to happen slightly more often by the assistants in the supporting specialities and by nurses of specialised wards than by personnel of regular wards and OPD's.

On average nurses and assistants seem to be more daring and active with younger specialists. Younger specialists more often spontaneously explain they find it difficult to get the right balance in relationships within the department, doing justice both to their intention of being pals and their intention of making clear they have the lead, at least in patient care. An example from the case study observations:

One of the assistants asks a young specialist to come her way to have a look at something. The specialist asks her to come to him. "O, you're just too lazy to get out of your chair", she replies. Later the specialist tells the researcher: "I think the assistants are too bold here. Not to X [older colleague], but to Y [young colleague as well] and me. Actually it should not be this way. But on the other hand, Y and me want to have friendly relationships with them."

Separate groups: secretaries and residents

Another group of department members worth mentioning in the context of the negotiated order on wards and units are the secretaries. Specialists quite often mention them as providing important support in daily specialist life. They also seem to find it difficult to deal with them. One of the specialists:

"We're having some problems with our secretaries at the moment. Formally they're part of the organisational unit now, with the organisational and specialist manager in the lead. But the partnership should deal with the present problems as well. In the past we didn't really bother leading them actively. The problems have started with our working in two hospitals. They find that difficult. And in general they are a bit harder to motivate. We realise now we have to give them flowers now and then."

The department members least found in specialists' negotiations for positions are the residents and students. In their relationship with specialists they're subordinate. The residents in training for specialist gradually grow to be a colleague in stead of a subordinate, and their responsibilities and independent working increase over the years. Even an experienced resident, however, is not an almost-specialist-colleague. The distance remains clear until someone really becomes a specialist. In spoken language in hospital a specialist is called "chief" by the residents ("Which one of the chiefs is available for supervision today?").

This relationship hardly seems to cause reasons for negotiating positions. If it is mentioned at all, it is covered in humour. An example from the case studies:

The specialist asks the resident if his colleague resident has gone home already. She has. The specialist, jokingly: "Mm, I can't remember having given her permission to leave hospital."

Resident: "Oh, but I have! Besides, it's way past five o'clock, so our collective agreement tells us we should have finished

working a long time ago..." He gives the specialist a challenging look. "Haha, are your adrenal cortices shrinking already??" [Physician joke: the adrenal cortices produce stress hormones, and they contract to release these hormones, for instance when you get mad]
Sp.: "O, man, mine are so hypertrophic! Just you wait, you'll find out for yourself."
Res: "Whatever! These next years I will still live quietly!"
Sp.: "I made 120 hours a week in my resident time. Don't you talk to me about the collective agreement!"

The residents of course have even more trouble than young specialists acquiring and maintaining a position in their relationship with nurses and assistants. Hierarchically they have no relationship at all. Functionally they have tasks and responsibilities in patient care that make it necessary to ask nurses and assistants for information and support, but technically they often lose from experienced employees when it comes to practical knowledge and skills. These are difficult combinations for getting a firm position in a department.

7.3.5 Positioning in relationships beyond department borders

The second kind of positions that are negotiated, affect the outside component of the role of department member. Specialists have relationships with parties beyond the borders of the department. The following paragraphs will address the relationships with 'the other department', which are the wards and units of the 'sister department' of the other hospital in the merger, and the aspects of representing or having a department.

'The other' department

Paragraph 7.3.4 addressed the inside component of the role of department member: being a member of the own department. The hospital mergers in the case studies affect the wards and units of the departments as well, bringing 'the other' department in sight.

The relationship with 'the other' department makes employees worry about the consequences of the organisational changes, and the specialists feel partly responsible for dealing with these worries. The individual styles of dealing with this vary. Incidentally specialists bond with the members of their own department by worrying with them about 'the others' and by grumbling with them at management for the hospital merger. Most specialists however seem to be neutral or positive in reassuring the department about the consequences.

The actual relationship with 'the other' department, from the specialists' perspective, is made via 'the other' peer group. Most specialists in the case studies gradually started working on both departments to get acquainted with the employees and to decrease the employees' fear of working with strange specialists. The specialists of the two case study groups relocating patient care had an exchange before the relocating of wards. Another activity of merging peer groups in their relationships with their departments is organising joint get-togethers. One of the specialists tells about this:

"When we knew relocations were necessary, we organised a get-together for the wards and departments of both hospitals. To get acquainted. I talked with the head of department from the other hospital. She told me she was really worried about the contacts with specialists from our group. And me talking with her reassured her. And one of my colleagues danced with the OPD-assistants. That helped too."

In general the specialists gradually seem to expand their department membership from their own department to 'the other' department. In the merging process the perspectives of the role of peer are more active and visible than the perspectives of the role of department member.

Representing the department or 'having' it

The role of department member in its sense of representing the department as a whole was not observed very often. Specialists do address the interests of the wards and units, for instance in their relationships with managers and other specialists, but more often from the perspective of their role of peer than from the perspective of the department itself.

For example, most specialists in the case studies experienced times of reorganisation, relocation and new building preparations. The positions of departments were literally at stake in these processes, and the specialists were eager to be involved in decisions about these aspects. Although their involvement concerned specific issues regarding arrangements of the department (in what division should it be structured, what units should be made part of it,

what should the housing arrangements be), it was defined more by representing the peer group than by representing the department as such.

Thus, in specialists' relationships with other parties, the department-role is hardly ever played in the representing sense of the role. The department does play a role in these relationships however, mainly as part of the mechanisms necessary to position the speciality and the peer group in its context. The department provides the base from which the peer group can protect or expand its speciality and its interests. It provides a potential forum and audience for individual specialists or for specialists in their peer-role consolidating or improving their positions in relationships with other parties. By involving department members in these dynamics they may strengthen their relationship with the department (inside component of department-role) and manifest the position of their peer group at the same time. Sometimes relationships with other parties are more important than the relationships within the department. Then other department members must give way to the third party, for instance another specialist or another peer group. An example:

The ward co-ordinator of a supporting speciality has sent the requesting specialities a letter about a change of arrangements in the OR. One of the other specialists walks by the supporting peer group while they're having coffee, to tell them, on behalf of two requesting specialities, he can't accept the changes. Later that day one of the specialists discusses the matter with the ward co-ordinator, telling him to withdraw the letter and to adjust the arrangements planned. "Because otherwise X [the specialist complaining] will be disappointed."

In short, 'having' a department is more often the manifestation of the outside component of being a department member than representing a department.

7.3.6 The role of department member: results from the questionnaire

This paragraph addresses the survey results about the role of department member.

Department structures, discussed in paragraph 7.3.1, were discussed in the survey as well. The questionnaire asked specialists for their opinions about their position in the hospital hierarchy, especially in the context of the department. It also asked for the level of involvement in decision making on the level of wards and department specialists experience and desire. The following paragraphs will address these two aspects.

Position in hierarchy

To find out specialists' opinions about their alignment with the hospital, especially in the context of the department, three statements in the survey reflected different aspects of hierarchical relationships. The results are given in **table 7.6**.

Almost one third of the respondents chooses the neutral position for answering these statements. A subordinate position of nurses in their relationship with specialists, and subordinate position of 'regular' managers in their relationship with specialist managers is more often supported than rejected. The idea of specialists 'taking over' in hospitals, is more often rejected than supported.

Table 7.6: Specialists in the lead, in percentages of respondents

	strongly disagree	disagree	don't disagree / don't agree	agree	strongly agree
3k Nurses should be organisationally subordinate to specialists.	2,7	19,8	26,1	37,8	13,7
3l Regular managers should be organisationally subordinate to specialist managers.	3,5	27,4	30,7	26,6	11,8
3o It is desirable that specialists gradually take over hospital policy and control from regular managers.	5,7	35,0	28,2	23,7	7,4
Scale: specialists in the lead	1,5	19,9	45,3	27,9	5,5

n = 678 (3 missing values) for 3k; n = 680 (1 missing value) for 3l and 3o; n = 678 (3 missing values) for scale; Crohnbach's alpha 0,65

These results are equal for salaried and self-employed specialists. Age, sex and speciality do make a difference though. Older specialists are more often in favour of the picture of specialists in the lead than younger ones, especially in the relationship between specialist managers and regular managers and in the 'taking over' by specialists. More women than men oppose the picture of specialists in the lead, in all three statements. Specialists in surgical specialities support specialists in the lead more often than specialists in medical specialities, especially regarding the relationship between the specialist manager and the regular manager. This difference is not caused by the larger group of men in the surgical specialities, because the same opinion is found within the female subgroup of specialists.

Involvement in decision making

To find out specialists' involvement in decision making in the hospital, they were asked to report the level of present involvement and to point out the level of desired involvement. The difference between the desired level and the present level is a measure for desired change.

The survey items referring to decision making represented the organisation of specialist patient care and specialist training (discussed in paragraph 6.5.2), the organisation of wards and outpatient departments (discussed here), and hospital policy and the distribution of hospital means (discussed in paragraph 7.5.3).

The levels for involvement given in the survey run from 1 to 4, in which 1 stands for 'no specialist involvement in decision making', 2 for 'specialists consulted before management takes a decision', 3 stands for 'specialists sharing decision making with management', and 4 means 'specialists take the decision'.

Table 7.7 shows the experienced level of involvement in decision making, and the percentages of respondents that are satisfied with the present level or desire more involvement ('less involvement desired' gives very small percentages, and is left out of the table).

Table 7.7: Present level of involvement in decision making about the organisation of wards and outpatient departments, in percentages of respondents

Decision making about:	no specialist involvement	specialists consulted	specialists share decision making	specialists responsible	this level of involvement is fine	more involvement desired
6o retrenchment on a ward	31,0	52,3	16,4	0,3	25,1	72,1
6q temporary stop of admissions	32,9	35,0	28,1	4,0	32,7	64,9
6r recruitment ward co-ordinator	24,6	40,9	33,7	0,8	41,2	58,9
6s recruitment co-ordinator OPD	21,8	39,3	37,3	1,5	40,0	58,0
6v annual policy plan department or unit	6,4	36,8	46,6	10,2	50,6	45,1
6w introduction of nurse practitioners function	10,6	34,3	49,1	6,0	43,7	53,3
6x furnishing of waiting rooms	32,5	48,9	17,9	0,6	36,8	59,4
scale: the organisation of wards and outpatient departments						
present	11,9	57,1	30,7	0,3		
desired	0,1	11,6	82,8	5,5		

n = 658 (23 missing values) for 6o, 6r; n = 651 (30 missing values) for 6q; n = 656 (25 missing values) for 6s;
n = 657 (24 missing values) for 6v; n = 635 (46 missing values) for 6w; n = 664 (17 missing values) for 6x
n = 613 (68 missing values) for present scale; Cronbach's alpha 0,82
n = 652 (29 missing values) for desired scale; Cronbach's alpha 0,80

Few specialists think the present level of specialist involvement in decision making about the organisation of wards and units is fine. In general they desire more involvement, especially in decisions about retrenchment on a ward and in operational decisions about a temporary stop of admissions.

Women want more involvement in decisions about the organisation of wards and outpatient departments than men, especially regarding the annual policy plan and the introduction of the function of nurse practitioners.

Age does not affect the patterns of opinions about involvement in decision making.

Specialists in surgical disciplines experience less involvement in decision making about the different aspects of the organisation of wards and outpatient departments than both medical and supporting specialists. The surgical physicians also express less need for involvement in decision making on wards and outpatient departments than other specialists. Medical specialists in general have and desire the highest level of involvement, and for supporting specialists the difference between the desired level and the actual level of involvement is the smallest.

Salaried specialists experience more involvement in decision making about the organisation of wards and outpatient departments than their self-employed colleagues. The desired levels of involvement of both groups are equal at the level of the scale, but salaried specialists wish for more involvement than self-employed specialists in a few separate items, for instance the annual policy plan.

7.3.7 Jurisdictional claims related to the role of department member

The negotiations specialists are involved in from the perspective of being a department member reflect several underlying jurisdictional claims. The following paragraph will present the jurisdictional claim on management, control and conditions on the level of the wards and units of the department. Then, the jurisdictional claim on functional leadership is discussed, after which the differences between the three categories of specialities will be addressed.

A jurisdictional claim on management, control and conditions

The wards and units of the department shape the actual workplace for specialists. From the paragraphs about the role of department member emerges the picture of a negotiated order that is defined more by interests from the perspective of the role of doctor and the role of peer than by intrinsic interests from being a department member.

Thus, the interests come from the perspective of these other roles, 'actually getting things done' starts at the department. To create the optimum conditions for getting things done, specialists claim a formal position and role in decision making at the level of the department. This role does not necessarily have to be played by every individual specialist, it should be played by one of the specialist colleagues, preferably from the own peer group. This claim is found both in the case studies and in the survey, and reflects a claim on self-management. Added to self-management, the interests of patient care and peer group cause specialists to put a jurisdictional claim on the functioning of the other members of the department and of the department itself, which transforms the claim into a claim on management as such.

Since complete 'specialist-management' is not feasible in the context of the hospital structures, specialists support the idea of management participation.

In line with the jurisdictional claim on management, specialists furthermore lay a jurisdictional claim on control. Complete specialist-control is not feasible either. Therefore specialists wish to concentrate control on the department, and they object to layered hierarchical structures for hospital control over the department.

In organising working processes, and acquiring and using space and equipment, specialists claim jurisdiction over conditions for work, largely from the perspectives of the doctor-role and the peer-role. The doctor-role is related to interests of uninterrupted patient care processes, adequately housed, and resulting in a smooth organisation of the acts of diagnosis, inference, and treatment. The peer-role is related to interests of an efficient relationship between workload and workforce (both for physicians and other members of the department), supported by the latest equipment, and resulting in an adequate patient care output. To meet these interests, specialists lay a jurisdictional claim on organising working processes, and acquiring and using space and equipment, but this claim seems to be hard to manifest as well. Specialists are dependent of many other parties in hospital, including other peer groups. Hospital buildings and equipment budgets by definition seem too small for the combined jurisdictional claims of all doctors and peer groups.

A jurisdictional claim on functional leadership

Specialists want to have good relationships with the other members of the department. Yet, these relationships can hardly be described as being 'fellow members' in the sense of being equals. Specialists have several mechanisms for acquiring and maintaining a special position at the department. Although they are not formally or hierarchically 'in charge', they are the social and functional superiors of

the other members of the departments. The underlying jurisdictional claim is not a claim on this position per se, but a claim on functional leadership from the perspective of the doctor-role. Specialists are responsible for patient care, and the special position in the daily context of the department is a starting point for taking up functional leadership. A quotation from a specialist, in an article about the relationship between specialists and nurses (Valk et al. 1997):

"It's alright if the nurses call me by my first name, just not in front of patients. It should be clear that not "John" or "Edward" is treating the patient, but the doctor."

Functional leadership is also reflected by the survey results that show that specialists do not by definition prefer their group to be 'in the lead' in all relationships, yet on the functional level (nurses) specialist superiority is supported by more respondents than on management and hospital level.

Thus, the jurisdictional claims underlying specialists' negotiations when they play the role of department member are defined by the interests from the perspectives of the role of doctor and the role of peer. A jurisdictional claim that reflects the 'pure' interests of the wards and units of the department is not found in the data. This explains why 'having' the department is more often the manifestation of the outside component of the department-role (in specialists' relationships beyond department borders) than representing the department.

Different categories of specialities

Survey respondents in surgical specialities support the idea of specialists in the lead more often than respondents in medical specialities, especially at management level (regarding the relationship between the specialist manager and the regular manager).

Specialists in surgical disciplines experience less involvement in decision making about the organisation of wards and outpatient departments than both medical and supporting specialists, and they also express less need for involvement in this decision making.

Medical specialists in general have and desire the highest level of involvement, and for supporting specialists the difference between desired and actual level of involvement is the smallest.

Specialists in the medical specialities apparently feel the need to be involved in the organisation of the department more than other specialists. This seems to be related to other aspects of work in medical specialities. First, the special doctor-patient-ownership makes medical specialists feel responsible for the complete spectrum of care 'their' patients receive. Second, for their act of inference, which is defined by reasoning, they need to be able to trust information they get from nurses and other members of the department. And third, the number of hospital sites where inpatients are met is limited, which enables medical specialists to focus attention on one ward or unit only. These features make the jurisdictional claim on department management and on functional leadership slightly heavier than in surgical or supporting specialities.

Specialists in surgical disciplines seem to feel the need for rather clear-cut responsibilities: one of them should play a formal role in management, and this peer should be hierarchically superior to the organisational manager. The other specialists should not be bothered too much with decision making about the department, because they need their time and attention for individual patient care. Surgical specialists are interested in taking care of logistics, not in taking care of the wider organisation of the department. This is their accent in the jurisdictional claim on management and control.

For supporting specialists, the desired level of involvement in decision making about the department resembles the present more than for other specialists. This probably reflects the fact that throughout history, most supporting specialities were already used to providing a department chief for the units and floors, usually in a dual construction with for instance a head laboratory worker or a head radiology assistant. The negotiated order within the departments of supporting specialities seems to be rather stable, allowing the specialists to give attention to the position control they need to execute in the context of relationships in patient care.

7.4 The role of staff member

The specialist staff is on one hand the group of all specialists working in a hospital and on the other hand the staff organ in hospital. This paragraph is about the latter. Membership in general is self-evident, because every specialist is obliged to

become a staff member when entering hospital. This is laid down in the documents that regulate the specialist-hospital relationships. The measure of active participation as a staff member depends both on the ambitions of the individual specialist and on the rules of his or her peer group. In some groups it is a "kind of tradition" to be a member of the staff board at least once in a specialist career. Other groups only make sure they are represented at plenary meetings and in a staff committee now and then, and don't feel the need to participate on board level.

In individual specialists' daily life the staff-role is not often found in negotiations. This doesn't necessarily mean the staff is unimportant. Chapter 2 already discussed the importance of collective protection of financial interests, especially for self-employed specialists. In 60% of the hospitals the self-employed specialists have established a staff partnership (Van Lindert 2003). Apart from the financial interests of self-employed specialists, the 'specialist staff document' makes the staff organ the primary consultative and negotiating partner for the board of directors. It binds the board of directors to informing the staff about strategic and organisational matters. Also the Integration Act mentions the "framework of specialist care" that should be respected by the hospital board. This means specialists should collectively agree about this 'framework', for instance by making a specialist staff policy plan.

Negotiators and negotiations

Thus, the specialist staff does create a context for specialist work. In negotiations in day to day work, however, the 'pure' role of being a member or representative of the specialist staff is largely reserved to specialists with a secondary function as chair of the staff or as another member of the staff board. From the perspective of the role of peer, other specialists sometimes have to negotiate in a staff meeting, when issues on the agenda affect their interests. In these situations, discussed in paragraph 7.2, the peer-role is in question, not the staff-role.

The few quotations reflecting negotiations specialists are involved in from the perspective of being a staff member show fellow staff members are the largest group of negotiators. The managers or 'the organisation' are the second group of participants in negotiations.

Specialists aim in this respect at defending or holding their stakes, for instance by negotiating and by forming coalitions.

Issues and patterns

The same two fields of negotiations are found here as in the other roles defined by relationships in the hospital: relationships and positions, and the organisation of work. Paragraph 7.4.1 discusses the former. The specialist staff, collecting all specialists, is a forum of positions.

Paragraph 7.4.2 elaborates the latter. In being a negotiating partner for the board of directors, the specialist staff is a starting point for organising work in hospital.

Paragraph 7.4.3 presents the survey results that are connected with the role of staff member, and paragraph 7.4.4 reveals the jurisdictional claims that underlie the negotiations related to staff membership.

7.4.1 The staff as a forum of positions

In the analysis of negotiations in the context of the staff-role, three kinds of positions were found to matter: an individual position on the staff board, the collective position of the peer group versus other peer groups, and the collective position of the staff versus hospital management.

Positions on the staff board

In both hospitals about five or six specialists join the staff board, usually for about two years. Some specialists become members of the staff board because it is "their turn" (see also Beijer 2001:33). They belong to peer groups that want to be represented on the board now and then and thus put some pressure on their members to step forward as a candidate board member. This pressure may get a specialist into 'intrapersonal' negotiations when the role of peer conflicts with the personal preferences that define the role of individual (personal preferences). One of the specialists in the case studies:

"I'm on the staff board now. Because it was my turn. But I'm only serving my sentence there. It is not my cup of tea. I don't like politics, and I don't want to read all those documents. If I don't watch out, I'll be attending meetings nine times a week.."

This specialist was more or less forced by his peer group to join the board, but his way of fulfilling this function was with as little activity as possible. The result was a compromise between his peer-role and his individual-role, the net outcome being a small, reluctant staff-role. Other specialists more actively choose to participate in the staff

board, but in both hospitals staff board members expressed their worries about the lack of enthusiasm for joining the board spontaneously.
Getting the chair of the board requires more than waiting "your turn". Specialists in the case studies who are or were chairman of the specialist staff (eight specialists) all mention their peer group supporting the function, because it takes up time and thus threatens output. Whether providing the chairman might also be profitable for the peer group remains to be seen. In both case study hospitals, as in most Dutch hospitals, the chair joins the hospital management team. For a peer group it is convenient to have someone around who knows a lot about the organisation and who will promote the group's interests. On the other hand, the specialist who is chair of the staff also has eyes for other interests, which leaves his or her own peer group with someone who will often bring up objections to plans or policies in advance. One of the specialists explains:

"Having the chair of the staff in your peer group is not that much of an advantage. Sometimes it's even the contrary. He always knows about the other side's reasons and interests, which often makes us think: 'I've made up my mind now, don't confuse me with facts!' "

In short, specialists may temporarily fulfil their role of staff member as member of the staff board. Negotiations about a position on the board are largely defined by the context of the role of peer and second by the role of individual.

The peer group position in the specialist staff

From the perspective of their role of peer, specialists are alert on the relative positions of specialities and peer groups within the staff. About 25 specialities have to form a shared staff organisation and at the same time protect their groups' interests. By definition this gives many opposite interests on one hand and a lot of pressure for forming coalitions of mutual interests on the other.

A peer group that wants to get things done that need the permission of the staff, needs to value the balance of opposite and mutual interests in the staff. When specialists discuss an issue on the staff agenda that affects their peer group, they always discuss tactics for improving their position in the context of the staff. For instance they get in touch with other specialists, convincing them about their cause, or trying to form a coalition that may protect their interests.

These processes make the staff-role become largely fulfilled from the perspective of the peer-role.

The position of the specialist staff versus the hospital organisation

Both case study hospitals had the issue of management participation on the agenda during the case study periods. The design of the triangle of relationships between hospital, specialist staff, and specialist managers was a difficult item in this discussion in one of the hospitals, and hardly an item in the other. In the latter hospital, a candidate specialist manager was recommended by the peer groups he or she would represent, and appointed by the board of directors. The relationship with the specialist staff was not separately designed.

In the other hospital this relationship was one of the reasons for delayed decision making. The staff board wanted the specialist managers to be chosen or recommended by the staff. The staff board also argued about the level of involvement: specialist managers should only be involved in operational or tactical matters, not in strategic matters where the staff board was supposed to be the directors' sparring partner. The board of directors just wanted to appoint the specialist managers without consulting the staff. And they also wanted less rigidity in the levels of involvement. These differences of opinion resulted in a long lasting impasse.

Only the specialists on the staff board, and a few specialists who were chair of the staff in the past were found to be actively involved in negotiations between specialist staff and board of directors. Other specialists incidentally commented on this relationship. The variety of the interests of specialities and specialists made them doubt the power of the staff: "Too big for cohesion".

7.4.2 The staff as a starting point for organising work

The issues on the agenda of the specialist staff are often about the organisation of work in the hospital context. Important categories of issues are announcements by the board of directors (for instance about quality projects, major or minor reorganisations, financial issues), specialist vacancies and recruitment, and financial issues (for instance about the introduction of DTC's or announcements from the staff partnership for the self-employed).

In daily life the specific content of these issues is far more often dealt with by specialists on the staff board than by other specialists. An example of a chairman of a specialist staff, considering several interests:

The chairman of the specialist staff finds a moment during his daily work to make a phone call to a specialist. This specialist has announced his departure, which is a real pity. He is a 'high potential' and might really organise his department right. The chairman wants to know why he is leaving. Is he not getting the right conditions? Is his peer group not co-operative? When he gets the specialist on the phone he explains to him he wants to talk separately, apart from the partnership and other players, because being the chairman, he doesn't want all kinds of indirect information showing up at the board meeting tonight.

Similar to most other aspects in the context of the specialist staff, specialists deal with the issues on the staff agenda, from the perspective of their role of peer, and sometimes from the perspective of their role of doctor. The role of staff member, played from the perspective of mutual interests seems to be reserved for the board members.

7.4.3 The role of staff member: results from the questionnaire

Position of the specialist staff in hospital

As discussed in respect of the peer group (paragraph 7.2.4), historically the collective organisations of specialists seem to have been developed partly to compensate the lack of formal organisational relationships. Do specialists expect their staff to lose importance when formal relationships grow stronger in the context of management participation? This was asked in the survey. **Table 7.8** gives the respondents' reactions.

Table 7.8: Position of specialist staff, in percentages of respondents

	strongly disagree	disagree	don't disagree / don't agree	agree	strongly agree
3n The importance of the specialist staff as a separate organ in hospital will decrease when specialists get a stronger position in the hospital organisation.	14,3	44,8	17,0	22,1	1,8

n = 678 (3 missing values)

These results are similar to the expectations about the position of the peer groups. Most specialists do not expect their peer groups and the specialist staff to lose importance.

Women more often than men expect replacement of the collective specialist position by the formal position.

Board members

One of the secondary functions mentioned in the survey was membership of the staff board, which was fulfilled by 12% of the respondents. About 34% reported to have had this function in the past. Both present and past experience was reported by 1%. About 32% of the remaining population, having no present or past experience on the staff board, thinks about the function for the future (this is 18% of the total population). Table 7.9 sums up these percentages.

Table 7.9: Member of the staff board, in percentages of respondents

	percentage
board member now (not in the past)	11
board member now and in the past	1
board member in the past (not now)	32
thinking about becoming board member in the future	18
no experience, not thinking about it	38
total	100

n = 657 (24 missing values)

Within the separate subgroups of respondents (sex, specialities, salaried or self-employed), equal percentages join the board. The number of respondents with board experience increases with age.

The only significant difference in participation percentages is shown in the past experience: specialists in supporting disciplines report past membership less often (24%) than medical and surgical respondents (about 35%).

Being on the staff board decreases time spent on individual patient care (61% versus 65% of the weekly hours in hospital) and increases time spent on organisation (15% versus 9%). Board members are in hospital more hours than the other respondents (on average 48 hours per week versus 45 hours).

Specialists who are on the staff board report a higher level of involvement in decision making about specialist patient care and specialist training, and about hospital policy. They also are more often than the other respondents in favour of a formal role for specialists in the hospital organisation, and of specialist integration into the hospital organisation. The details about these opinions will be discussed in paragraph 7.5.3.

Specialists who are on the staff board now have these opinions. Past or maybe-future board members do not differ in their opinions from the other respondents. The only significant difference between maybe-future board members and specialists without experience who do not consider the function for the future regards specialist integration into the hospital organisation: future board members are more strongly in favour of 'integration' than the other respondents who never were board members.

Members of staff committees

About half of all respondents sit on a staff committee. The other percentages are given in **table 7.10**.

Men are (56%) and were (30%) relatively more often a member of a staff committee than women (respectively 38% and 20%). Considerations about future membership are equal for men and women. Self-employed specialists sit more often on a staff committee than salaried specialists (57% versus 42%).

The specialists in staff committees are statistically more positive about their own peer group, they desire more involvement in decision making about hospital policy, and they are more often in favour of a formal specialist role in the hospital organisation.

Table 7.10: Members of staff committee, in percentages of respondents

	percentage
member now (not in the past)	43
member now and in the past	10
member in the past (not now)	19
thinking about becoming member in the future	6
no experience, not thinking about it	22
total	100

n = 657 (24 missing values)

7.4.4 Jurisdictional claims related to the role of staff member

The only specialists who express specific jurisdictional claims from the perspective of being a staff member are the specialists on the board of the staff. They are the ones who actively try to protect mutual specialists' interests. Underlying the negotiations from the perspective of the staff board seems to be a claim on staff jurisdiction over the principles for the organisation of specialist work in the hospital context. So, the staff board negotiates with the board of directors for staff involvement in decision making in hospital.

This jurisdictional claim is supported by the other specialists, because the survey shows that respondents expect the staff to continue its role in decision making in the hospital.

Specialists who are not on the staff board hardly play the role of staff member actively. For them, the interests from the perspectives of the roles of peer and doctor define their conduct in the staff context. In this respect, the way the staff-role is played is largely the net result of jurisdictional claims from these other perspectives.

The amount of negotiations specialists are involved in as staff members is limited. The role is not very visible in average daily specialist life. Of course a study concentrating on staff board members would have given different results.

7.5 The role of hospital member

The hospital-role is played when specialists manifest themselves as members of the hospital organisation or as acting in behalf of the hospital. In the case studies, the specialists were not often observed to play this role actively. In this, the role is rather similar to the staff-role.

Negotiators and negotiations

When specialists play the role of hospital member, the organisation and its managers are the negotiators most often met. Members of the hospital workforce (not in patient care) come second. The membership component of being a hospital member is more often in question than the representing component, because external parties (for instance patients, insurance companies, other hospitals) are hardly found in quotations that reflect the role of hospital member. In their relationship with patients, specialists rarely manifest themselves as hospital representatives. When they do mention the hospital, they more often dissociate from it or apologise for it, which is discussed in paragraph 7.5.1.

Negotiations in the context of the hospital are meant to hold or defend specialists' stakes. Specialists for instance demand or request conditions, form coalitions, and organise things. Flight and surrender result in more passive reactions (grumble).

Issues and patterns

The patterns in negotiations are similar to the ones found in analysing the staff-role. The hospital provides a forum of positions as well, which is discussed in paragraph 7.5.1, and is a starting point for organising work, which is outlined in paragraph 7.5.2. The details of these fields are of course different from the staff-role.

Paragraph 7.5.3 discusses the survey results that are connected to the hospital context, and paragraph 7.5.4 addresses the jurisdictional claims.

7.5.1 The hospital as a forum of positions

The hospital provides the larger context of the specialist relationship network, in which specialists are aware of their relative positions. The hospital context provides three parties for 'positioning': hospital employees, managers and the hospital organisation.

Hospital employees: individual relationships

Some members of the hospital workforce have already been discussed in earlier paragraphs and chapters. For instance the nurses and other personnel in patient care and the employees 'owning' purchasing processes (paragraph 7.3). These workforce members discussed so far belong to processes specialists are involved in from the perspectives of the role of doctor, peer or department member.

Here, in the role of hospital member, specialists meet the employees of departments not directly connected with actual specialist work processes. For instance cleaning personnel and restaurant workers. Some individual specialists, on average the elderly somewhat more than the young ones, have special relationships with these employees. These relationships do not reflect negotiations as such, but they do reflect tactics in which specialists 'get things done', for instance in organising their own work and their working circumstances in the negotiated order of the hospital. These special relationships bring small privileges, the cleaning ladies for instance watering the specialist's plants or the restaurant workers keeping food apart when the specialist is working late. One of the cleaning ladies also advised a specialist about a free room further down the corridor, which made it actually possible for this specialist to get a better working room.

Thus, these employees are parties to form a kind of coalition with, in the first place because of good relationships in general and in the second place because they might improve working circumstances. These coalitions are only made on an individual level. They do affect being a member of the hospital organisation, but in 'getting things done' the perspective of the individual specialist is served rather than the perspective of the hospital as a whole.

The specialists in medical disciplines seem to have these kinds of relationships a bit more than the other ones.

Specialists' position towards and in hospital management

When talking about hospital management, the general feelings in the case studies are: "we see too many office suits in the restaurant these days", "the directors don't know what's really happening on the work-floor", and "we specialists should participate in management". The process of management is necessary, but managers have made it too complex and hence they now have too much power.

In short, specialists as members of the hospital organisation largely define managers, especially higher managers, as a party to dissociate from. But they do want to be involved in management as a process. One of the specialists sums up the arguments:

"We specialists should join the process of organising in hospital, because we understand patient care and how it should be organised and because our participation is necessary in the hospital relationship with insurance companies and the government. Actually our involvement really belongs to the kind of trade we have."

The relationships between departments' managers, including specialist managers, and the board of directors is an important subject of debate in designing the organisational structure in both hospitals. In one hospital the debate focused, and still focuses, on the hierarchical structure: do function group managers, including the specialist managers, interact directly with the board of directors? Or should an intermediate function deal with the function group managers first? The specialists favour the direct construction because they don't want the specialist managers to be forced into a relationship with intermediates. The board of directors favours the intermediates because they fear lack of control if they

should deal directly with all function groups (18 function groups). The compromise was the temporary appointment of three intermediate functions who should coach and support the function groups in their section and who should control the financial results on behalf of the board of directors. These persons have no hierarchical power, so 'hire and fire', and management agreements are taken care of by the board of directors.

In the other hospital the specialist management design at first only presented specialist managers on the division level. The debate about surrounding organisational relationships here focused, as explained in paragraph 7.4.1, on the triangle between specialist managers, specialist staff and board of directors. The board of directors just wanted to appoint the specialist division managers, but the board of the staff wanted the specialist managers also to relate formally with the specialist staff. For instance by means of elections or by combining a specialist manager function with membership of the staff board. At the end of the case study period the design changed. Specialist management is now introduced in three pilot projects on the level of departments.

Specialists' position in hospital

Within the hospital organisation most specialists favour a 'special position'. In discussions about integration into the hospital organisation they fight the suggestion they are to become regular employees. This means they cannot become subordinate to managers, regardless of their being self-employed or salaried. They wish to keep the position a little separate from the rest of the hospital members:

"I favour a special position, not an employee's status. Patients come here because of us. Of course we must have good relationships with the employees in hospital. But towards the public we need a certain distinction. Which is good for the employees in hospital too, because this indirectly affects them. It doesn't mean I think I'm a better human being or something. But the social positioning is different."

Being a member of the hospital organisation, yet feeling the need to have a position separate from the organisational structure makes specialists have a paradoxical relationship with the complete hospital. On one hand specialists want the hospital to be a place they can work in and be proud of, on the other they don't always want to be identified as part of the hospital.

This paradox is recognised in meetings with patients and in other conversations. Some specialists tend to withdraw themselves from their hospital membership, for instance by telling patients to write to the board of directors about waiting lists or by explaining the equipment is not of the newest sort because "this hospital is very economical". Only occasionally will a specialist express his or her pride about a hospital:

A patient explains why he went to the casualty department here a few days ago. The specialist replies: "You were very right about that. And you chose the best hospital in town!"

Summarising the positions specialists take in the hospital organisation, the hospital-role is hardly played from a 'pure' hospital perspective. Specialists are not often found to play the role of being a member of the hospital actively in negotiations. When they do 'use' relationships and positions within the hospital, this is rather a tactic in 'getting things done' in favour of other perspectives than in favour of the hospital as such. They do want to be involved in hospital management, not because of hospital management but because of the perspectives of the doctor-role or the peer-role.

7.5.2 The hospital as a starting point for organising work

The hospital boundaries are the last ones before the outer world is entered. Therefore, as hospital members, specialists meet issues caused by external factors but influencing the organisation of work on the inside of the hospital. There is shortage of (junior) physicians, employees and budget. And the outer world forces specialists to take up tasks that are not always considered useful. Keeping track of all activities per patient, because of the preparations for the new DTC-financial system, is not done enthusiastically by everyone.

Specialists sometimes blame hospital management for scarcity and extra tasks, others directly blame the outer world:

"The problems we have in hospital are not caused by management. Politics and government are to blame. And we doctors are to blame, for letting it happen. We're too nice and all we do is work even harder."

Within these circumstances the hospital level is the starting point for creating and maintaining the framework of the organisation. The two most important structural frameworks are the hospital building and the structure of the organisation. The specialists meet these themes more often in their role of department member, because that is the level where the specific items are worked out. In their role of hospital member they mainly meet the issues involved when they have secondary functions in committees or working groups.

Lack of abundance forces organisations to choose. Within the hospital this creates conditions for conflicting roles and tasks of specialists. From the perspective of being hospital members specialists know about scarcity and even urge hospital management to make choices. From the perspective of being doctors, however, they don't want to be forced to choose themselves:

"From a general role in hospital I can for instance decide to spend less OR-time on a certain procedure. But I cannot economise on my own patients. Really, if that's necessary someone else will have to decide on that."

In the organisation of work, the role of hospital member is hardly found to define negotiations from an all over hospital perspective. Specialists do want to be involved in hospital, not strictly because of hospital interests but rather because of patient care or peer interests.

7.5.3 The role of hospital member: results from the questionnaire

The survey results reflecting specialists' opinions about the context of the hospital address four themes. The first one concerns specialists' feelings towards hospital and hospital management. Second the present and desired level of involvement in decision making about hospital policy was being studied. Third, the survey asked for specialists' opinions about integration and participation. Finally, the survey asked respondents for secondary functions, among which was membership of a hospital committee.

Feelings towards hospital and hospital management

Specialists' feelings towards their own group (paragraph 7.3.3) are more positive than towards the hospital in general. **Table 7.11** shows the respondents' feelings about the hospital and about hospital management.

Most specialists do feel at home in the hospital they work in, almost half of all respondents think the hospital they work in functions all right and higher management takes specialists' interests seriously. Less than half of the respondents feel higher managers devote themselves to specialists' interests.

These opinions are not different between the various groups of age, sex, employment or speciality. What makes a significant difference though, is whether a peer group meets the board of directors on a regular basis. Respondents in a peer group that has frequent formal meetings with the board of directors report positive feelings towards hospital and hospital management more strongly than respondents who do not meet their board of directors frequently.

Table 7.11: Feelings towards hospital, in percentages of respondents

	strongly disagree	disagree	don't disagree / don't agree	agree	strongly agree
4a I feel at home in this hospital.	0,7	3,7	8,1	51,6	35,9
4b I think this hospital functions all right.	2,8	22,7	24,9	41,0	8,6
5a Higher management devotes itself to specialists in this hospital.	4,7	23,5	30,2	37,9	3,7
5b Higher management takes specialists' interests seriously in this hospital	4,3	18,6	26,9	45,9	4,3
Scale: positive feelings hospital	0,9	7,8	31,6	51,5	8,2

n = 680 (1 missing value) for 4a; n = 678 (3 missing values) for 4b; n = 676 (5 missing values) for 5a and 5b; n = 656 (25 missing values) for scale; Cronbach's alpha 0,80

Involvement in decision making in hospital

As explained earlier (paragraphs 6.5.2 and 7.3.6), the levels for involvement in decision making given in the survey run from 1 to 4, in which 1 stands for 'no specialist involvement in decision making', 2 for 'specialists consulted before management takes a decision', 3 stands for 'specialists sharing decision making with management', and 4 means 'specialists take the decision'.

Table 7.12 shows the present, experienced level of involvement in decision making about hospital policy and the distribution of hospital means, and the percentages of respondents that are satisfied with the present level or desire more involvement ('less involvement desired' only gives small percentages, and is left out of the table).

Few specialists think the present level of specialist involvement in decision making about hospital policy and the distribution of hospital means is fine. In general they desire more involvement, especially in decisions about the distribution of the hospital budget and about the annual output agreements with insurance companies.

Different sub-groups do not report different involvement in the present scale. On the separate items surgical specialists experience less involvement than medical respondents in decision making about the distribution of OR-hours and about the hospital policy plan.

Self-employed specialists on average desire more involvement than salaried specialists. This is especially true for the distribution of beds, the distribution of OR-hours and the annual output agreements with insurance companies.

On the desired scale level the other sub-groups do not show differences, but when analysed per item the medical specialists desire more involvement in decision making about the distribution of beds than the surgical specialists.

Table 7.12: Present level of involvement in decision making about hospital policy and the distribution of hospital means, in percentages of respondents

Decision making about:	no specialist involvement	specialists consulted	specialists share decision making	specialists responsible	this level of involvement is fine	more involvement desired
6a distribution of the hospital budget	16,1	58,1	25,2	0,6	29,8	69,2
6d distribution of beds	7,9	46,0	44,0	2,1	40,7	57,6
6e distribution of OR-hours	4,9	39,9	48,7	6,5	43,2	54,3
6f annual output agreements with insurance companies	11,5	45,6	39,2	3,7	34,0	64,0
6g hospital policy plan	4,2	46,4	47,4	2,1	44,1	54,0
6t terms of employment for specialists	10,9	34,7	43,5	10,9	39,5	58,7
6u hospital reorganisation	7,2	54,8	37,4	0,6	39,2	59,7
Scale: hospital policy and the distribution of hospital means						
present	2,8	56,0	40,9	0,3		
desired	0,1	3,0	85,5	11,4		

n = 671 (10 missing values) for 6a and 6f; n = 657 (24 missing values) for 6d;
n = 632 (49 missing values) for 6e;
n = 673 (8 missing values) for 6g; n = 643 (38 missing values) for 6t; n = 663 (18 missing values) for 6u;
n = 597 (84 missing values) for present scale; Cronbach's alpha 0,80
n = 651 (30 missing values) for desired scale; Cronbach's alpha 0,76

Integration and participation in hospital

To find out how specialists feel about their role and position in the hospital organisation, the survey contained two statements about specialists' integration into the organisation, and four statements about formal specialist involvement, reflecting the general idea of management participation.

The term 'integration' is an abstract concept with different interpretations. To find out whether specialists have positive feelings about the concept as such, the survey gave one statement that deliberately referred to 'integration' without further definition. Another statement suggested the incorporation of specialists into the hospital hierarchy.

As shown in **table 7.13**, specialists feel positive about integration as such. About one out of three specialists takes integration a bit further and endorses specialist incorporation into the hospital hierarchy.

Specialists in surgical disciplines favour integration and incorporation less often than their colleagues in supporting specialities, as do self-employed specialists compared to salaried specialists, and men compared to women. Age does not affect specialists' opinion about integration and incorporation.

Table 7.13: Integration and incorporation, in percentages of respondents

	strongly disagree	disagree	don't disagree / don't agree	agree	strongly agree
29 I think specialist integration into the hospital organisation is a good development.	3,1	9,3	13,4	51,5	22,7
3j Eventually specialists, like other employees in hospital, should be incorporated in the hospital hierarchy.	19,4	32,3	18,2	23,6	6,5
Scale: integration and incorporation	2,5	12,8	36,3	33,7	14,7

n = 675 (6 missing values) for 29; n = 674 (7 missing values) for 3j;
n = 668 (13 missing values) for scale; Crohnbach's alpha 0,57

The specialists' opinion about a formal specialist role in organisation, reflecting the idea of management participation, was asked in four statements, as shown in **table 7.14**.

Almost all respondents favour a formal specialist role in the hospital organisation. The different groups of specialists do not have different results on the scale of the formal specialist role. Only in the separate statements do men favour a formal specialist role related to the optimum organisation of patient care more than women.

Table 7.14: Formal role in organisation, in percentages of respondents

	strongly disagree	disagree	don't disagree / don't agree	agree	strongly agree
3d Formal specialist involvement in the hospital organisation is necessary for implementation of specialist staff policy.	0,1	0,4	3,0	53,9	42,5
3c Formal specialist involvement in the hospital organisation is necessary for the optimum organisation of patient care.	0,1	1,5	3,2	52,7	42,5
3a Formal specialist involvement in the hospital organisation is necessary for the promotion of specialist interests.	0,6	2,7	3,1	48,4	45,3
3b Formal specialist involvement in the hospital organisation is necessary for cost containment in hospital.	0,6	8,1	17,2	55,8	18,3
Scale: formal specialist role in the organisation	-	0,1	3,2	59,5	37,1

n = 678 (3 missing values) for 3a and 3c; n = 679 (1 missing value) for 3b; n = 677 (4 missing values) for 3d; n = 675 (6 missing values) for scale; Crohnbach's alpha 0,65

Members of hospital committees

Sitting on a hospital committee is the secondary function that is fulfilled most: 70% of the respondents sit on a hospital committee. The other percentages are given in **table 7.15**.

Table 7.15: Member of hospital committee, in percentages of respondents

	percentage
member now (not in the past)	56
member now and in the past	14
member in the past (not now)	18
thinking about becoming member in the future	3
no experience, not thinking about it	9
total	100

n = 657 (24 missing values)

Surgical specialists sit less often on a hospital committee (about 50%) than other specialists (about 60%), but they have more past experience (25% versus 16% in the medical specialities and 11% in the supporting specialities). Men relatively have more past experience than women (35% versus 20%).

The survey shows members of staff committees (paragraph 7.4.3) resemble members of hospital committees in being more positive about their peer group than other specialists, having a higher level of involvement in decision making about hospital policy and the distribution of hospital means, and more strongly favouring a formal specialist role in the organisation. Men and women, and self-employed and salaried specialists are relatively equally represented in hospital committees, while staff committees have more male, self-employed members.

7.5.4 Jurisdictional claims related to the role of hospital member

Negotiations specialists are involved in in their day to day work hardly ever address their hospital membership in a 'pure' form of being a member or representative of the organisation. Specialists are aware of their position in the hospital, in individual relationships, in their relationship with hospital management, and in hospital in general. This 'position awareness' mainly serves purposes from the perspective of other roles, especially the peer-role. Another field in the context of the hospital is the organisation of work, but the perspective of the department-role is far more important for defining the negotiated order in the day to day organisation of work than the perspective of the hospital-role.

The survey results show specialists want to be involved in hospital decision making more strongly.

The negotiations reflecting the hospital-role seem to be based on a claim for jurisdiction over a special specialist position, which renders them jurisdiction over the organisation in general. They do not want to be incorporated in the hospital organisation and workforce, yet they do want to be involved in decision making about it, because the organisational arrangements made here affect specialists' and specialities' interests.

This claim is not made in behalf of the role of hospital member as such, but rather on behalf of the role of doctor and the role of peer.

7.6 Specialist managers

Being a specialist manager is a special role in hospital, only performed by those who have a formal secondary function in management. This paragraph addresses the role of the specialist managers in the case studies and the survey results concerning specialist managers.

In four of the seven cases, in one hospital, specialist managers were appointed during the case study period, one in every group. The other hospital only discussed the design of specialist management.

Despite these small numbers of specialist managers the role deserves discussion because it reflects the processes of integration and participation in the integrated specialist company.

Negotiators and negotiations

Specialist managers in the case studies most often meet other managers as negotiators. The board of directors, the organisational managers and the managers on the wards are the ones met in specific issues of organising work in the function group. The second group they meet are other specialists.

Specialist managers try to hold or defend their stakes mainly by negotiating about relationships and the organisation of work. Being a specialist and a manager brings special role and task combinations: situations in which different roles or tasks are connected with different and potential conflicting interests. Specialist managers deal with these situations by choosing for one of the roles or by combining them. Another tactic specialist managers are observed to adopt is taking the lead. Specialist managers often take initiative in the matters they have to deal with.

Issues and patterns

Two fields of negotiations matter to specialists in their manager-role, both equally important: relationships and positions, and the organisation of work.

Paragraph 7.6.1 addresses the former, the position of the specialist manager amidst organisational relationships. Paragraph 7.6.2 addresses the latter, the specialist manager's role in organising work. The other specialists have something to say about specialist managers as well, which is reported in paragraph 7.6.3.

Paragraph 7.6.4 presents the survey results reflecting aspects of management participation, and paragraph 7.6.5 reveals the specialist managers' jurisdictional claims underlying their negotiated order.

7.6.1 The position of the specialist manager

According to one of the specialist managers, his role is important because it symbolises specialist involvement in hospital organisation. "Doctor and organisation are inseparable," and therefore doctors should join the act of organising in hospital. What position does a specialist manager have in his or her context from this perspective? Formally the specialist managers chair the management team of their 'function group'. They explain they do indeed have the final say in important matters in practice, especially when aspects of patient care are concerned in some way. The other side of the negotiated order of their relation with regular management, however, is that they only have half a day or one day a week available for management. The organisational manager, their partner in function group management, is able to spend more time on management and therefore takes care of most of the operational decision making.

Specialist managers also have organisational relationships with the specialists and peer groups within their function group. From the perspective of their manager-role the specialists negotiate for their position in these relationships too. Some specialist managers for instance chair multidisciplinary function groups, which makes it hard to rely on a common ground of shared work. One of the specialist managers explains he therefore can only administratively represent all disciplines in his group:

"I'm only their administrative representative. I cannot touch anything that involves their specialities. That's why I don't want some obstacle between us and the board of directors. I fiercely oppose these division managers or whatever these persons are called... I'm already in-between, don't add another layer to that."

A third category of parties a specialist manager has relationships with are managers and departments outside the function group. The board of directors is among these parties as well. Within these relationships specialist managers watch their position as well. They are careful not to be neglected when it comes to decision making and negotiating.

Thus, specialist managers negotiate for their position in organisational relationships with their organisational manager, with the specialists and peer groups within their function group, and with managers and departments outside their function group.

7.6.2 The manager-role in organising work

Physician managers sometimes are like puppets, having their strings pulled, and sometimes like puppetmasters, pulling strings (McKee et al. 1999). In the organisation of work the balance between being a puppet and a puppet master defines the negotiated order.

In becoming and being a manager specialist managers learn about this. The next paragraph elaborates on this aspect. Playing the role of manager has to be combined with playing various other roles. Especially the combination of the role of manager and the role of peer may bring conflicting interests, which is discussed in the second subparagraph.

Becoming and being a manager

The four specialist managers all followed a management training provided by a Dutch business school. The specialists and the organisational managers took this training together. In this training and in the first practical experiences they renewed their knowledge of difficulties they already knew from being a hospital member: shortage (paragraph 7.5.2). They also found out their fellow specialists are hard to 'manage'. One of the specialist managers explains about these difficulties:

"You almost always get an insufficient budget. And a reorganisation like this usually is retrenchment in disguise. Besides, at first you just don't know exactly what you're talking about. [..]

What I've learnt about managing specialists so far is first of all, they have a short term perspective. They want to take care of their patient now and in general they don't think much further than now. Second, they're lord and master of their speciality. It makes no difference whether they're self-employed or salaried by the way. These two aspects together make you negotiate everything over and over again. And every decision can only be made in consensus.

It is very inconvenient, but I'm a specialist too, I understand these mechanisms. Partnerships in history were introduced by two individual specialists only sharing a secretary and later taking alternate shifts. Now we're a lot bigger than that and it makes sense to assign some authority to representatives of the speciality group. But that still is not easy at all."

Management in itself will never be the specialist managers prime task. This may bring them in negotiations with regular managers. The specialist managers in the case studies for instance meet the intermediate managers (see paragraph 7.5.1), who challenge them now and then to find their own funding for financing equipment. They might increase some private activities that may help them make money to invest in new equipment. Maybe not completely uncommon in managerial terms, but the specialist manager who first heard a suggestion like this explains why he became furious:

"This is beyond all limits! As if the management secretary would ever sell cookies at the parking lot, so she can buy her personal computer! We need this equipment for our regular patient care. We're not talking about extra's here. I hope I've made this clear now and that we can cut the knot soon."

Role and task combinations

The combination of the role of peer and the role of manager creates role conflicts. From the perspective of the peer-role the specialist aims at smooth specialist working processes, at profit ratios and at the responsibilities of the hospital to the partnership and vice versa. But from the perspective of the manager-role he is also responsible for other persons and parties in the function group and its departments. Therefore specialist managers sometimes deliberately have to ignore the interests of the partnership.

Thus, in the field of organising work, specialist managers negotiate for managerial issues, such as retrenchments and managing their peers. In negotiations with 'real' managers they try to support patient care and to prevent management from putting too much financial pressure on work in patient care.

In the course of these processes they are confronted with role and task combinations, for instance when the peer-role perspective brings other interests than the manager-role perspective.

7.6.3 Non-managers about specialist-managers

Allegiance to the peer group is considered to be important, and Ong and Schepers (1999) explain that colleagues closely watch specialist managers as to whether they let hospital interests prevail. In the four case studies with specialist managers, most specialists are positive about management participation: specialist managers guard decision making in its consequences for patient care and they help prepare information for decision makers.

One of the specialists, not a specialist manager, explains the benefits of having a specialist manager:

"The surplus value is the better feedback between partnership and organisation. After about 100 years of grumbling we are fighting less now. Our specialist manager helps creating this feedback, and we also get more feeling for the organisation ourselves. We are looking for a new member of the partnership now and we have put organisational acumen in the qualifications. Our relationship with the board of directors is less hostile as well. We have a better relationship now."

Not all specialists feel good about specialist participation though. Some think the structure becomes too hierarchical, with the specialist managers becoming new "powers that be". Others think the specialist managers are too busy managing financial and organisational aspects of the function group, while they should pay attention to organising patient care:

"Specialist management is all about management. I don't see much difference with earlier times. The organisational manager and the specialist manager talk about the same things. And that's not patient care from the physicians' point of view. [..] I expect the specialist managers to focus on the organisation of patient care within the speciality, in stead of on the organisation of management. And I don't see this focus yet."

In general the manager-role is valued positively by specialists and specialist managers, although some negotiations address the content of the issues specialist managers are dealing with: maybe the perspective is too much managerial and too little professional.

7.6.4 The role of specialist manager: results from the questionnaire

The survey addressed the specialists' opinions about the way the manager-role should be played. It also asked for the introduction of management participation in the own hospital, which created the chance to compare respondents' opinions in hospitals with and without specialist participation.

Finally, the survey asked for management as a secondary function, so differences between specialist-managers and non-managers could be found.

The position and role of the specialist manager

What should the position and role of specialist managers be? Three statements in the survey reflected three different aspects. **Table 7.16** shows the results.

Table 7.16: Position and role of specialist manager, in percentages of respondents

	strongly disagree	disagree	don't disagree / don't agree	agree	strongly agree
3g A specialist manager should create conditions for professional practice.	0,4	1,3	5,5	62,6	30,1
3h A specialist manager should be intermediate between partnerships and speciality groups and hospital management.	2,4	9,9	15,2	59,4	13,1
3i A specialist manager should actively lead the specialists of partnerships and speciality groups.	2,8	16,7	33,8	40,9	5,8
Scale: specialist management	0,3	1,9	28,0	61,9	7,9

n = 677 (4 missing values) for 3g and 3i; n = 678 (3 missing values) for 3h; n = 674 (7 missing values) for scale; Crohnbach's alpha 0,46

First and foremost specialist managers should create the conditions necessary for professional practice. Second, specialist managers should play an intermediate role between partnerships or speciality groups and hospital management. The option of specialist managers actively leading specialists comes third and is supported by less than half of the responding specialists.

In the separate statements women are found to support the intermediate role of specialist managers more strongly than men.

The introduction of management participation

Table 7.17 shows the results for the level of management participation in respondents' hospitals. Most respondents (80%) work in hospitals that have introduced formal functions for specialist managers.

Table 7.17: level of management participation, in percentages of respondents

	percentage
only unit level	25
only division level	27
only board level	6
unit level and division level	11
unit level and board level	2
division level and board level	3
unit level and division level and board level	6
no participation	20
total	100

n = 679 (2missing values)

On average respondents in hospitals with management participation spend their time differently to respondents in hospitals without specialist managers, which is shown in **table 7.18**. This is partly related to the fact more teaching hospitals than general hospitals introduced management participation. About 93% of the respondents in the larger teaching hospitals[5] (n = 229) reported working in a hospital with specialist managers. For respondents in smaller teaching hospitals (n = 283) this was 80% and for respondents in general hospitals (n = 168) 60%.

Based on the numbers reported by respondents, hospitals with participation on average hold about 600 beds, hospitals without participation on average hold 465 beds. More than 90% of the specialists who reported working in a hospital with decentralised structures also reported management participation. For specialists in hospitals with traditional structures this was 60%.

Respondents in hospitals with management participation were less often than other respondents in favour of subordination of managers or nurses to specialist managers or to specialists in general. They reported higher levels of involvement in decision making about the organisation of specialist patient care and specialist training (paragraph 6.5.2), and about the organisation of wards and outpatient departments (paragraph 7.3.6).

The other opinions about or experiences with professional orientation or specialist alignment with the hospital were not found be different for respondents in hospitals with or without management participation.

5 In Dutch: STZ-ziekenhuizen (Samenwerkende Topklinische opleidingsziekenhuizen)

Table 7.18: Activities; distribution of time in mean percentages reported by respondents in hospitals with or without management participation

	% of time spent on this activity
patient care	
with participation	63,3
without participation	70,3
care related	
with participation	14,5
without participation	12,5
supervision & training	
with participation	6,1
without participation	4,1
research & education	
with participation	6,3
without participation	5,3
organisation	
with participation	9,9
without participation	7,8

n = 673 (8 missing values)

Specialist managers

About 20% of the respondents is a specialist manager now, and almost 20% has past experience.[6] Asked about the future, about 20% of the respondents without past or present experience expresses the thought of becoming a specialist manager (this is 13% of the total population). Half of the group of respondents does not have experience and does not report to consider the manager-role for the future. The numbers are shown in table **7.19.**

6 The total number of specialist managers in Dutch hospitals is not known.

Table 7.19: Specialist manager, in percentages of respondents

	percentage
specialist manager now (not in the past)	16
specialist manager now and in the past	3
specialist manager in the past (not now)	18
thinking about specialist manager in future	13
no experience, not thinking about it	50
total	100

n = 657 (24 missing values)

Surgical specialists are less often a specialist manager (13%) than supporting specialists (25%). Medical specialists are in between (20%). All speciality groups have equal percentages of physicians with management experiences in the past.

Salaried specialists, having 24% specialist managers among them, are more often seen in management than self-employed specialists with 16% managers. Their past experience is equal though.

Women report past management experience less often than men (9% versus 22%).

Specialist managers spend significantly more time on organisational tasks (14% of their time versus 8% for non managers) and less on individual patient care (60% versus 66%).

If the present specialist managers are compared with the other respondents, specialist managers on average support the professional principles of professional primacy, autonomy and egalitarianism less than the other specialists. They express more positive feelings towards hospital than the non-managers and, as might be expected, they experience more involvement in decision making. The level of desired involvement is higher as well, except for decision making at hospital level. They favour the link between specialists' formal organisational role and cost containment more strongly than other respondents.

Specialist managers also favour integration more often, and they expect the importance of collective forms (especially the specialist staff) to continue, more often than other specialists.

7.6.5 Jurisdictional claims related to the role of specialist manager

The jurisdictional claims underlying negotiations specialist managers are involved in seem to reflect a 'hybrid foundation' of the role. Both the case studies and the survey show that specialist managers value organisational principles (for instance management and policy, cost-containment) higher than other specialists, and that they favour integration more often. These aspects suggest a claim on jurisdiction over the organisation of specialist work from a managerial point of view.

When specialist managers meet regular managers they try to protect work in patient care, based on a claim on jurisdiction over the organisation of patient care from a professional point of view.

Maybe they expect, more often than non-managers, the specialist staff to continue its role in organisation (a survey result) because they feel the need to counterbalance the power of managerial forces.

7.7 Conclusion: specialists roles defined by relationships in the hospital

The research question for this chapter concerns the nature of negotiations from the perspectives of the roles that are defined by relationships in the hospital, and the jurisdictional claims underlying these negotiations.

The roles defined for all specialists by relationships in the hospital are the role of peer, the role of department member, the role of staff member and the role of hospital member.

Some specialists have a formal secondary function in management. Their role of manager was discussed in this chapter as well. In every role negotiations are defined by the organisation of work and by relationships and positions. The details of these categories are different for the different roles.

The role of peer

The nature of negotiations specialists are involved in as peers is first of all defined by the inside component within the peer group. Peers among themselves ideally are both good pals and business partners. When being pals fails, being good partners (sharing work and income) usually seems to be difficult as well. Negotiations about these aspects seem to be intertwined. Being pals brings negotiations, usually of an indirect character, about relational manners. In being partners the negotiations are for output and finances.

The jurisdictional claims on the inside of the peer group reflect the individual specialists' desire for personal jurisdiction over the content and the organisation of their practice. Individual jurisdiction is limited because individual specialists need the group. So, the group by definition touches individual borders of jurisdiction. The survey results suggest most of the specialists feel well within their group, suggesting the negotiated order in the peer group is relatively stable, or reflecting the acceptance of mutual dependencies.

The peer-role has an outside component as well, in which specialists represent their group. In this respect, specialists quite often refer to their practice as a shop that they own together with their fellow specialists. From this perspective negotiations are for the position of the peer group in their context and for business interests, like output and finances. Members of a peer group share a claim on jurisdiction over the professional, financial and organisational aspects of their work.

The peer-role is found to be more visible in negotiations in the surgical and supporting specialities than in the medical specialities. This is in line with the accents in patient care, in which mutual dependencies are larger in surgical specialities (traffic control) and supporting specialities (position control) than in medical disciplines (entrance control).

The role of department member

The nature of negotiations from the perspective of the specialists as department members is defined by three fields of negotiations for the organisation of work and by two fields of negotiations for relationships and positions. Concerning the organisation of work, the specialists' role in department policy and management is in question, as are the issues of organising work processes (logistics, availability of capacity, interruptions), and getting adequate space, equipment and materials. Specialists negotiate for these aspects with each other and with managers. The survey results show specialists want more influence on decision making on the level of the department. Different specialities have different desires in this respect. The surgical specialists for instance seem to be less interested than other specialists, probably because their (logistical) interests go beyond separate wards.

The jurisdictional claims underlying these negotiations on the department address management, control and conditions, largely determined by the interests from the perspectives of the role of doctor (organisation of patient care on wards and units) and the role of peer (efficient organisation of work).

In the field of relationships, specialists define the inside component of membership of the department in several processes ('semi-employership', contributing to a positive atmosphere, relational manners) that result in a social position 'above' the other members of the department. In relationships outside the department, specialists rather 'have' the wards and units than represent them. The underlying jurisdictional claim is not a claim on this position per se, but a claim on functional leadership from the perspective of the role of doctor.

The role of staff member

Most specialists in the survey think their formal integration into hospital will not affect the importance of the staff. Neither the staff itself, however, nor the staff-role of individual specialists are often visible in day to day specialist life. Yet, because the staff meeting in the end votes on important organisational aspects, and because positions in the staff can threaten or strengthen other positions and roles, the staff provides an important background for specialists' negotiations.

Negotiations from the perspective of the specialists' staff role are about positions (of an individual specialist on the staff board, of the peer group in the context of the staff, and of the staff in the context of the hospital), and about the organisation of work in the hospital context. Especially the latter is most visible in the daily work of board members, because they have to deal with staff issues in between other activities.

The only specialists who express specific jurisdictional claims from the perspective of the staff role are the specialists on the board of the staff. They are the ones who actively try to protect mutual specialists' interests. Underlying the negotiations from the perspective of the staff board seems to be a claim on staff jurisdiction over the principles for the organisation of specialist work in the hospital context. So, the staff board negotiates with the board of directors for staff involvement in decision making in hospital.

The role of hospital member

In day to day specialist work negotiations do not often directly affect specialists in their hospital context. When they do, the positions in hospital or the collective organisation of work is in question. Under the former, the specialists either individually (towards hospital employees) or collectively (towards management and the hospital in general) negotiate for relationships and positions they can 'use' from the perspectives of the other roles. Under the latter, the specialists negotiate (or 'grumble') about the hospital working contexts (scarcity and shortage) and the structural framework.

The survey results show specialists feel positive about integration as such.

From the perspective of the hospital-role, specialists claim a special specialist position in hospital, which renders them jurisdiction over the organisation in general. They do not want to be incorporated in the hospital organisation and workforce, yet they do want to be involved in decision making about it. This claim is made in behalf of the roles of doctor and peer. The shop owners need to have a special position in the organisation of the mall.

The role of specialist manager

The roles discussed so far are played by all specialists. The manager-role is only played by those who have a formal role in hospital management. In the survey 20% of the respondents reported to be a management participant or specialist manager. In the case studies only four specialists were specialist manager.

In the case studies, the specialist managers negotiate for their position in organisational relationships with their organisational manager, with the specialists and peer groups in their function group, and with managers and departments outside their group.

Next, they negotiate for organising work, during which they have to manage issues (dealing with scarcity) and their peers. In the course of these processes they are confronted with role and task combinations, for instance when the peer-role perspective brings other interests than the manager-role perspective. In negotiations with real managers they try to support patient care and to prevent management from putting too much financial pressure on work in patient care.

The jurisdictional claim specialist managers seem to base their negotiations on, reflects a hybrid claim. In negotiations with managers they make a claim on jurisdiction over the organisation of patient care from a professional point of view. In 'managing' their peers, they make a claim on jurisdiction over the organisation of specialist work from a managerial point of view.

Conclusion

The specialists' roles discussed here are defined by relationships in the organisation, and not by characteristics of work in patient care. On this level, the three speciality groups have different accents, but the patterns of negotiations and jurisdictional claims are more similar than in patient care.

The roles defined by relationships in hospital seem to be played on two large fields of negotiations: 'positioning' and

'organising'. In all roles, specialists are aware of their individual and collective position in relationships with other parties, and negotiations are meant to confirm or improve these positions. They are also keen on 'getting things done', and therefore they negotiate for organisational aspects of their work, alone or together.

Patient care, or the interests from the perspective of the doctor-role, can be seen as motives in most jurisdictional claims. The peer-role adds business interests to the reasons for claiming jurisdiction. From the perspectives of the other roles, different jurisdictional accents are made, but the common ground is largely defined by the claims from the perspectives of the doctor-role and the peer-role.

Table 7.20 shows the characteristics of the negotiations and jurisdictional claims from the perspectives of the roles discussed in this chapter.

Table 7.20: Negotiations and jurisdictional claims in roles

	peer
negotiations about	relationships and positions: - peers among each other (pals and partners) - other parties organisation of work: - finances and output
negotiators	fellow peers 'other peer group' hospital and managers
tactics	negotiations, forming coalitions organising flight / surrender
jurisdictional claims	individual peers among each other: - personal jurisdiction over the content and the organisation of their practice shared: - jurisdiction over the professional, financial and organisational aspects of work

defined by relationships in the hospital

department member	staff member	hospital member	specialist manager *NB only for specialist managers*
organisation of work: - department structure + role of specialist - work - space and material	relationships and positions: - individually: on staff board - peer group in staff - staff in hospital	relationships and positions: - individually: with employees - relationship with management - position in hospital	relationships and positions: - versus organisational manager, specialists and peer groups, managers
relationships and positions: - within the department - from the department with external parties	organisation of work: - background for regular specialists - negotiations for staff board members	organisation of work: - shortage and scarcity - structural framework	organisation of work: - managerial issues - role and task combinations
colleagues other specialities hospital workforce (nurses and others) hospital and managers	fellow staff members hospital and managers	hospital and managers members of hospital workforce (not in patient care)	hospital and managers colleagues own and other specialities
organising negotiations flight / surrender	negotiations, forming coalitions	demand or request, forming coalitions organising flight / surrender	negotiations choosing or combining role and task combinations taking the lead
- jurisdiction over management, control and conditions on department; underlying this: claim on self-management	staff board: - staff jurisdiction over the principles for the organisation of specialist work in the hospital context	- jurisdiction over a 'special specialist position', which renders specialists - jurisdiction over organisation in general; underlying this: doctor-role and peer-role	hybrid jurisdictional claims: - jurisdiction over work in patient care from professional perspective - jurisdiction over specialist work from managerial perspective
- jurisdiction over the other department members; underlying this: claim on functional leadership	other specialists: - jurisdictional claims from other perspectives (doctor-role and peer-role) define their conduct in staff		

References **Chapter 7**

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8 Specialist roles defined by relationships outside the hospital

8.1 Introduction

So far, the specialist roles discussed in Part 2 of this thesis were defined by relationships in the hospital. Two other roles provide the specialists with contexts for negotiations in day to day work in the hospital, although the roles are defined by relationships outside the hospital.

The first one is the role of individual, which refers to the specialist as a person who needs to balance individual and private needs and expectations, and work related needs and expectations, sometimes being the representative of the private context or the personal needs. The second one is the role of the professional, which refers to the specialist as a member or representative of the profession of physicians and of their own speciality.

Paragraphs 8.2 and 8.3 will add the negotiations specialists are involved in from the perspectives of these roles to the spectrum of day to day specialist work. These paragraphs will open with a short description of the day to day negotiated order from the perspective of the role in question. First, who are the negotiators and what nature do the negotiations have in general? Second, what issues are the negotiations about and what patterns will be discussed in more detail? The patterns will be outlined in subparagraphs, after which the survey results that belong to the role in question will be presented, as well as the underlying jurisdictional claims.

The chapter's conclusion is paragraph 8.4.

8.2 The role of individual

The role of individual is defined outside the workplace, by the individual characteristics and psychology of the specialist and by him or her representing private needs and personal preferences. Within the workplace this role is visible, for example when specialists mention their personal opinion or when they refer to private circumstances or individual needs they want to take into account at work.

Negotiators and negotiations

The majority of negotiations of specialists as individuals reflect 'intrapersonal' negotiations: negotiations that occur because the specialist has to combine different interests from the perspectives of different roles. These negotiations became visible in the case studies when specialists mentioned them in conversations or remarks.

If other parties were involved, the peer group colleagues were most often observed as negotiators.

Individual specialists seem to aim at keeping control of their stakes. They mainly do so by compromising between different interests in intrapersonal negotiations, by negotiating with other parties claiming personal time, and by organising work themselves. Surrender is necessary when these tactics fail.

Issues and patterns

The negotiations specialists are involved in as individuals are defined by three categories. Paragraph 8.2.1 discusses the intrapersonal negotiations that occur in the situation of role-contests. Paragraph 8.2.2 outlines peer-relationships, because the individual specialist often negotiates with his or her peers. Negotiations individual specialists are involved in when they think about their career are addressed in paragraph 8.2.3.

Paragraph 8.2.4 addresses the survey results that reflect certain aspects of individual specialists, and paragraph 8.2.5 discusses the jurisdictional claims connected with the role of individual.

8.2.1 Individual specialists in intrapersonal negotiations

This category is the largest group of issues specialists meet as individuals. It consists of the situations in which a specialist needs to weigh his or her personal and private interests against the interests at stake in his or her workplace.

The first subparagraph addresses the intrapersonal negotiations brought by the combination with the role of doctor, after which the combinations with the roles of peer and department member are addressed. Sometimes outside parties press individual specialists to choose for one of the contesting roles, which is explained in the last subparagraph.

The role of individual versus the role of doctor

The largest field of negotiations here is defined by intrapersonal negotiations in which the specialist needs to weigh the individual perspective against the perspective of the role of doctor. Specialists as doctors need time and attention for patient care and patients; specialists as individuals have to watch the balance between time at work and private time, taking into account the interests of the private and personal situation. Specialists most often deal with these contesting roles by compromising: they give and take a little from both sides. For instance they come into hospital early on days the children are taken to school by the other parent, or they incidentally go into hospital to dictate letters on rainy vacation days ("Although my family expresses strong opinions about this").

Sometimes both roles just have to be combined, without clear options for compromising or prioritising:

One of the specialists is late on every appointment today. He explains his family is out this week, so he has got to take care of himself at home. And last night he went to bed too late. That's why he is a bit behind today.
KK: "Is that also why you're wearing two different shoes?"
The specialist curses, he hadn't noticed his pair of shoes yet.

The specialist also needs to weigh the doctor-role against the individual-role when the speciality requires specific physical efforts or has physical effects. Anaesthesiologists for instance are reported to have a shorter life expectancy than the average population. This made one of the specialists conclude: "I've definitely made up my mind now. I certainly won't continue working until I'm 65!" Physical limitations to specialist practice, temporary or lasting, also cause specific problems. Sport injuries may hamper the handling of heavy equipment and one of the radiologists, who once suffered a retinal detachment, still should be careful in burdening his eyes, for instance watching the films against overly bright backgrounds.

In the compromises specialists try to find for combining being doctors and individuals, the interests from the perspective of the doctor often seem to outweigh individual interests.

When compromises are not possible (anymore), and the scale tipped in favour of one of the roles, the specialist may regret this from the perspective of the other role:

"We used to be on call for a whole week, seven nights in a row. Obviously that is not possible anymore, no one would accept it. But now the continuity of patient care is threatened."

Female specialists might be expected to spend more attention on combining private life with specialist life. Female specialists, both in the case studies and in the survey, work part-time more often than men (see also paragraph 5.5). This is probably related to their coping mechanisms in the role-contest in question. Apart from that, the case studies do not reveal women to be more often confronted with this category of role-contests between private and work related interests than men. Men, at least as often as women, tell about ad hoc 'contests', for instance having a sleepless week because of the combination of being on call and having a sick child at home, and about arrangements for dealing with the 'contests', for instance scheduling long lunch breaks to be able to have lunch with the children.

The small numbers of women in the case studies (eight out of 51) make drawing conclusions difficult.

Individual and personal characteristics may also have synergy with the role of doctor. Although synergy is mentioned less often, and reveals less information about jurisdictional claims, it is shortly mentioned here to prevent the suggestion that these roles are by definition difficult to combine.

Several specialists mention their personal sense of humour and their ability to take things light-heartedly. These are important characteristics to be able to deal with patients, who belong to many different groups, to deal with patients' problems, and to deal with the daily pace of many different tasks and responsibilities.

Other characteristics are gender and age. Women, according to some specialists, may have more empathy in their relationships with patients than men. But it might incidentally be a disadvantage they are less authoritarian. A male specialist:

"Sometimes you have to convince patients they are not sick, and they really should not 'shop' for further treatment. In those situations it helps when you're taller, and male, and a bit older. For me, I think I have the right age for that now. People do not see me as a youngster any longer."

Because of these differences, some specialists think a peer group should comprise male and female specialists. The proportion of women, however, is still small, and at the moment of the case studies, three out of seven peer groups had an all-male composition.

The role of individual versus the role of peer and department member

On the second field of intrapersonal negotiations individual and private interests stand opposite groups' interests, either in the context of the peer group or in the context of the department. The specialist, as an individual, needs time and attention for his or her private circumstances or personal needs, while in both group-roles he or she needs time and attention for the group. A compromise is again the usual outcome of these negotiations. For example when a part-time working specialist does come in for a partnership meeting on a day off, or when a specialist agrees to a maximum of two free weeks in a row, to protect the colleagues from longer periods of understaffing.

The interests from the perspective of the role of peer and department member are partly internalised by the specialist and cause intrapersonal negotiations when the individual-role brings contesting interests. The next paragraph discusses situations with fellow members of the peer group or of the department appealing to the specialist's peer- or department-role.

Claims and expectations from outside

Contesting roles open a third field of negotiation when other parties claim the specialist's time and attention. They may appeal to his or her being a doctor, peer or department member. All parties around the specialist are potential negotiators in these situations. Patients by definition need the doctor's time and attention. Occasionally they want to go further than the usual arrangements, for instance by asking the specialist's private phone number, to ask for help if necessary. This phenomenon is only brought up by specialists in the medical disciplines, probably connecting with the special relationship between specialist and patient here, described earlier. The specialists all know one or more older colleagues who used to give in to these requests. These days most specialists refuse to give their home number.

Occasionally a physician deliberately brings his private life into the consulting room to influence the relationship with patients:

In the office of one of the physicians hang some pictures of his children. Quite a few patients say something nice about them. Later the physician explains:
"These pictures always do the trick with patients! They help getting the message across: I'm only human too."

The fellow members of the peer group sometimes appeal to the specialist's co-membership, for instance by asking or urging him or her to get secondary functions in committees, or to work on problems that not necessarily match the individual's priority.

Specialists tend to actively negotiate their individual and private interests in their relationship with other negotiators. They refuse to give their home phone number to patients, they negotiate the membership of a committee by wanting one that does not take too much time, or they refuse to put effort in a cause they find uninteresting. Sometimes the external pressure cannot be refused, and specialists have to 'surrender', grumbling or otherwise.

8.2.2 Relationships with peers

As discussed shortly in paragraph 7.2, every individual peer wants his or her interests to be served and his or her individual style and needs to be accepted and respected by the peers. This personal need affects a specialist's relationships with peers.

All specialists acknowledge that good peer relationships, in which peers respect each other both professionally and personally, make specialist life easier. From stories about past or present problems, three mechanisms emerged for trying to fulfil individual needs in periods of bad peer relationships. First, when an individual specialist feels the need for good peer-relationships he or she may take on an active attitude from the perspective of the role of peer, for instance by organising mediation. Second, when an individual specialist feels the need to protect individual interests, he or she may interact with persons or parties around, for instance by trying to form a coalition with individual peers, with nurses, or with managers. Third, when an individual specialist feels helpless, he or she may just give up dealing with bad peer-relationships, either by denying the impact, "I love my job and I am happy doing patient care. Our bad co-operation... I only laugh about it", or by suffering from it: "These years with bad relationships, they really put a lot of years on me".

Irritations and incidental clashes are a milder form of problems in peer relationships. Because of the intertwined professional and organisational interests and the interdependence, irritation about colleagues develops quite easily, and may threaten individual job satisfaction. Specialists tend not to discuss these feelings openly. They are mainly dealt with in indirect and covert ways. Sometimes two individual peers have different characters, giving incidental clashes in the peer group. According to one of the specialists in the case studies clashes like these are not necessarily bad, "because it is a good thing to have different characters in the peer group".

Of course most specialists, in the interest of their individual satisfaction, care for good relationships with peers. In negotiations for the organisation of work they take these relationships into account. When, for example, they seek personal compromises between personal interests and their role of doctor, they try to prevent the development of differences between themselves and their peers. One of the specialists tells about working hours:

"When I first came here, the two other specialists worked until nine in the evening. I didn't want that; I wanted to see my children in the evening. Then my two colleagues said: "Okay, you can go home earlier, we don't mind working late." But I really didn't want that. I didn't want a difference like that between them and me. Then you get false positions. I wanted a joint effort for normal working hours. So, together we changed our day to day schedule. For example we skipped meetings late in the afternoon. Classes and meetings are held in the morning now, and our afternoon meeting ends about five."

Individual business interests in the context of the peer group, for instance the income share of one of the members of a partnership, are easier to deal with and to negotiate than interpersonal relationships. The agendas of meetings of peer groups, especially partnerships, repeatedly hold the theme of the distribution of income. The issue of individual needs concerning the atmosphere of the peer group is not found on the agendas.

8.2.3 Taking care of career

Specialists are not likely to ask a personnel department for advice about their career, neither is coaching by superiors or even peers usual in specialist practice. Specialists have to take care of themselves when it comes to job satisfaction, career or secondary functions. Other negotiators hardly ever play an active role in this.

Specialists telling about their career or job satisfaction relatively often express a feeling of powerlessness, or at least they present their situation as a matter of fact, rather than as a choice. They are members of their peer group, and they have to stay, because their children go to college or because they do not have enough money for switching. Self-employed specialists 'bought' their position in the partnership by paying goodwill, and this financial system hampers specialists in thinking easily about job transfers. Some specialists nevertheless think goodwill cannot keep a specialist a prisoner of a partnership:

"It would be a good thing to get rid of the system of goodwill. But it doesn't keep specialists imprisoned in their partnership now. If things were turning really bad here, I would just leave. If necessary without getting my goodwill back. It is written off already anyhow."

A passive attitude is fairly frequently observed in situations in which specialists express disappointment about their career. They might be expected to start negotiations for new challenges or better conditions, but they do not seem to do so. Five of the specialists in the case studies quite spontaneously expressed unhappiness with their work situation. They did so in conversations in this study, but seemed to be less open about it in their own group. The seriousness of their disappointment varied from "It's a tough job, but I can handle it now. Never mind, I'm in a good partnership. I'm not desperate," to "I'd leave tomorrow. Immediately, without second thoughts. If only I got the chance. I often calculate when I could quit."

For specialists who do show an active attitude regarding their own career and job satisfaction secondary functions in committees or management are important opportunities. Occasionally a specialist is very precise, for instance about wanting to become chief of specialist training. Another option is further training and specialisation, acquiring new knowledge and skills.

Whether active or passive in 'taking care of the career', specialists rarely negotiate openly for their individual interests. In the passive mode they tend to keep silent about it, and in the active mode they create opportunities for new positions and activities, for instance by applying for secondary functions or by acquiring new specialist knowledge and skills.

8.2.4 The role of individual: results from the questionnaire

This paragraph provides a short overview of survey results concerning differences between individual respondents' of different sex and ages. The relationship between respondents' characteristics and their opinions and experiences are discussed in detail in other chapters.

Sex

Women are still a small minority in the specialist population. More than 80% of the respondents is male. More than 60% of the women is younger than 45, while about 30% of the men is younger than 45. Female specialists on average are 43 years old, their male colleagues on average are 50.[1]

The medical specialities hold about 40% of the women in the survey. The supporting specialities have about 35% of the female specialists and 25% of the women work in surgical specialities. A proportion of about 40% of men works in the surgical field. The medical specialities hold 35% of the male specialists and the supporting specialities 25%.

Women more often work salaried than men, about 40% versus 15%. The variants of employment are listed in **table 8.1**.

Table 8.1: Employment per sex, in percentages of male and female respondents

	male (n = 565)	female (n = 103)	total (n = 668)
self employed	76,8	51,5	72,9
combination	5,1	3,9	4,9
salaried	16,3	41,7	20,2
other	1,8	2,9	1,9
	100	100	100

n = 668 (13 missing values)

1 Differences in nominal data are identified by a $p < 0,05$ using Chi-square test or ANOVA.

Respectively 70% and 20% of women and men work part-time. The average amount of working hours in hospital per week is 37 for women and 47 for men. Within the separate groups of full-timers and part-timers men and women do not work different numbers of hours per week (50 and 33 hours per week respectively; see paragraph 5.5 for working hours).

Autonomy reflects the principle that patient care and specialist practice should be performed without interference or control by others. This principle is more strongly supported by men than by women.[2] When asked about desired involvement in decision making, women would like a higher level of involvement than men when the organisation of wards and (outpatient) departments is in question.

Women more often than men feel their involvement in decision making should take place in the context of specialist integration and incorporation into the hospital organisation. Men more often and clearly more strongly than women support the picture of specialists in the lead in hospital and they are less likely than women to expect a replacement of the collective specialist position in staff and speciality group by the formal specialist position in hospital.

Women have less past or present experience than men in secondary functions. Only in professional and national organisations is their participation statistically equal to the participation of men.

Age

On average the respondents are 49 years old. Female respondents are younger than the male respondents, 43 versus 50 years respectively.

The differences between age groups are analysed for two age groups (50 or younger, and 51 or older) and for five age groups (40 or younger, 41 - 45, 46 - 50, 51 - 55, and 56 or older).

The number of women is increasing. Almost half of the youngest group of specialists (40 years or younger) are women. In the oldest group (56 or older) the female proportion is 5%. Sex per age group is given in **table 8.2**.

Table 8.2: Sex per age group, in percentages of respondents per age group

	40 or younger (n = 100)	41 - 45 (n = 136)	46 - 50 (n = 145)	51 - 55 (n = 136)	56 or older (n = 129)	total (n = 646)
male	60,0	81,6	86,2	94,9	95,3	84,8
female	40,0	18,4	13,8	5,1	4,7	15,2
	100	100	100	100	100	100

n = 646 (35 missing values)

The group of specialists younger than 50 consists of more supporting specialists than the group older than 50. The group of surgical respondents is relatively larger for respondents over 50 than under. This is shown in **table 8.3**.

2 Differences in ordinal data are identified by a $p < 0,05$ using T-test or Bonferroni posthoc test for multiple comparison.

Table 8.3: Specialities per age group, in percentages of respondents per age group

	40 or younger (n = 101)	41 - 45 (n = 138)	46 - 50 (n = 140)	51 - 55 (n = 135)	56 or older (n = 129)	total (n = 643)
medical	32,7	34,8	41,4	36,3	34,9	36,2
surgical	35,6	37,7	30,7	40,0	47,3	38,3
supporting	31,7	27,5	27,9	23,7	17,8	25,5
	100	100	100	100	100	100

n = 643 (38 missing values)

Table 8.4 shows that the proportion of self-employed specialists decreases in the younger groups. Specialists younger than 50 hold a self-employed proportion of 70%, versus 80% of the older specialists. In the five age groups the significant difference is found between the youngest (under 40) and the oldest group (over 56) with about 65% and 80% self-employment respectively.

Table 8.4: Self-employed and salaried, in percentages of respondents per age group

	40 or younger (n = 100)	41 - 45 (n = 138)	46 - 50 (n = 143)	51 - 55 (n = 135)	56 or older (n = 128)	total (n = 644)
self-employed	64,0	68,1	75,5	74,8	81,3	73,1
combination	2,0	8,7	4,2	5,9	3,1	5,0
salaried	29,0	21,0	19,6	18,5	14,8	20,2
other	5,0	2,2	0,7	0,7	0,8	1,7
	100	100	100	100	100	100

n = 644 (37 missing values)

The youngest group of respondents, 40 years and younger, holds a proportion of 44% of part-time working physicians, which is connected to the 40% proportion of female specialists in the youngest group, because the significant difference is not found within the group of male respondents. Due to the part-time component the youngest group of specialists is in hospital less hours per week than specialists between 46 and 50 and between 51 and 55: respectively 42 hours, 47 hours and 48 hours per week on average.

The principle of autonomy is more strongly supported by specialists of 51 or older than by younger specialists. The smaller age subgroups do not show significant differences.

Specialists younger than 50 endorse the principle of egalitarianism more often and stronger than older ones. In the smaller subgroups this difference is found between the youngest (under 40) and the oldest group (over 56).

The group below 50 reports a slightly higher level of present involvement in decision making about the organisation of specialist patient care and specialist training than the older group.

As might be expected, the experience in secondary functions increases in higher age groups.

8.2.5 Jurisdictional claims connected with the role of individual

The interests of workplace roles (doctor, peer, department member) may collide with the interests of individual specialists. Individual specialists seem to seek a compromise when this happens in intrapersonal negotiations, and they tend to negotiate when other parties appeal to workplace roles at the individual expense. In the peer group, specialists do not easily negotiate peer relationships, and they are reluctant in openly negotiating for their individual careers. The survey results showed specialists of different sex and different age groups organise their work differently and have different preferences about relationships in the workplace.

The jurisdictional claim connected with the issues discussed here is a personal claim on jurisdiction over the content and the organisation of practice. Specialists wish room for individual and personal needs and preferences in the workplace. This claim is not very loud in day to day work. In the compromises between interests of the role of individual and the role of doctor, specialists slightly tend to favour the latter. They negotiate only reluctantly and covertly for individual preferences and interests when it comes to peer-relationships and career. Specialists might be expected to make their personal interests a bigger issue in negotiations. Apparently professional and organisational interdependencies hinder strong jurisdictional claims on behalf of individual interests.

The survey results for autonomy and integration indicate that men lay a stronger claim on specialist jurisdiction in the hospital context than women. Women seem to claim jurisdiction more often on the level of wards and OPD's. Younger specialists favour equal jurisdiction (egalitarianism) among specialists more often than older ones.

8.3 The role of professional

Specialists in their role of member or representative of the profession, discuss patient care or its organisation in the wider context of politics, the profession of physicians, or their speciality. Because specialists in the case studies were not accompanied outside their daily work in hospital, actual negotiations in this role were not observed. The negotiations, and specialists' opinions about them, were found indirectly, for instance in discussions about the national level.

Negotiators and negotiations

The other negotiators in these matters are external parties (politics, government) and professional parties (professional organisations or scientific associations). In conversations about local and regional situations, hospitals and hospital management are involved.

The number of quotations in this role is too low to be able to find different patterns between specialities. As the negotiations about most of the themes discussed here are not observed directly, the actual aims and tactics cannot be described.

Issues

The three categories of issues related to specialists as professionals concern conditions for specialist work, especially the financial systems, relationships, especially the profession's position in society, and specialist care,

especially developments in patient care processes. These categories of issues reveal three sub-roles of being a professional: being an employee of the health care sector, being a member of the profession of physicians, and being a member of the speciality. Paragraphs 8.3.1, 8.3.2 and 8.3.3 will address these sub-roles respectively.

Paragraph 8.3.4 will present the results of the questionnaire that are related to the role of professional, and paragraph 8.3.5 reveals the jurisdictional claims.

8.3.1 Being an employee of the health care sector: worries about finances

New financial arrangements were being designed and prepared for implementation at national level during the case study periods. This made the specialists in the case studies discuss decision making and the sequence of negotiations of the national specialist organisation and the government, the way fellow specialists deal with preparations, and the impact of the new arrangements all together. The present financial arrangements were discussed as well, since they define the daily situation.

In general specialists do not have great faith in the new system when it comes to their payment, but the present system (lump sum remuneration in local initiatives or variants, see Chapter 2) is not optimum either. The parties negotiating these systems at national level are national representatives of specialists, hospitals, and insurers, and the government and its organisations in health care. Individual specialists reflecting on these matters blame the government for not providing a financial system that follows the rapid developments in specialist care, and for considering to get certain procedures or drugs out of the national insurance system, which might threaten the accessibility of some aspects of specialist care.

They also blame their representatives in national specialist organisations for not being able to change these matters, and for having new systems designed by old specialists:

"This new financial system is defined by specialists who are in the business for a long time. It should be defined by the younger generation!! It won't bring in anything now, zilch, nothing!"

Occasionally, an individual specialist in the case studies is actively involved in negotiations at national level, for instance as a specialists' representative. These specialists seem to bring their representing role into the hospital to inform their peers and fellow members of the specialist staff, and to hear their opinion to take back to the formal moments.

The financial arrangements on national level are the framework for financial arrangements on hospital level. Despite the present structure of a lump sum remuneration, specialists and hospitals still have different perspectives on making and earning money. The negotiations about this do not take place openly and were not observed. According to one of the specialists, the bottom line is:

"Specialists' and hospitals' interests just are not the same. Even different specialities have different interests. But in general, specialists want to do as much patient care as possible and they want to make as much money as possible. Hospitals want to do as little as possible, and keep money in the pocket."

As explained before, the new financial arrangements are based on a system of a kind of Diagnosis Related Groups, DTC's (Diagnosis and Treatment Combination). To get data for the design of this system, all specialists have to keep track of activities in patient care. Some specialists have thought about the potential tips and tricks in this administration, in attempts to get the best fees at the moment the new system is implemented:

"This administration of activities and work holds some strange aspects. We all say we work at least 60 hours a week, but when it comes to the negotiations about the specialist tariff per hour, we only seem to work 30 hours a week. Because the calculations will result in higher fees per hour then. So, if you're smart, you report very few DTC's now, because the tariffs for one DTC will be based on average numbers. The lower the amount of DTC's, the higher the tariff. Then, as soon as the system is implemented, you start reporting as many DTC's as possible. Then you'll really benefit from the high average tariffs!

Well, most specialists don't understand this. They're reporting everything, obediently. And you know, in the end it won't make any difference at all, whatsoever."

8.3.2 Being a member of the profession: relationship with society

This sub-role is defined by the profession's relationship with society. Its inside component, being a member of the profession, regards the inner world of the profession of physicians in general. The outside component, being a representative of the profession, concerns the profession's relationship with society.

Inside the profession: quality of practice

The specialists in the case studies connect being a professional with watching the quality of practice together, and negotiating requirements and quality systems that might support them. Their scientific associations co-ordinate important activities regarding quality norms and standards on a national level, and some individual specialists are actively involved in working groups or committees of their scientific associations. One of them illustrates the fact that negotiations are quite common in groups like these:

"I'm a member of a quality committee in our scientific association. When we were discussing an appropriate title for our committee, one of the options contained 'forum'.So I said: "Mister Chairman, would it not be even more appropriate to use 'arena'?" Mister Chairman was not amused..."

Beside the scientific associations other national organisations are involved in quality control, especially of hospital care. One of the hospitals in the case studies was taking part in a quality accreditation procedure of a national organisation. The specialists here were not very impressed by the way this organisation operated. They felt the essence of quality of specialist care was not captured in these procedures.

Occasionally, during coffee or lunch, specialists discuss other national initiatives, for instance the suggestion of rating individual doctors in a kind of 'Michelin Star system'. The specialists stress the difficulties related to systems like these: "The best doctor will probably have the worst results, because he will get the toughest patients."

The specialists regard the profession's own system of 'visitaties'[3] as a serious quality system. One of the groups in the case studies is preparing a teaching visitatie and puts a lot of effort into getting the practice organisationally in optimum order.

The profession's relationship with society

The outside component of the role of professional, being a representative of the profession, is related with the pact between the profession and society, that is the outcome of negotiations for public trust and the right for self-regulation on behalf of the specialists in return for quality specialist work and accountability on behalf of society (paragraph 3.4).

Both components, inside and outside, are connected. Some specialists in the case studies for instance repeatedly stress the importance of avoiding criticising colleagues in front of patients. Others, however, in the presence of patients phone colleagues of another speciality about their mistakes. The latter may strengthen the patient's trust in the individual specialist, but doesn't support the collective specialist position. This phenomenon might be connected with developments in specialist care, discussed in the next paragraph.

On one of the case study days, two specialists discussed an article in the weekend's newspaper. The article quite elaborately addressed a fight between several specialists and professors over the scientific quality of a research program. One of the specialists in the case study revealed some inside information about a few professors, adding to the suggestion already made in the article, that the story was more about intrigues than about a scientific debate. He concluded:

"These things are so bad for the profession. A story like this should never have been made public in the papers."
KK: "You might expect professors to support the profession's position and to avoid intrigues like these in the first place?"
Sp.: "No! Your expectations of doctors should not be too high. They take care of themselves first, just like everybody else! People really expect too much of doctors.... "

3 The system of 'visitaties' is twofold (see Chapter 2): peer groups who teach residents in specialis training are visited by a team of colleagues every five years; the team judges if the training facilities meet the recommendations of the Central College. This system is co-ordinated by the Specialists' Registration Committee. Peer groups without residents in specialist training are visited every five years by a team of colleagues who assess the circumstances under which clinical practice takes place. This system is co-ordinated by the scientific associations (Van Gennip 2002:212; Lombarts 2003:8).

The specialist thought for a moment and then switched to the outside component of the professional-role:

"People really expect too much of doctors.... Well, actually that is necessary too. Because it is important people trust the doctor. I am very aware of that. I'm never informal with patients, never use my first name. The patient needs a role like that. You should not tell in public that specialists or professors are just people like everybody else."

Newspapers and other media play a role in the relationship between the profession and society, as the aforementioned example illustrates (see also Van Heteren 2000). Not only do they report on doctors and the profession, they also bring the public information about specialist care and knowledge. In the case studies only few patients refer directly to this kind of information. About ten patients in the observations at OPD's (of more than 400 contacts observed) asked something about what they saw on television, five patients asked about information on the internet, and one was reading a PhD-thesis on his condition.

Specialists in the case study feel the status of their profession is lower than it used to be. Because of the availability of information, people are better equipped to discuss their situation with the doctor than in earlier days. The specialists also mention the "spirit of the time". The doctor and the notary are no bigwigs anymore.

8.3.3 Being a member of a speciality: shifts in specialist care

This field of the professional-role is about the content and organisation of specialist care in the own speciality. Themes in general, on national agendas, are the increasing shortages of the specialist workforce, the increasing numbers of female specialists, and the changes in the organisation of specialist training, suggested by a national working group of government and physician organisations.[4] The specialists in the case studies may discuss these themes during lunch, but more often they connect developments in their specialities to changing relationships with other specialities or primary care. Sometimes they suggest a kind of competition or turf battle. Remarks and discussions about this were observed more often in the medical and supporting specialities than in the surgical specialities.

Patient care in the medical specialities for instance is changing, according to some specialists, because of the decreasing quality of general practitioners, at least in the region. This forces specialists to deal with more 'basic' and psychologically oriented problems than before. Patient care in supporting specialities is changing because of shifts between specialities. Anaesthesiologists for instance take over preoperative assessment from medical specialities, and radiologists take over diagnosis from medical specialities and procedures from surgical specialities.

The observed difference between specialists stressing the importance of avoiding criticising colleagues in front of patients, where others in the presence of patients phone colleagues of another speciality to point out their mistakes (see paragraph 8.3.2), might partly be connected with these developments between specialities. The specialists who are keen on avoiding openly criticising colleagues seem to be observed more often in the surgical specialities, and the specialists who in front of a patient discuss a colleague's mistake, or question another physician's treatment, seem to be found more often in the medical and supporting specialities. The connection might be that specialists in medical disciplines feel the competition around them and need to manifest themselves more than surgical specialists. Another factor may be the special doctor - patient relationship in the medical specialities. By phoning another doctor in front of the patient, the specialist reinforces the relationship by proving he or she acts on behalf of the patient. The surgical specialists may feel less threatened: even if supporting specialities become involved in surgical procedures, for instance in vascular surgery, they still join these procedures and at least they have to be around in case something goes wrong and open surgery is necessary.

Specialist care in the supporting specialities by definition touches specialist care of other specialities, hence developments here easily touch other specialities' developments in a kind of turf battle. Occasionally, a specialist is very explicit about competition:

4 In Dutch: 'De arts van straks'

"Internal medicine is like a snail that slows down to turn around a corner! Their diagnostic processes are becoming paralysed by radiology. And they know very well they do all sorts of things that just don't make sense anymore. Feel a bit here, listen a bit there... We should just put four ultrasound machines at the hospital's front door and get an ultrasound of every patient entering there."

Various negotiations are connected with these developments. Partly the developments are gradual, almost without recognisable transactions. Sometimes, as shown in the aforementioned quotation, specialists take position and may try to stimulate competition between specialities. Negotiations, for instance between different specialities and the hospital board, take place when developments result in changing activities that require a change of budget.

8.3.4 The role of professional: results from the questionnaire

Being an employee of the health care sector or a member or representative of the profession gives specialists a formal role when they represent their profession in a national organisation within health care or within the profession. Therefore the survey asked for the secondary functions of active membership of a board or working group of a national organisation in health care or in the profession.

The third aspect of the professional-role links the specialist to his or her speciality. To illustrate this aspect, the different results of respondents of different specialities will be summed up here.

Health care: national organisations

Almost 30% of the respondents reported having experience as an active member of a national organisation in the profession or in health care. Almost 25% were active members at the time of the survey. About 8% said to think about becoming an active member of a national organisation.

Table 8.5: Active in a national organisation in health care, in percentages of respondents

	percentage
active now (not in the past)	19
active now and in the past	4
active in the past (not now)	9
thinking about becoming active in the future	8
no experience, not thinking about it	60
total	100

n = 657 (24 missing values)

Self-employed specialists report more often than salaried specialists having been an active member of a national organisation in the past.

Active members of national organisations report a higher involvement in decision making about the organisation of wards and (outpatient) departments. They also show a different pattern of activities than the other respondents. They spend more time on supervision and training (8% versus 5%), on research and education (7% versus 6%), and on organisation (11% versus 9%). They get this time by spending less on individual patient care (61% versus 66%).

The profession: scientific associations

Almost 40% of all respondents have past or present experience being an active member of one of the scientific associations; 30% of all respondents is an active member at the moment of the survey. About 10% think about becoming active in the future. Salaried specialists are more often found to be an active member than self-employed specialists. Table 8.6 shows the percentages.

About half of all chiefs and deputy chiefs of training are active members versus 28% of the other specialists. The active members of scientific associations show less support for the principles of autonomy and egalitarianism than the other respondents. They report a higher level of present involvement in decision making about specialist care and specialist training, and they want this more often in a context of specialist integration and incorporation into the hospital organisation.

They also show a different pattern of activities than the other respondents, which is similar to the pattern reported by respondents in active memberships of national organisations.

Table 8.6: Active in a scientific association, in percentages of respondents

	percentage
active now (not in the past)	26
active now and in the past	5
active in the past (not now)	12
thinking about becoming active in the future	10
no experience, not thinking about it	47
total	100

n = 657 (24 missing values)

Speciality

Throughout this thesis the three categories of specialities have been compared. This subparagraph once more gives an overview of differences between the specialities.

The proportion of female surgical specialists (10%) is smaller than the female proportion in medical and supporting specialities (about 20%). Table 8.7 presents the percentages of men and women per category of specialities. This causes the mean age of surgical specialists to be higher (49) than the age of supporting specialists (47).

Specialists in medical and supporting specialities are more often salaried (approximately 25% and 30% respectively) than in the surgical specialities (10%).

Table 8.7: Sex per speciality, in percentages of respondents per speciality

	medical (n = 231)	surgical (n = 249)	supporting (n = 163)	total (n = 643)
male	82,3	90,4	79,8	84,8
female	17,7	9,6	20,2	15,2
	100	100	100	100

n = 643 (38 missing values)

Respondents in the three speciality groups have different patterns of activities in hospital. Surgical physicians spend more time on individual patient care and less on care related activities than medical and supporting physicians. They also report spending relatively less time on organisational activities than supporting specialists.

Physicians in medical specialities are more likely to prefer a decrease of the proportion of individual patient care than surgical and supporting physicians. Medical physicians more often would like to have more time for research and education than surgical physicians. Specialists in medical and surgical disciplines express a bigger desire for a cutback in time spent on care related activities than the supporting specialities.

Surgical specialists endorse the principle of professional primacy more often and stronger than supporting specialists. Surgical and supporting specialists report more support for autonomy than respondents of medical specialities.

The surgical specialists report a lower present level of involvement in decision making about the organisation of wards and (outpatient) departments than their medical and supporting colleagues. They also express less desire for involvement. Medical specialists experience a higher present level of involvement in decision making about the organisation of specialist patient care and specialist training than surgical specialists.

Integration and incorporation of specialists into the hospital organisation is supported less often by surgical specialists than by supporting specialists. The idea of specialists in the lead in hospital is supported by them more often than by medical specialists.

Specialists in supporting specialities have less experience in being a board member of the specialist staff than medical and surgical specialists, they also have less often experience in being a member of a staff committee.

8.3.5 Jurisdictional claims connected with the role of professional

Being a professional puts the specialist in the wider contexts of health care, the profession, and the specialities. In the case studies the professional-role is observed only indirectly, in specialists' remarks and discussions about transactions and developments. This has to be taken into account before the following jurisdictional claims are allowed to emerge from the data, again in three subparagraphs

Jurisdictional claims in the health care sector

Individual specialists, employees of the health care sector, do not have any jurisdiction over national matters in the financing of health care, and most of them can only worry about the impact of the planned changes. Incidentally a specialist indirectly suggests a jurisdictional claim on the DTC preparations, by 'strategic administration', but this does not seem to be worked out collectively (see also Crommentuyn 2002). Since formal national representatives of specialists are not being accompanied in the case studies, their jurisdictional claims cannot be identified there. Presumably they lay jurisdictional claims on the organisation of specialist work, on information about specialist work, and on specialists' interests in the financial systems in health care and specialist care.

The survey results show that active members of national organisations do not report different principles about the organisation of specialist work.

Jurisdictional claims in the profession

The professional-role in the context of the profession of physicians has an inside component, being a member of the profession, that the specialists in the case study relatively often connect with designing and using methods for quality control of specialist practice and patient care. This is needed for being representatives of the profession, for the profession's relationship with society.

The profession's jurisdictional claim in society is a claim on self-regulation. This is reinforced by the specialists who take their own system of visitaties more seriously than other systems, initiated outside the profession. By reporting support for autonomy less often, support for integration more often, and more involvement in decision making about specialist care and specialist training, active members of scientific associations seem to lay a more moderated claim on specialist jurisdiction in the hospital context than other respondents. Jurisdiction over specialist care and specialist training seems more important to them than specialist jurisdiction per se.

Jurisdictional claims in the specialities

In the context of the specialities the jurisdictional claims are linked to the content of specialist care. Specialities seem to compete, and touch each others jurisdictional claims. The patient care processes in supporting specialities by definition are intertwined with other specialities' processes, and developments here easily cause new jurisdictional claims, at the expense of specialities now having these jurisdictions.

The medical specialities report being forced to widen their jurisdictions on their border with primary care, but this is hardly a jurisdictional claim. To the contrary, Chapter 6 showed the specialists' emphasis on entrance control, and their reluctance to adopt problems and patients that might jeopardise the careful composition of their portfolio.

Shifting jurisdictional claims on the content of specialist care are less often discussed in the surgical case studies than in the medical and supporting case studies.

The survey results show respondents of different categories of specialities organise their work differently and have different preferences for relationships in the workplace.

By their preferences for involvement in decision making, and for the specialist role in the organisation, medical specialists seem to focus their jurisdictional claim on specialist patient care and specialist training, and on the organisation of wards and OPD's, rather than on wider specialist jurisdiction in the hospital organisation.

By their endorsement for the principles of professional primacy and autonomy, the surgical respondents lay a claim on specialist jurisdiction in hospital.

Supporting specialists seem to focus their jurisdictional claim on the level of wards and departments. They rather favour integrated jurisdiction in hospital than exclusive specialist jurisdiction.

8.4 Conclusion: specialist roles defined by relationships outside the hospital

This chapter regards the question about the nature of negotiations specialists are involved in from different roles defined by relationships outside the workplace, and the jurisdictions specialists claim from the perspectives of these roles.

Although the roles are defined by relationships outside the hospital, they do affect the negotiations in day to day work inside the hospital,

The role of individual is defined by the specialist as a person who needs to balance individual and private needs and expectations, and work related needs and expectations, sometimes being the representative of the private context or the personal needs. The role of professional is defined by the specialist as a member or representative of the profession of physicians and of the own speciality.

The role of individual

The first category of negotiations specialists are involved in as individuals are intrapersonal negotiations. Specialists quite often need to weigh personal interests against interests they have to take into account from the perspective of workplace roles, especially the role of doctor, peer and department member.

The second category of negotiations concern the individual specialist's peer-relationships. Specialists find themselves daily amidst peers. In their personal interest, specialists of course care for good relationships. They are vulnerable in

this respect, because the interdependence between peers is high, and conflicts and irritation quite easily develop.

The last category of negotiations is for a specialist's career. Specialists have to take care of themselves when it comes to job satisfaction, career or secondary functions. Negotiations seem to take place only covertly and indirectly. Open discussions about career plans are unlikely to happen.

The survey shows individual specialists of different sex and age have different patterns of preferences and activities. Future specialists may be expected to gradually adopt the idea of specialists integrating and incorporating into the hospital organisation. Women support this view more often than men, and younger specialists support autonomy less strongly than older ones.

Women more often work part-time and salaried than men. Their growing proportion will change the present dominance of fulltime and self-employed specialist practice.

The jurisdictional claim connected with the individual-role is a claim on room for personal needs and interests. In day to day work specialists do not express this claim very loudly. In negotiations they tend to compromise or give up individuality on behalf of other roles and they negotiate only reluctantly and covertly for individual interests.

This might seem an unexpected conclusion, since specialists are publicly caricatured as being 'loud' about their interests and negotiating these fiercely. These fierce negotiations, however, are about collective interests of income and other terms of employment. Negotiations for individuality and for personal interests are something else. These are difficult, because the group interests are too important to be jeopardised by individual needs.

The role of professional

This role is largely played outside the hospital, and can be described here only on an indirect basis.

The first aspect of being a professional makes specialists employees of the health care sector, where financial arrangements are designed by government and specialists' representatives. Incidentally an individual specialist in the case studies is actively involved in negotiations on a national level, for instance by being a representative in negotiations at a national level. The survey shows that specialists who are active members in a national professional organisation do not have other preferences from other specialists. They do spend their time differently though: less on individual patient care and more on supervision, research, and organisation. The other specialists may discuss the negotiations taking place, but the jurisdictional claim on decision making about the financial systems in health care and specialist care can only be fought for by formal representatives.

The second aspect of being a professional makes specialists members of the profession (inside component) or representatives of the profession (outside component). On the inside, specialists watch the quality of specialist practice together and negotiate requirements and quality systems that might support them. The outside component of the professional-role is related with the pact between the profession and society, that is the outcome of negotiations for public trust and the right for self-regulation on behalf of the specialists in return for quality specialist work and accountability on behalf of society.

Specialists formally take part in negotiations on the inside when they have secondary functions, for instance in quality working groups of their scientific associations, or when they participate in the peer system of visitaties. The survey shows that specialists who are active members of a scientific association less often than other respondents support the principles of autonomy and egalitarianism. They also feel more often that specialists should be integrated and incorporated into the hospital organisation.

Informally, specialists discuss quality systems at lunch or on other occasions. All specialists also take part in negotiations on the outside, because they represent their profession in every patient contact. The jurisdictional claim worked out from the professional role is the collective claim on self-regulation.

The last element of being a professional makes specialists a member of his or her speciality, in which the content and organisation of patient care develop. Especially in the medical and supporting specialities these developments touch other specialities. The jurisdictional claims are linked to the content and expansion of specialist care and processes, and specialities seem to touch each others claims here.

Table 8.8 shows the characteristics of the negotiations and jurisdictional claims from the perspectives of the roles discussed in this chapter.

Table 8.8: Negotiations and jurisdictional claims in roles defined by relationships outside the hospital

	individual	professional: employee of health care sector	professional: member or representative of profession	professional: member or representative of speciality
negotiations about	colliding interests from the perspectives of the individual versus other roles peer relationships job satisfaction and career	financial system administration of DTC's	inside component: - quality of practice and the way quality of practice is watched / protected outside component: - public trust and autonomy	patient care shifts in jurisdiction in patient care
negotiators	'intrapersonal': specialist negotiates with him- or herself peers patients	politics government hospitals and management	inside: - fellow professionals outside: - patients (individual specialists) - government / hospital media (collective)	(colleague specialists of) other specialities
tactics	compromise negotiations flight / surrender (avoidance)	[not observed directly; presumably negotiations]	negotiations coalitions (avoid public criticism)	expansion / shift in a rather gradual development
jurisdictional claims	- personal jurisdiction over the content and the organisation of practice - men: specialist jurisdiction on hospital level - women: specialist jurisdiction on level of wards and departments	[not observed directly; presumably claims on the organisation of specialist work, information about specialist work, and on specialists' interests in the financial system]	- collectively: claim on self-regulation - specialists who are active in scientific society: claim on jurisdiction over specialist care and specialist training more important than specialist jurisdiction per se	jurisdiction over patient care, developments on the boundaries of specialities cause jurisdictional collisions

References Chapter 8

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Empirical epilogue

Introduction

The negotiated order of specialist day to day work was presented in various pieces in the chapters of Part 2 of this thesis. As seen in the empirical prologue, real life is not structured in orderly pieces. In the many moments of day to day work different roles are connected with different, sometimes conflicting stakes. Specialists also often face various tasks and responsibilities, in need of time and attention simultaneously. And parties around them may pressure them to take more tasks. One of the specialists in the case study:

"Too often I hear: "You specialists can take up this too." Sure, technically we can do a lot of things. I can perform surgery, but give me a swab and I can clean your floors and I also can wash someone's buttocks and I can make a bed... These kinds of things are expected of us way too often these days. Because we can do things, we have to do them."

These situations of 'contesting combinations' were analysed in the case studies. Their occurrence was quantitatively equal in medical, surgical and supporting specialities, but the issues in question are different. This will be illustrated in this epilogue.

The epilogue, like the prologue, does not contain conclusions, because conclusions and discussion will follow in Part 3, Chapter 9.

The empirical prologue, the opening chapter of Part 2, was meant to create a feeling of daily routines in specialists' work. This empirical epilogue, the finishing chapter, is meant to create some insight into the feeling.

Contesting combinations in the medical specialities

In the medical specialities patient care itself is more often involved in moments of contesting combinations than in the other specialities. In the situations in question interests of individual patients or patient care processes compete with the interests of the specialists getting their work organised and their time efficiently distributed over their tasks and responsibilities.

In some of these situations individual patients may be involved. An example from the case studies:

The specialist is paged. He answers the phone: "Yes, but only yesterday he wanted to have an appointment with me, and now he wants to go to the other location? Whatever! I quit. Let him make his own appointments!"
Later he explains this was about a patient for whom he had rescheduled already two other OPD-appointments himself. The patient keeps changing his mind about which hospital is most convenient to reach, forcing the specialist to keep putting off the appointment.

More often the situations affect arrangements for patients in general, for instance when patients can have their blood examined in another hospital (closer to home), while the physician then needs to pay more attention to getting the results.

One of the specialists in the case studies even deliberately had adopted extra tasks in the patient care process. Especially at the OPD, he 'owned' all aspects, including ancillary tasks like addressing forms and prescriptions. According to him, this way patients received better service, for they did not have to walk by the counter after meeting the specialist, "and it is better for the girls as well" (the OPD-assistants).

The specialists tend to deal with moments of 'contesting combinations' by avoiding negotiations and combining all tasks or roles in question. They try to serve all interests at stake, thus they allow the contest to continue. When too many of these moments or situations occur, specialists end them by choosing to grant one task priority over another. They then seem to favour an efficient distribution of their time over the interests of patient care, but only after having tried otherwise. Regarding the efficient distribution of their time, most specialists try to keep control over time and attention by choosing between tasks or by prioritising. If somehow, this is not possible, the multitude of items can quite easily create stress or at least frustration:

"Usually it's around this point in the consultations that steam starts to come out of my ears. Take yesterday for instance. One of the ward co-ordinators gets here to tell me he's closing the ward for admissions. Afterwards I got a lot of phonecalls about it. I had to do some procedures before the OPD, but I was paged all the time and then one patient brought a file the size of a book. Finally I started the OPD-program three quarters of an hour late."

In short, physicians in the medical specialities seem to meet contesting combinations relatively often in the field of patient care, where the interests of patients and patient care processes are at stake. This may reflect the nature of work in patient care, in its dominance of reasoning and in its importance of the mutual patient-doctor ownership.

Contesting combinations in the surgical specialities

The situations of contesting combinations in surgical specialities relatively often involve the style and way of patient contacts, especially at OPD's. One of the surgical groups does not want waiting lists for their patients, and they want to keep a high output. Sometimes this principle causes very tight OPD-programs, with many patients to be seen. A few specialists are bothered by the hurry needed in the patient contacts then. They sometimes create their own way out, for instance by scheduling a patient with a serious illness for an appointment in their own time, at the end of the day or in the evening.

Logistics are found to create contesting combinations as well. Some physicians for example co-ordinate their own OR-program by planning patients for procedures immediately, during OPD-hours. In the teaching hospital the training of residents invites questions too. For example, should the resident be allowed to finish the procedure at his or her own pace, or is speeding up necessary? How can we keep output high and spend time on supervising and training as well?

Apart from logistics, the field of the joint organisation of work in general, is a source of contesting combinations. An example from one of the case studies:

The peer group is considering recruiting two more residents (not in specialist training), to cover the shifts. Whether the hospital will share the costs is not yet sure. A few peers want to continue recruitment anyhow, because they want to avoid having to take the first availability shift themselves. A few others do not want to accept the risk they end up paying the full price for the residents, and they give priority to preventing higher costs for the partnership.

Situations like these require negotiating in the partnership first, sometimes in other contexts later, for instance in a meeting with the board of directors.

The specialists tend to deal with contesting interests by combining them, which requires compromising between tasks, responsibilities and roles. Especially when patients' interests are at stake, the specialists seek ways to prevent prioritising. In the interest of logistics and a smooth daily organisation, incidentally they choose for speeding up procedures by taking over from a resident.

Specialists in the surgical disciplines seem to meet contesting combinations relatively often when the joint organisation of patient care processes is in question. Underlying this is probably the importance of the organisation of logistics and joint decision making.

Contesting combinations in the supporting specialities

Specialists in supporting disciplines, more than elsewhere, seem to be alert to what to spend their time on. In radiology this is more obvious than in anaesthesiology, because requesting physicians tend to invite the radiologist to spend time on ancillary tasks ("Where are the X-rays?", "When will you perform the ultrasound?"), because the number of interruptions is high, and because the content of the speciality itself is very wide. This phenomenon forces radiologists, but anaesthesiologists as well, to be specific about what they are available for, in contacts with requesting specialities, the department, and their peers.

Contesting combinations in the supporting specialities are therefore mainly connected to the distribution of time and attention of specialists, relatively more than in other specialities.

Anaesthesiologists meet relatively more contesting combinations in patient care, for instance at the ICU. Their formal role here is to co-ordinate patient care of the specialities involved. They do, however, become actively involved in decision making now and then.

Their OPD-hours provide other examples. They do not want people waiting in the waiting room for longer than five minutes, so they have to watch their schedule. Sometimes this means they have to hurry patients through the program:

"Sometimes it's difficult to keep pace in our OPD-program. Especially with many patients wanting to discuss an itchy little finger. Working efficiently is not always friendly for patients."

Other themes in the supporting specialities are similar to the themes already discussed in the medical or surgical field, for instance the importance of residents being allowed their own pace, versus the importance of logistics, and the importance of service for patients versus financial interests:

"Many different considerations cause physicians to act the way they do. I don't care for money. And yet I sometimes have financial considerations too. Then I ask a patient to make another appointment for taking a biopsy. In stead of taking a biopsy immediately. That way I can charge twice."

Relationships with other specialities are involved relatively often in moments of contesting combinations in the supporting specialities. This reflects the intertwining of supporting patient care processes with the patient care processes of other specialities.


OPNAME

Part 3 Conclusions and Discussion

9 Conclusions and discussion

9.1 Introduction

Negotiations for specialist jurisdiction occur frequently in specialist day to day work. The nature of negotiation processes does not allow an absolute qualification of negotiations in numbers. In the analysis of the fieldnotes, however, about three quotations per observed hour of specialist work address moments of negotiation (with means of 3,2 in the medical specialities, 3,4 in the surgical specialities, and 2,9 in the supporting specialities). The average number of quotations not addressing negotiations was 10 per observed hour.

Of course this is not a valid measure for the 'negotiations-volume' in specialist work. The number nevertheless reflects that every working day brings a multitude of negotiations.

This final chapter first presents the conclusions about the study in paragraph 9.2. The subparagraphs address the various research questions.

The study presented in this thesis invites discussion about various subjects. Paragraph 9.3 provides reflections on the concepts and theories that were used, and presents recommendations.

9.2 Conclusions

Paragraphs 9.2.1, 9.2.2, 9.2.3 and 9.2.4 answer the various research questions. Paragraph 9.2.5 addresses the main research question.

The validity of this study is discussed in paragraph 9.2.6.

9.2.1 The nature of specialist work in patient care

What is the nature of specialists' day to day work in patient care?

Patient care is at the heart of specialist work, directly related to the knowledge and skills acquired in specialist training. Specialists spend most of their time on patient care, since respondents to the national survey in this study reported to spend 80% of their weekly hours in hospital on patient care: 65% on individual patient care and 15% on care related activities (for example dictating letters, or attending meetings about patient care). They reported to spend 6% on research and 'keeping up-to-date', and another 6% on training and supervising residents and students. About 8% of the time in hospital is left for activities in organisation (for instance attending committees, or making schedules).

Since work in patient care is pivotal in specialists' day to day work in general, it is important to know its nature before other aspects are approached.

The nature of specialist work in patient care was studied by analysing patient care processes, and the organisation of work in day to day patient care: places where work is done, times at which work is done, and persons with whom work is done. The study did not address the quality of content of physicians' work.

First the conclusions concerning patient care processes will be discussed, followed by the conclusions for the organisation of work in patient care, and for logistics. The last subparagraph addresses general conclusions for the nature of work in patient care.

Patient care processes

Three professional acts (Abbott 1988) define specialists' work in patient care processes: the act of diagnosis, the act of treatment, and the act of inference. The act of inference is crucial for professional work. It relates professional expert knowledge to client characteristics, and chance, which makes it the middle game between diagnosis and treatment.

The members of medical specialities cover a wide range of disciplines. The specialities focus on particular organs or disease processes. The disciplines in the case studies were internal medicine and cardiology. The act of inference in the medical specialities is defined by reasoning. Diagnosis and treatment for the individual patient should be connected by a narrative that makes sense in terms of the expert knowledge of the speciality in question.

The members of surgical specialities specialised in operating on particular parts of the body or to address specific injuries, diseases or degenerative conditions. The disciplines in the case studies were general surgery and gynaecology. Generally speaking the technical act of surgery, either in

diagnosis or in treatment, defines work in these specialities. Inference is defined by decision making about surgery.

The members of supporting specialities in general are specialists in applying knowledge and equipment to support medical or surgical patient care. The disciplines in the case studies were anaesthesiology and radiology. Specialists in supporting disciplines have double acts of inference that need to be connected. In a supporting act of inference they offer services or information to the requesting disciplines. In their own act of inference they connect the requests for technical services (for example an X-ray or sedation) with the application of their knowledge and skills.

The organisation of work in day to day patient care

The places where work is done, times at which work is done, and persons with whom work is done were studied to find the characteristics of the organisation of everyday work in patient care. These elements were found to have different accents in the different categories of specialities.

In medical specialities the weekly schedules for times and places of work are defined by OPD-hours, rounds on the ward, and supervision of residents. Technical work with instruments, machines or equipment is limited (more prevalent in cardiology than in internal medicine). In surgical specialities the schedule makes specialists work in the OR and the OPD, and on wards for the rounds. They are scheduled to supervise residents as well. Technical work with instruments and some equipment is an element of surgery processes. The schedules of supporting specialists show the room they are supposed to work in or the equipment they are supposed to operate or supervise. Technical work with machines and equipment is an element in everyday work.

Patients of course are the largest group of persons all specialists work with. Other important groups of persons are peers (same speciality), colleagues (other specialities), and non-physicians in patient care (nurses and assistants).

In medical specialities, more than in other specialities, the relationship between a physician and a patient is defined by a reciprocal 'ownership' ("my doctor", "my patient"). Every doctor refers to patients as "his" or "her", and every doctor highly values physician-patient relationships. In medical specialities, however, these elements are more outspoken and visible than elsewhere. This is, among other things, because relationships are more often long lasting. Doctors and patients may 'grow old' together. Also, the nature of diseases and the nature of reasoning invite subjects of discussion that concern various aspects in life. Medical specialists' working together among each other is characterised by joint reasoning. In co-operation with nurses reasoning is essential as well. Specialists want the nurses to provide information about the patient's bodily functions (parameters) and about the co-ordination of the care process.

In surgical specialities, physician-patient 'ownership' mainly depends on the act of surgery: who operated on the patient is important for the relationship. The essential questions in surgical decision making are quite specific. This gives both conversations with patients and with ward nurses a more matter-of-fact character than in the medical specialities.

Surgical specialists' working together among each other is characterised by joint decision making. Specialists test each others decision making.

In supporting specialities, physicians do not have 'their own' patients (an exception in the case studies: the anaesthesiological sub-discipline of pain management): patients 'belong to' their attending physicians who request support. Often a supporting specialist communicates more intensly about the patient than with him or her.

The importance of making the connection with the process of the requesting specialists is noticeable in supporting specialists' mutual co-operation, defined by joint service. Supporting specialists work closely with each other and with non-physician assistents.

Logistics

In the course of the case studies, the data about individual patient care processes on one hand and about the organisation of work in patient care on the other were found to be intertwined

in many ways. The combined data revealed another important aspect of specialist work: the aspect of logistics. Logistics combines individual patient processes with organisation of work in patient care over time.

Patient care logistics in hospital are balanced when demand and supply in patient care match: the right patient at the right place at the right time, with the right information being available and enough qualified physicians, other workforce and capacity.

Logistics in medical specialities focus on patient contacts. Logistics in surgical specialities focus on patient flows, while physicians in supporting specialities think about logistics in terms of synchronisation with requesting specialities.

General conclusions about the nature of specialist work in patient care

Work in patient care is fragmented. First, because specialists 'process' various patients serially. Second, because specialists have to keep various parallel processes going, as much in patient care as in other work processes. In a consultation with patient X they may be paged about patient Y, or about a meeting with partnership Z.

Because of these serial and parellel processes, specialists' work has many switches.

Only surgery or other longer lasting activities may give a few hours of unfragmented concentration, provided that the pager is answered by someone else and somewhere else.

9.2.2 Negotiations in day to day patient care

What is the nature of the negotiations in specialists' day to day work in patient care and what jurisdictional claims underlie these negotiations?

Specialists are involved in negotiations in patient care from the perspective of the role of doctor, which is the role of seeing and treating patients or being the patients' representative. The role of department member is also important in patient care. This is the role of being a member or representative of a department, co-operating with colleagues, residents, nurses and other workers on the wards and units of the speciality.

The negotiated order in day to day specialist work in patient care in all categories of specialities is defined by negotiations about patient care itself, and by negotiations about logistics in patient care. These themes have different accents in the three different categories of disciplines. The conclusions for each category will be discussed in the following subparagraphs respectively, after which general conclusions are drawn.

Entrance control in medical specialities

The various specialities in hospitals may be compared with different pigeonholes: clients and problems have to be categorised in terms of the functional specialists who serve them (Mintzberg 1983). Allowing, refusing, or expelling patients or problems from the pigeonhole are critical moments in professional work. Especially in the medical specialities the inclusion or exclusion of patients and problems are important subjects of negotiations in patient care itself. This field of negotiations is called 'entrance control', because medical specialists control the entrance of patients and problems into their pigeonhole.

Entrance is negotiated when specialists wonder whether the patient or problem is at the right pigeonhole address. Inclusion, or exclusion and referral is a subject in the act of reasoning about patients and problems. Specialists for example negotiate about who should admit a patient with multiple problems, hence with multiple candidate attending specialities. They also negotiate with patients themselves, for instance about a problem a patient wants to discuss when the specialist thinks it should be discussed with the general practitioner. Discharge from OPD-care may be negotiated with patients as well, when patients want to keep attending but the specialist thinks specialist care is no longer justified.

Specialists are involved in negotiations like these because they want to keep control over the pigeonhole. Underneath the dynamics of inclusion and exclusion lies a test of patient and problem suitability, which connects to a jurisdictional claim on exclusivity. Since reasoning is the act that distinguishes them as medical professionals, they have to be careful with what they reason about. In the interest of their professional status they have to lay a claim on jurisdiction over the entrance of patients and problems into their pigeonhole, so they can control the content of their act of reasoning.

Negotiations about logistics in medical specialities concern planning of patient contacts, continuity of individual patient processes, and availability of information. These negotiations do not reflect a claim on jurisdiction over logistics per se, but over the standards for patient contacts. Specialists want jurisdiction over when a patient should be admitted or seen, organised in frequencies and at times that make sense in the medical process. Furthermore, the continuity of reasoning about individual processes should not be hampered by discontinuity of supply, and hence the information about proceedings must be available on demand. Thus, the negotiations for logistics reflect a jurisdictional claim on the standards for logistics, in the interest of the act of reasoning.

Traffic control in surgical specialities

The distinct field of negotiations in patient care in surgical specialities concerns logistics of patient care. This field is called 'traffic control', because specialists here try to prevent traffic jams. They want to keep patient flows going.

The specialists negotiate with managers and with hospital employees (planning office for admissions) for patient flows, hospital capacity (OR-hours, beds), and information logistics.

They also have many ad hoc negotiations among each other, for example to check or reschedule the planning of procedures, or to weigh the importance of residents' working their own pace against the importance of speeding up. Surgical specialists organise a lot of logistics themselves, and they are always alert to stagnating flows.

One patient usually needs surgery only once. So, specialists continuously need new patients to protect their central act of surgery. The specialists' negotiations for logistics reflect a jurisdictional claim on the logistics themselves, because of the direct connection with the heart of the surgical profession, surgery.

Decision making in patient care is the second field of negotiations in day to day surgical work. Surgical specialists negotiate with peers about diagnosis, treatment, probabilities, and the connection of these aspects with the individual patient in question. Usually joint decision making requires little negotiating. When opinions differ individual specialists claim jurisdiction over the final decision about procedures and treatment for the patients they treat. Also in negotiations with patients, specialists try to hold jurisdiction over decision making.

Position control in supporting specialities

Physicians in supporting specialities by definition support patient care processes of requesting specialists. Within their patient care they negotiate 'position control'.

In the daily rhythm of medical and surgical specialities, physicians may tend to approach supporting specialities as taken for granted. Supporting specialists aim at maintaining or improving their position by continuously reminding the requesting colleagues they have a speciality of their own. This is more obvious in radiology than in anaesthesiology, because of higher numbers of patients in radiology, more 'patient ownership' in anaesthesiology, the surgical recognition of anaesthesiological expertise at the OR, and because of all physicians having some basic radiological skills. Obviously specialists mainly meet requesting colleagues of other specialities in these negotiations.

In their negotiations for position specialists lay a jurisdictional claim on an independent patient care process, including an own act of inference, and they need the requesting specialities to recognise them in this independent professionalism.

Since the processes of supporting specialities by definition are intertwined with processes of requesting specialities, the presence of a field of negotiations about logistics might have been expected. The other specialities again are the party most often met, and negotiations concern the planning of patient care and the availability of information.

Information logistics and ad hoc planning issues are more often the subject of negotiations in supporting specialities than in other specialists. In these negotiations specialists point out a claim on jurisdiction over their equipment, techniques and knowledge. Indirectly this claim is again a claim on independent professionalism.

General conclusions about negotiations in patient care

When it comes to patient care processes, the survey showed that specialists are lead by the principles of professional primacy (patient care itself should provide the standards for

organisation and decision making) and collective autonomy (the profession decides on standards for clinical work and is responsible for quality control). These principles make specialists claim jurisdiction over the content of patient care processes and the logistics of patient care processes. Specialists work out this claim - with different accents per category of specialities - in negotiations in patient care. Their perspectives in these negotiations are those of being doctors (having direct relationships with patients) and being department members (working in patient care in the context of wards and units).

9.2.3 Specialist roles defined by relationships in the hospital

What is the nature of the negotiations in specialists' day to day work from the perspectives of the roles that are defined by relationships in the hospital, and what jurisdictional claims underlie these negotiations?

Day to day work in hospital brings negotiations that are not necessarily related to patient care, because specialists work in relationships within the hospital, other than the relationships with patients. These relationships define four roles specialists can play: being a peer, being a department member, being a staff member, and being a hospital member.

One role in hospital is only played by a few specialists: the role of specialist manager.

Specialists of different disciplines bring different accents to these roles. In general, however, the similarities are stronger than the differences, so conclusions about the roles will be drawn in the following subparagraphs. The conclusions about the roles of peer and department member are taken together, as well as the conclusions about the roles of staff member and hospital member. The specialist managers are discussed separately, after which general conclusions follow.

The roles of peer and department member: 'our own shop'

The roles of peer and department member are more important in defining the negotiated order in specialists' day to day work than the other two roles defined in hospital.

Being a peer is defined by being a member or representative of the partnership (self-employed specialists) or speciality group (salaried specialists). Peers are thus defined as having the same speciality, sharing patient care and the business aspects of their practice.

This role is crucial for being a specialist, since working solo is virtually impossible for specialists. Together they need to cover 24 hours availability for seven days a week. They also need to evaluate each other and to complement each other professionally, since professional knowledge multiplies fast and no one can know everything.

A peer group without a department makes no sense in specialist work. The wards and units and floors provide the specialists with everything they need to work, shaping the actual specialist workplace. The department, in this context, is not defined in the strict sense of a certain part of the organisational structure. When specialists play their role of department member, they are a member or representative of one or several of the wards or units where patient care of the speciality takes place. In the department-role, specialists co-operate with colleagues, residents, nurses and other personnel on the wards or units of the speciality.

The item of relationships and positions is important for day to day negotiations from the perspectives of both roles. Specialists seek confirmation or improvement of position amidst the relationships with people and parties around them. Inside the peer group this is about the individual peer versus the other peers. On the outside of the peer group this is about the situation of the group compared to other groups. Inside the department, specialists care for their position in the relationship with other department members, and on the outside they care for the comparison with other departments, for example in terms of rooms or equipment.

Inside the peer group every specialist wants an equal right of say: the principle of egalitarianism is endorsed by most respondents in the survey. Thus, specialists lay a claim on individual jurisdiction over the content and the organisation of specialist practice. Specialists cannot work out this claim freely, because the peer group's negotiated order serves the group, not its individual members. Individual or personal interests and preferences, especially the ones not

related to business aspects, are rather difficult to negotiate. The circumstances of working relatively close together, being mutually dependent, and tending to avoid open negotiations invite at least occasional irritation about each other. Periods of conflict are difficult to take care of. Most specialists in the survey, however, say they feel at home in their peer group. About 10% hesitate or deny feeling at home. About 20% hesitate or deny being satisfied about the way the peer group functions.

Negotiations from the peer group with outside parties and persons (other peer groups, managers) are about the relative position of the group in the hospital and about the organisation of work, especially finances and output (what are the correct numbers, how should hospital capacity be distributed). In a merger situation the 'other peer group' (the same speciality in the 'other hospital') is an important party in negotiations.

Specialists often refer to their practice as a shop that they own together with their peers. They call it "a nice shop" or, even more important, "our own shop". Underlying the negotiations from the peer group with outside is a shared peer group claim on jurisdiction over the shop: the professional, financial and organisational aspects of specialist work.

Medical specialists seem to find sharing the shop slightly less important than surgical and supporting specialities. The main jurisdictional claims in patient care of surgical and supporting specialities, respectively traffic control and position control, bring more relationships with parties surrounding the peer groups. These relationships cause shared interests to be more obvious than in the medical specialities and to strengthen the importance of jointly acting as co-owners of a shop.

The peer group needs the wards and units of the department to actually start working. So, the specialists' interpretation of their role of department member serves the interests of specialist work from the perspectives of their roles of doctor and peer. The jurisdictional claims specialists make as department members are rather extensions of the ones made by specialists in their roles of doctors and peers than new claims.

As department members specialists negotiate about the organisation of work. First, they want their group to have a leading or at least a decision making role in the context of the wards and units of the department. In other words, they favour management participation at the level of the department. Second, specialists negotiate the organisation of work itself: logistics (rules and regulations for planning and admissions), workforce capacity (residents and nurses), the organisation of day to day work (how to prevent the pager from disturbing work throughout the day), and various other issues (quality of care). They also negotiate working space, and materials and equipment.

Respondents in the survey report a desire for more involvement in decision making about the organisation of wards and units. Medical specialists, having a focus on working in OPD's and on wards, want more involvement than other respondents. For surgical specialist, more than for the other respondents, the principle of specialists in the lead is important for the organisation of departments. They do not need more involvement per se.

The difference between the present level and the desired level of involvement in decision making about wards and units is smallest for respondents from supporting specialities. The last result is in line with history, because the function of head of, for example, the radiology department or the anaesthesiology department was always fulfilled by one of the specialists. In this, they have more historic experience with management participation than other specialists.

Inside the department specialists claim functional leadership, which they need from the perspective of their doctor-role. Although they are not formally or hierarchically 'in charge' of the wards and units, in social negotiations (being 'semi-employers', different relational manners) they try to manifest themselves as superiors of the other members of the departments. Negotiations in relationships with outside persons and parties are defined by the roles of doctor and peer more than by the role of department member. Thus, 'having' a department is more important than representing one. Negotiations in this respect concern merger issues (the merger of departments), reorganisations, and building matters. The jurisdictional claims underlying these negotiations address management, control and conditions, largely determined by the interests from the perspectives of the role of

doctor (organisation of patient care on wards and units) and the role of peer (efficient organisation of work).

The roles of staff member and hospital member: few negotiations

Negotiations from the perspectives of the roles of staff member and hospital member are of little significance for the negotiated order in specialists' day to day work. By definition specialists belong to the specialist staff and to the hospital. The stakes they negotiate for in these contexts, however, are extensions of the stakes defined by being doctors and peers, even more than in the context of the department. The negotiations specialists are involved in as department members are largely coloured by being doctors or peers as well, but this role acquires its own perspective because of the many moments where the department provides the direct context for specialist work.

In day to day negotiations specialists are involved in as staff members or hospital members, the mutual positions or the collective organisation of work are in question. Under the former, the specialists either individually (for example towards hospital employees) or collectively (towards fellow staff members, management and the hospital in general) negotiate for relationships and positions they can 'use' from the perspectives of the other roles. Under the latter, the specialists negotiate (or 'grumble') about the hospital working contexts (scarcity and shortage) and the structural framework.

From the perspective of the hospital-role, specialists claim a special specialist position in hospital, which renders them jurisdiction over the organisation in general. The survey results show specialists feel positive about integration as such. They do not want to be incorporated in the hospital organisation and workforce, yet they do want to be involved in decision making about it. They support the phenomenon of management participation. The claim on jurisdiction - or at least on jurisdictional participation - over the organisation is made on behalf of the roles of doctor and peer: the shop owners need to have a special position in the organisation of the mall.

Specialists only play the 'pure' roles of staff member and hospital member actively when they have a secondary function in one of these contexts, for instance on the board of the staff, or in a staff or hospital committee. Members of staff boards, staff committees and hospital committees all endorse the idea of specialists playing a formal role in the organisation of the hospital more strongly than other respondents, which suggests these active specialists, more than other ones, claim shared specialist jurisdiction over the organisation of specialist work in the hospital context.

The role of specialist manager: a hybrid claim

The role of specialist manager is only played by those who have a formal role in hospital management. In the survey 20% of the respondents reported to be a management participant or specialist manager.

Specialist managers negotiate their position in relationships with managers around them, with the specialists and peer groups in their 'function group', and with managers and departments outside their group. They also negotiate organising work, during which they have to manage issues (dealing with scarcity) and their peers.

In negotiations with 'real' managers they try to support patient care and to prevent management from putting too much financial pressure on work in patient care.

The jurisdictional claim specialist managers seem to base their negotiations on, reflects a hybrid claim. In negotiations with managers they make a claim on jurisdiction over the organisation of patient care from a professional point of view. In 'managing' their peers, they make a claim on jurisdiction over the organisation of specialist work from a managerial point of view.

General conclusions about specialist roles defined by relationships in the hospital

Specialists, either individually or collectively, are alert to what their position is compared to the positions of other persons and parties around them. They also take care of the organisation of their work. These fields define the negotiated order in specialists' everyday work that is not necessarily directly related to patient care. The actual negotiations on these fields are connected to the roles of peer and department member. The peer-role brings its own jurisdictional claims: the individual peer's claim on jurisdiction over the content and the

organisation of specialist practice, and the shared peer group claim on jurisdiction over the shop: the professional, financial and organisational aspects of specialist work. The department-role is visible in negotiations in day to day work, because of the many moments units and wards provide the direct context for specialists' work. The jurisdictional claims specialists work out in this role actually do not stem from the department-role itself. Specialists claim jurisdiction over management, control and conditions on the wards and in the units of the department, which is largely determined by the interests from the perspectives of the role of doctor (organisation of patient care on wards and units) and the role of peer (efficient organisation of work).

9.2.4 Specialist roles defined by relationships outside the hospital

What is the nature of the negotiations in specialists' day to day work from the perspectives of the roles that are defined by relationships outside the hospital, and what jurisdictional claims underlie these negotiations?

Specialists belong to two contexts of relationships beyond the hospital building. As individuals they are persons who need to balance individual and private needs and expectations, and work related needs and expectations, sometimes being the representative of the private context or the personal needs. As professionals, they are a member or representative of the profession of physicians and of their own speciality. Although the roles are defined by relationships outside the hospital, they do affect the negotiations in day to day work inside the hospital as well.

The role of individual: finding compromises

As individuals, specialists have personal interests and ideas about the organisation of day to day work, for example because of the private situation (working hours, breaks, free nights, vacations), or because of personal preferences (working style, time per patient).

These interests and ideas may conflict with interests and ideas that stem from the perspective of other roles, which causes intrapersonal negotiations.

The doctor-role versus the individual-role is the most important cause of intrapersonal negotiations. Specialists usually try to end these in compromises that enable the combination of all interests in question. If compromises are not feasible, the role of doctor seems to 'win' more often than the individual.

From outside, the peers may appeal to the specialist's peer-role, at the expense of the specialist's individual-role. Again, compromising seems to be the favourite reaction, although the individual point of view is defended harder here than in intrapersonal negotiations.

Specialists have to take care of themselves when it comes to job satisfaction, career or secondary functions. Negotiations seem to take place only covertly and indirectly. Open discussions about career plans are unlikely to happen.

The individual specialist needs room for personal and private interests and preferences. Thus, the role of individual is related to a claim on jurisdiction over the organisation of their own day to day work and the own career. Business interests are quite commonly negotiated openly. The personal aspects are more difficult to voice. The interests of patient care (being a doctor) and the shared interests of the group (being a peer) seem to outweigh the 'softer' personal interests. Paragraph 9.3.4 will elaborate this phenomenon.

Future specialists may be expected to gradually adopt the idea of specialists integrating and incorporating into the hospital organisation. Women support this view more often than men, and younger specialists support autonomy less strongly than older ones.

Women more often work part-time and salaried than men. Their growing proportion will change the present dominance of fulltime and self-employed specialist practice.

The role of professional: three levels

Negotiations specialists are involved in as professionals take place on three levels. A specialist is an 'employee' of the health care sector, a member or representative of the profession of physicians, and a member or representative of his or her speciality.

Specialists on boards or working groups of national organisations or scientific associations are the ones formally negotiating the interests at stake in the health care sector. In day to day life, the other specialists can only comment on these negotiations. The preparations for introducing the new financial system especially give rise to

comments. Most specialists are negative about the DTC's and the negotiations on national level.

It is a joint effort of all physicians to confirm or improve the profession's pact with society when it comes to public trust and the right of self-regulation. As members of the profession, specialists watch the quality of specialist practice together and negotiate requirements and quality systems that might support them. The jurisdictional claim worked out here is the collective claim on self-regulation. In the survey, active members of a scientific association less often than other respondents supported the principles of autonomy and egalitarianism. They felt more often that specialists should be integrated and incorporated into the hospital organisation.

Ensuring public trust also requires standards for meetings with non-physicians, especially for meetings with patients. Specialists acknowledge the fact they are increasingly considered to be 'ordinary people'. On behalf of their role of doctor, however, patients should still look up to them, otherwise physicians' advice may risk not being taken seriously.

On the level of the speciality the content of patient care is dynamic. Scientific, technological and social developments affect the inside of patient care in one speciality, and the distribution of patient care among various specialities and health care disciplines. Especially medical specialists report a shift from general practice towards their specialist practice, bringing more 'basic' and psychologically oriented problems than before. They regret this, because of their need for entrance control. Patient care in supporting specialities is changing because of shifts between specialities. Anaesthesiologists for instance take over preoperative assessment from medical specialities, and radiologists take over diagnosis from medical specialities and procedures from surgical specialities. These dynamics develop gradually. Actual negotiations occur when shifts in patient care are connected with budgettary shifts. The claims underlying these dynamics address jurisdiction over certain segments of patient care, causing shifts in care. Specialities may touch each others jurisdictional claims, which occasionally makes specialists talk in terms of competition and turf battle about each other.

General conclusions about specialist roles defined by relationships outside the hospital

The roles that are defined by relationships outside the hospital are visible in day to day work inside the hospital as well. Their impact on the everyday negotiated order is limited in terms of the amount of actual negotiations. Still, these roles colour everyday work by providing a background of personal and professional standards. The former for instance makes female specialists work part-time more often than their male colleagues. The latter makes specialists follow professional codes of ethics.

9.2.5 Specialists' negotiations and their jurisdictional claims

What is the nature of the negotiations that define the negotiated order in specialists' day to day work in hospitals, and what jurisdictional claims underlie these negotiations?

Understanding the theme of jurisdiction was the inspiration and motivation for this study, not in its policy context of national decision making and legislation, but in its practical context of specialist work in Dutch hospitals. To summarise the conclusions discussed so far, specialists were found to negotiate jurisdiction over patient care, over logistics in patient care, and over the organisation of their business. They were also found to 'watch their backs' and negotiate their position in relationships with parties and persons surrounding them in hospital.

The nature of the negotiations that really define the negotiated order in specialists' work, and the jurisdictional claims underlying these negotiations are laid down in **table 9.1**.

Taking specialists' day to day work all together, which was done in the empirical prologue and epilogue, reveals that specialists' day to day work is not structured in orderly pieces. Roles and tasks tumble over each other throughout the day. This is a result of the specialists' overall claim on jurisdiction over the organisation of their own work. They have to be available themselves in almost every role, at almost every time, in almost every place.

Table 9.1: The negotiations that define the negotiated order in day to day specialist work

	negotiations in medical patient care	negotiations in surgical patient care	negotiations in supporting patient care
negotiations about:	- patient care itself: ***entrance control*** patients and problems allowed into the pigeon hole - logistics in patient care: planning of contacts, process continuity, availability of information	- logistics in patient care: ***traffic control*** patient flows, capacity, information availability - patient care itself: decision making and evaluation in patient care	- patient care itself: ***position control*** relationship with requesting specialists, the specialists' 'own' position in patient care - logistics in patient care: planning of patients, availability of information
negotiators:	patients GP's (only indirect) other specialities	management nurses, patients employees planning office other specialists	requesting specialists
tactics in negotiations:	organising flight / surrender (grumbling)	organising flight / surrender (grumbling)	organising negotiations fight / expansion
professional orientation / alignment with hospital:	- professional primacy - autonomy (less strongly than other specialists)	- professional primacy (stronger than supporting specialists) - autonomy	- professional primacy (less strong than surgical specialists) - autonomy
underlying jurisdictional claims:	- jurisdiction over the entrance into the pigeonhole on behalf of the content of reasoning - jurisdiction over the standards for logistics	- jurisdiction over patient care logistics to keep the act of surgery going; claim on availability of information - individual jurisdiction on final decision about procedures and treatment, especially when opinions differ	- jurisdiction over an own, independent patient care process, recognised by requesting specialists - jurisdiction over equipment, techniques and knowledge of the speciality

negotiations in the role of peer: inside component	negotiations in the role of peer: outside component	negotiations in the role of department member
- relationships and positions (being ***pals***): relational manners	- relationships and positions with other persons and parties	- the organisation of work: specialist role, organising work (logistics, capacity, time management), space and equipment
- organisation of work (being ***partners***): sharing work and money	- the organisation of work: finances and output	- relationships and positions: within the department and from the department
fellow peers	'the other peer group' hospital / managers financial department other hospitals	department managers fellow members of department 'the other department'
avoiding negotiations form coalitions	form coalitions negotiating organising fight / expansion	organising negotiating
egalitarianism	- positive feelings towards the own group - importance of the 'own shop' will continue, despite 'integration' in hospital	- specialists and managers need to share decision making about the organisation of wards and units
- personal jurisdiction over the content and organisation of practice	- shared jurisdiction over the professional, financial and organisational aspects of work, control over the shop	- jurisdiction over management, control, and conditions, from the perspectives of the doctor-role and peer-role - jurisdiction over patient care: functional leadership in relationships on wards and units

9.2.6 Validity

This paragraph will put the conclusions of the study in the perspective of validity. The study's strengths and weaknesses in this respect were summed up in table 4.7. These factors should be taken into account as well.

First, the results concerning the nature of work in patient care are discussed. Second, the negotiations and underlying jurisdictional claims are addressed in terms of validity. The third subparagraph will outline the internal validity related to the researcher's bias.

Results concerning the nature of work in patient care

The nature of work in patient care, discussed in Chapter 5, was analysed in terms of professional acts for the nature of patient processes and in terms of times, places and persons for the nature of the organisation of work. The case study analysis combined two different disciplines per category of specialities, which made specific details per discipline disappear. For example in the item of persons: patients in gynaecology are always female, which probably colours the patient-physician relationship differently to the relationship in general surgery. Every single discipline has accents like these, as discussed in paragraph 5.5 as well, which creates variants and combinations compared to the results found here. In general, however, the results may be expected to hold in the other disciplines within the three categories of specialities.

The two supporting specialities in the case studies (anaesthesiology and radiology) were the most difficult to combine because of the different characteristics of patient care processes. Since the other supporting specialities are heterogeneous in processes as well, this implies external validity is most limited in the supporting specialities.

The survey results showed various differences between the three categories of respondents for time spent on various activities in day to day work. The external validity may be limited due to the bias of respondents compared to specialists who did not respond. The character of this potential bias is difficult to define. Paragraph 4.3.3 discussed two variants. Specialists interested in organisational and professional aspects of their work might be more liable to respond because they like the survey themes. Specialists fed up with organisational debates might want to respond because they want to air their grievances.

The numbers found for 'chiefs' of peer groups (paragraph 7.2.4)[1] suggest that the 'positive' bias is slightly more likely to have occurred than the 'grievances' bias.

The percentage of time spent on organisational activities (9%) may therefore be a little bit lower in the population of specialists outside the respondents.

Since the study focused on specialists in general hospitals, the results will not apply fully on specialists in university hospitals or in specialised clinics. For example, specialists in university hospitals spend less time on patient care, because they spend more time on training, supervision, and research. The work processes and the organisation of work may have other accents as well, because of the more complex problems patients have, or because of the larger scale organisation.

Results concerning the nature of negotiations and underlying jurisdictional claims

The nature of negotiations in specialists' day to day work and the underlying jurisdictional claims, discussed in Chapters 6, 7 and 8, are coloured by circumstances on national, regional, hospital and group level.

Present national circumstances that apply to the hospital sector in general may be identified as a situation of demand exceeding supply. The negotiations found in this situation would probably not have the same intensity if supply was exceeding demand.

Medical specialists who are in want of work are probably less eager to negotiate the entrance of patients and problems than medical specialists with full wards. Surgical specialists who have plenty of OR capacity available do not need to negotiate traffic. Supporting specialists waiting for referrals probably are careful in fighting for their position in relationships with requesting specialists. The amount of contesting combinations, presented in

1 Based on the assumption that each peer group has one chief, and based on the amount of members per peer group (asked in the survey), a percentage of 22% present chiefs was expected. Since smaller peer groups probably often do not have a formal chief or head, a lower percentage is more likely than a higher one. The percentage of respondents reporting to be chief of the peer group was 24 . This suggests a slight overrepresentation of present peer group chiefs in the population of respondents.

the empirical epilogue, would also be lower in circumstances of more supply and less demand.

Regional circumstances affect the results found in the case studies as well. The peer groups work in surroundings with several other hospitals and peer groups. Despite the large demand, the presence of potential competitors probably increases the specialists' awareness of the peer group's position.

The local situation of the hospital colours a peer group's working circumstances as well. Mergers, reorganisations and new buildings make local relationships tense, which makes specialists more alert to their positions.

Finally factors on the level of the peer group and the peer group members influence the nature of negotiations and the underlying jurisdictional claims. The majority of peer groups in the case studies were partnerships (self-employed specialists), and the majority of peers were men. Salaried peer groups with more women are probably involved in different kinds of negotiations, based on different jurisdictional claims.

The aforementioned factors limit the external validity of the case study results. The internal validity is defined by the study's focus on work processes, from the perspective of work in patient care as well as from the perspective of work in an organisational context. Therefore the case study analysis combined data of two different disciplines per category of specialities, and it combined data of all disciplines per role (doctor, peer, department member, staff member, hospital member, individual, professional). These combinations strengthen the analysis of work processes, but they make specific details per case study disappear. In this respect, the study lacks a systematic cross case analysis.

The survey results are probably slightly affected by the 'positive' bias discussed in the former subparagraph. Opinions concerning feelings towards own group, or feelings towards hospital or integration into the hospital organisation may be more negative in the population that did not respond to the survey.

The validity limitations discussed here do not jeopardise the study's exploratory aim. The results found in this research may not apply in the same extent to every peer group in every Dutch hospital, and the existence of many variants of the patterns found here is very likely. Knowledge of the underlying dynamics, however, may be expected to be of value to peer groups and hospitals anywhere. For the underlying dynamics are more universal than the circumstances discussed in this paragraph. Patient care processes have different accents in different specialities, but the main processes are fairly comparable because of the relative homogeneity in physicians' training and their body of knowledge. Organisational relationships in hospital are coloured by different circumstances, but the main roles discussed here are fairly comparable - at least in the Netherlands - because of the relative homogeneity in organisation of hospitals.

In short, the results presented in this thesis may not hold in detail outside the specialist population involved in the study. The results, however, may help to understand and improve or support the organisation of specialists' day to day work in general.

Internal validity related to the researcher's bias

Throughout the study the researcher dealt with her multiple roles and biases by following the measures discussed in paragraph 4.2.5. The specialists in the study for example received the case reports, reflecting their work in patient care in the five-step model and their co-operation with persons and parties around them. They liked these reports for providing insight in what their processes looked like. Meetings with specialists after the case studies (members' checks) revealed that they recognised the descriptions in the case report and that most of them missed practical recommendations for improvement of their co-operation and organisation. Recommendations were discussed in these meetings.

Appendix 3 reflects the patterns of reactions to the researcher. Her double roles in one of the hospitals (combining work and study) were not criticised, although sometimes she was specifically asked not to give certain information to hospital management. One awkward moment was when she made the mistake of pressing the elevator button for her working floor in stead of for the floor of the clinical department. The specialist she was with at that moment had a good laugh and yelled: "Shame on you! You're not working, you're with me today!"

Paragraph 4.2.5 presented some notes from the researcher's diary, reflecting her feelings about wanting to understand specialists without wanting to belong to them and her doubts about specialists as managers. Two years later, halfway through the case studies, the following diary notes illustrate the researcher's feelings:

"In the mean time, I'm going totally 'native'.[2] Times are hard for specialists, and I feel very sorry for them. I dislike managers and I think specialist management participation is a bad idea. The concept is a way of making specialists co-responsible for managerial failure.
But am I only going native? Going native is what anthropologists do, who will in the end leave the population they are studying. I probably won't leave the world of hospitals, so could my sympathy for specialists be part of a socialisation process? Whatever it is, in my research I have to forget my sympathy for doctors and my dislike of managers again. I cannot allow this changed way of looking and thinking guide my observations. I have to start with a clean sheet."

Wanting to start with a clean sheet is a good intention for a researcher in trying to keep some distance to the persons and situations in the study. Remaining neutral completely, however, is impossible.

Starting the study, the researcher identified with managers more than with specialists, feeling she did not want to belong to the specialist population and thinking specialists in general were not the right persons to be leaders and managers in hospital. Halfway through the case studies the researcher identified with specialists and their work in patient care more than with managers. She felt sorry for the hard work specialists faced, and blamed management for not supporting specialists' work and for dragging specialist managers - some of them adequate leaders after all - into the power game of control. Finishing the study and writing the thesis provided the distance necessary to accept the complexity of roles and relationships in the hospital, and for bringing some structure to this complexity by applying the research framework. If, despite this distance, the internal validity of this structure is coloured by the researcher's bias, the identification with specialists and their work in patient care probably outweighs other potential biases.

9.3 Discussion

Paragraph 9.3.1 will discuss some research issues. Paragraph 9.3.2 presents the discussion about specialists' day to day work, and paragraph 9.3.3 outlines the recommendations. Paragraph 9.3.4 gives the discussion's conclusion.

9.3.1 Research issues

This paragraph first reflects on the theories used in the research framework, then goes on to present further points for research.

Reflection on the theories of the research framework

Analysing professional work processes by analysing the nature of the three professional acts (Abbott 1988) of diagnosis, treatment, and inference was found to be useful in this study on specialists' work in patient care. Adding the simple items of places where work was done, times at which work was done, and persons with whom work was done (Carlson 1951/1991:32) completed the analysis that revealed the essential characteristics of specialist work in patient care.

The study confirmed the idea that social order in hospitals is a dynamic phenomenon. Thus, theories on negotiated order (Strauss 1978, Strauss et al. 1973, Strauss et al. 1985, Van Oorschot 1995) proved helpful in understanding the theme of jurisdiction. Hospitals are a complex context for specialists' work, in which 'order' should be defined as an outcome of continuous negotiations. The case studies showed that specialists, individuals as well as groups, have a large 'position awareness'. The concept 'negotiated order' therefore deserves a twin concept: 'negotiated position'. Order reflects the total outcome of negotiations in a social constellation. For one of the parties participating in the negotiations, the outcome is a position within that constellation, a negotiated position. This outcome at the same time is the starting point for new dynamics in the continuum of negotiated order and negotiated

2 When researchers 'go native' they identify with the persons they are studying and sometimes lose the ability to make critical judgements.

positions. The continuum character of these processes explains specialists' position awareness. They constantly evaluate and compare all positions in the constellation, even when no actual negotiations are going on. Negotiations provide opportunities for improving positions, but these opportunities are often not predictable. Therefore, at any moment in time the relative positions have to be clear, because these are the starting blocks when a run for a better position may suddenly start.

Theories on professions and professionals (Abbott 1988, Wilensky 1964; Dawson 1996:35; Hulst and Schepers 1999; Freidson 2001, Van der Wee 2000) provided the third element of the research framework, for studying the 'structural context' of negotiations. Specialists' professional orientation and their opinions about alignment with the hospital were studied in the case studies and in the national survey. The survey results largely match the conclusions of Van der Wee's study 'Differentiation and adaptation' (2000), which was based on a national survey among specialists as well.[3] In professional orientation she found the same patterns of opinions for medical, surgical and supporting specialists. Medical specialists for instance supported autonomy less strongly than surgical and supporting physicians among the respondents (Van der Wee 2000:136). She also found that Dutch specialists provide support for 'integration'.

In terms of Freidson's control mix (2001), the observations in the case studies revealed a great extent of 'professionalism' in specialists' day to day work in all specialities. 'Managerialism' defines some aspects of the background of everyday work, because management 'owns' the hospital's organisational structure and defines many rules and regulations for policy and financial decisions.

'Management' in this respect not only consists of managers, for the board of the specialist staff is involved in decision making for the whole hospital, the specialist managers are involved in decision making for departments, and 70% of all specialists somehow participate in the organisation by sitting on hospital committees.

Consumerism was mainly found indirectly, with specialists representing patients' interests from the perspective of their role of doctor.

Freidson links the three ideal-typical models of control to different groups of people. Managerialism is linked to managers, professionalism to professionals, and consumerism to consumers. He states that these models do not "mirror the empirical world" (2001:179). The relationships presented in this thesis reveal another kind of link, which does not mirror the empirical world either, but may add a little to understanding it: different control models should not be linked to people, but to different perspectives, each of them providing its own criteria and goals for control and organisation.

Professional criteria and goals (for example professional quality of care, standards, innovation) may be promoted by managers, as well as by professionals, as well as by clients. Managerial criteria and goals (for example efficiency, financial control, leadership) may be promoted by professionals, as well as by managers (clients may be less liable to do so). This idea provides three variants of models for control and organisation in hospital. The 'control perspective' stands for the model in which efficiency and smart organisation provide the criteria and goals for organising work in hospital. The 'care perspective' focuses on criteria and goals that matter for the quality and effectivity of patient care processes. The 'client perspective' reflects the criteria and goals of patients as clients, for instance service and friendly treatment.

All three perspectives are necessary in organising specialists' work and in organising hospital work in general. Negotiating the proper mix of criteria or control and organisation is part of the hospitals' negotiated order of clinical governance.

Clinical governance comprises "the arrangements of command, communion and contract relationships by which authority and function are allocated and rights and obligations established and regulated and through which clinical policies and practices are effected." (Gray 2004:5).

The integrated specialist company (see paragraph 2.5.3) focuses on contract relationships, leaving the communion mode (shared values) and the command mode (who is in charge of whom) largely out of consideration.

3 The questionnaire designed by Van der Wee was used as a base for the surveys in this study.

Thus, the present relationships between specialists and hospitals are characterised by the regulation of functional procedures rather than by an integrated system of interests, values, or command.

The three perspectives for control and organisation may be combined with the three modes of governance. **Table 9.2** tentatively sums up the nine combinations and presents some examples, either from the case studies or in general.

Table 9.2: The combination of perspectives and governance modes

	communion mode	contract mode	command mode
care perspective	*criteria and goals for good patient care are realised because parties involved follow the same values*	*criteria and goals for good patient care are realised because parties involved agree on realisation*	*criteria and goals for good patient care are realised because one of the parties or persons is in charge*
for example:	supporting specialists following a shared frame of reference in patient care	specialist staff and board of directors agreeing about a project for the redesign of patient care	physicians having functional leadership in patient care in relationships with nurses and other personnel
client perspective	*criteria and goals for high client satisfaction are realised because parties involved follow the same values*	*criteria and goals for high client satisfaction are realised because parties involved agree on realisation*	*criteria and goals for high client satisfaction are realised because one of the parties or persons is in charge*
for example:	specialists trying to do everything for the patient in one single OPD-visit	specialists and management agreeing on quality projects for improving patient satisfaction	physicians being subject to evaluation of their functioning in terms of patient satisfaction about them
control perspective	*criteria and goals for a smooth organisation are realised because parties involved follow the same values*	*criteria and goals for a smooth organisation are realised because parties involved agree on realisation*	*criteria and goals for a smooth organisation are realised because one of the parties or persons is in charge*
for example:	peers sharing their financial interests	specialists and hospital management agreeing on annual output and finances	"The past was better. The specialist was in charge, kept his own shop. Everybody had to do what he told them to."

Even combinations of 'perspectives' and 'governance modes', as presented in table 9.2, do not mirror the complexity of real life processes, for many situations need to be approached from more than two angles. For example, surgical specialists who take care of logistics in patient care try to organise flows of patients in an efficient planning system (control perspective) that takes urgency (care perspective) as well as the patient's preferences (client perspective) into consideration before planning procedures. Surgical specialists would probably want to adopt a command governance mode in organising this, since they tend to support a chain of superior and subordinate authority, with themselves in superior position. They also need to negotiate hospital capacity (contract mode) with management. Among themselves (communion mode) they have to decide about the balance between output (control perspective) and time per patient (client perspective).

Reality is hard to fit into a two-dimensional table of concepts. Using the combination of perspectives and governance modes is nevertheless more complete than using only one of these angles.

Further research

Further research of specialists' work in hospitals should proceed with the separate analysis and comparison of work in medical, surgical, and supporting specialities. Patient care processes in different specialities have different characteristics of content and organisation, which deserves to be analysed and treated separately.

This thesis analysed processes in patient care 'cross sectionally' and from the specialists' point of view only: different moments in different processes were studied sequentially by observing specialists' work. It might be worthwhile to follow complete processes in patient care, to get a more complete picture of the nature of work processes in different specialities. This requires another kind of research design, in which for instance patients are followed in stead of specialists.

Comparable to the analysis of work in patient care, the negotiations specialists are involved in in patient care and from the perspectives of different roles were analysed 'cross sectionally' as well. This picture presents only one side of the negotiations in the hospital context. It might be completed by following complete processes in which negotiations occur. This requires a design that, for example, focuses on decision making processes in hospital. A research framework for this analysis might combine the negotiated order with the 'garbage can' model for decision making (see paragraph 3.2). All parties involved in decision making should be taken into account.

Special attention should be given to the combinations of perspectives and governance modes, presented in the former subparagraph: what kind of criteria define decision making, who promotes these criteria, and what kind of governance mode seems to be used?

As discussed in paragraph 9.2.6, this thesis did not contain a systematic cross case analysis. Therefore another suggestion for further research recommends a study that focuses on comparing negotiations in different circumstances: different kinds of peer groups, hospitals, maybe different countries.

Finally, this thesis may be considered a source of hypotheses to 'falsify'.[4] **Table 9.3** gives a few examples.

4 An hypothesis cannot be verified (shown to be true), whereas it can be falsified (De Groot 1969:127).

Table 9.3: Examples of hypotheses to 'falsify' in further research

Medical specialists discussing patients among themselves reason about diagnosis and treatment more often and longer than surgical and supporting specialists.
Surgical specialists on average see more new OPD patients than medical specialists.
Medical and supporting specialists more often than surgical specialists criticise other physicians in front of patients.
Nurses on surgical wards can predict what the specialist will ask during rounds better than nurses on medical rounds.
Supporting specialists are more strongly embedded in the culture of their department than medical and surgical specialists in the culture of their wards and units.
Medical specialists negotiate with patients more often than surgical specialists.
Specialist managers more often use managerial criteria than professional criteria in their organisational work.

9.3.2 Discussion about specialists' day to day work

Chapter 3 mentioned the article 'Why are doctors so unhappy?', that made many physicians from many different countries react. Smith (2001) explained about the 'bogus contract' between the physicians and society, resulting in false positions in the relationships between individual doctors and patients.

This thesis was not about the happiness or unhappiness of Dutch specialists, it was about their day to day work. When asked about their work, most specialists react enthusiastically about their discipline. They love their patients, the variety of the day, the techniques they use, and the skill they develop. Asked whether they find their work hard, most of them deny or avoid a direct answer: "It's not hard, but I am tired after OPD-hours though", "No, but I do have a high blood pressure", "The shifts make it hard", or "Patient care in itself is not hard, but I'm more and more afraid of complications happening." Only occasionally would an individual specialist in the case studies spontaneously express real unhappiness at work.

Some spontaneous remarks on the questionnaires referred to other feelings of unhappiness as well, for example:

"A frightful lot of burnout among colleagues, because they can no longer influence their work situation meaningfully or positively."

An additional conclusion of this study is that many specialists do find their day to day work hard now and then. The case studies (five unhappy specialists out of 51) and the survey (10% do not feel at home in the peer group) show that about 10% of the specialists are more or less unhappy. Articles about Dutch specialists feeling burnout or feeling stressed report higher percentages, but these feelings are not exactly similar to being unhappy (Pool 1998, Smets et al. 1999, Van Rooijen 2002, Van Rooijen et al. 2002; see also Elsendoorn et al. 1998, Ankoné 1999, Lutke Schipholt 2000 and 2003, Visser 2003).

The remarks about specialists' work being hard or about specialists being unhappy, on the questionnaires as well as in the conversations in the case studies, were often combined with blaming hospital management, government and politics, and - to a lesser extent - the national specialists' organisation for allowing specialists' work to become increasingly hard. What makes it so hard is a matter of multiple explanations (articles mentioned before). Three factors emerged from the analysis in this study: the nature of specialists' work, the 'regulated specialist arena', and the dominance of the group versus the individual. These factors will be discussed, after which the recommendations of this study are given.

The nature of specialists' work

Specialists' work, especially in patient care, is demanding and 'greedy.'[5] Processes in patient care increasingly require co-operation between physicians themselves and between physicians and other workers, which calls for more standard practices. Quality of care also calls for standard practices. Specialists' work is fragmented, because they 'process' various patients and tasks serially, and they have to keep various parallel processes going as well. Thus, specialists switch roles and tasks many times a day. The pager (or the mobile phone) both organises and symbolises the multitude of specialists' tasks and roles. The weekly schedule organises some accents in daily work, especially in patient care, but it does not prevent other tasks or roles from entering as well. Being available for every role or task at any time enables specialists to protect their jurisdiction, and to organise their own work, which is what self-management is about. Self-management, however, at the level of the individual specialist, sometimes gets down to managing yourself through the daily fragments of work, largely led by the weekly schedule, the standard practice, and the pager. In this respect, specialists seem to surrender to the rhythm of the day and to the work that calls for attention. Grumbling is a reaction that was very often observed in day to day negotiations (see appendix 2 for an overview of numbers), because the surrendering attitude can gradually wipe out feelings of personal control.

The regulated specialist arena

Schaaf (2000:257) suggested that the phrase 'regulated specialist arena' might be more appropriate than 'integrated specialist company'. This thesis showed that specialists indeed work in an arena of relationships and that they watch their back to prevent losing position there. All relationships, between specialists themselves as well as between specialists and management, are laid down in documents, but in real life these papers do not create a safe haven for specialist work and specialists. Overall, colleagues from other specialities are the negotiators most often met in day to day work, with managers coming in second (see appendix 2). Negotiations define the order specialists work in, and negotiating work and interests on a day to day basis may gradually intensify feelings of being threatened.

The group versus the individual

Students and young doctors acquire a professional identity in a process of socialisation in education, internships and residencies (Shapiro 1988). Being a specialist requires "the specific combination of knowledge, skill, temperament and ethos, necessary to function correctly" within the group of specialists (Keizer 1997:280). The peer group is conditional for functioning. Working solo is hardly possible anymore, for professional reasons (covering various areas within the speciality, evaluating and supporting each other's work in patient care) and for organisational reasons (covering 24 hours seven days a week and a multitude of tasks in patient care, training, and organisation).

The peer group is the context for promoting business interests as well. Specialists' incomes are defined by a complex set of formulas and the rules have been changing since the eighties of the last century. External insecurity about income provides the group its importance for the promotion of interests.

The importance of the peer group may gradually wipe out feelings of individual importance.

Taking these three factors together, specialists' work consists of a multitude of tasks and roles, sometimes tumbling over each other throughout the day. They work in arenas of relationships in which they have to watch their back to prevent losing position. Sharing work with peers in this arena is essential for professional and organisational reasons and for business interests. The importance of the relationships in the peer group makes individual specialists avoid voicing their personal preferences.

9.3.3 Recommendations and further discussion

This study gives rise to three groups of recommendations and further discussion. The first group addresses both specialists and managers. The second group of recommendations addresses specialists as individuals and as groups. The last category addresses managers in hospitals and health care.

5 A moderate form of 'greedy' in the sense of 'greedy institutions', which "make total claims on their members and which attempt to encompass within their circle the whole personality" (Coser 1974:4).

Recommendations for specialists and managers: how to organise work in a negotiated order

The first recommendation is to develop the 'care perspective' and the 'client perspective' together. As discussed earlier in this chapter, the integrated hospital company is based on the contract mode of governance. This focus deserves a countervailing power from the communion mode, introducing shared values for all persons and parties in hospital. The care perspectives and the client perspective, discussed in paragraph 9.3.1, imply that organisation and control are defined by patient care and patients' criteria. Hospitals' core business is patient care, and all groups in hospital, managers, specialists, nurses, and other persons and parties, are recommended to grant these perspectives priority. This means patient care processes, and the needs and demands of patients, should define the criteria that are used to make decisions and to evaluate or change work in the hospital.

Of course the 'control perspective' should not be wiped out. Financial control and other managerial aspects, are conditional for the organisation. These processes, however, are ancillary to patient care, and this relationship should be recognised. Choosing these perspectives does not mean that physicians and nurses or other carers are more important than other workers in hospital. Every party has its own knowledge and skill, together they form a collective that aims at patient care and patients.

The second recommendation is to respect the differences between specialities and categories of specialists. The suggested development of the care perspective and the client perspective should be based on the nature of work in patient care. Processes in patient care are different for different specialities, and so are patient populations. This variety should be visible in the organisation of patient care, in the ways of specialist participation, and in clinical governance.

Many specialists in medical specialities for example may feel well in the communion mode of governance, since they are used to constructing narratives together, sharing knowledge and values among each other. Specialists in surgical disciplines tend to favour the command mode of governance, because this mode fits in well with their rather clear-cut style of decision making in patient care processes. Many physicians in supporting specialities may like the contract mode, because they are already used to 'bargaining' with the requesting specialities about their share in patient care processes.

Whatever the favourite mode of governance may be, medical, surgical and supporting specialists all want to be involved in decision making in the hospital differently, because they have different needs shaped by the perspectives of their patient care processes. Specialists do not form a homogeneous group, and patient care is not a homogeneous process. Specialists and managers should respect this and build in room for differences, for instance in the design of management participation and of management in general. They should also be aware of the 'blind spots' specialists of different specialities have for certain subjects or for ways of communication.

Developing the care perspective and the client perspective, with respect for the differences between specialities, should take shape in the context of the wards and units of the department. The third recommendation, therefore is to respect and develop the natural specialists' context of the department. The department with its wards and units is the organisational level closest to specialist work. The specialists' role of department member, now an extension to serve the roles of doctor and peer, deserves to be strengthened by choosing the department perspective for designing specialists' work processes. Processes that are already going on, for instance the implementation of evidence based medicine, task substitution from physicians to nurses, and 'business process redesign' in patient care may support this (Shortell et al. 2001). Specialists from different specialities should design the new department-role 'made to measure'. This way the slightly paradoxical desires found in the survey may be fulfilled: obtaining more involvement in decision making at the department, without having to spend more time on organisational activities.

The fourth recommendation concerning the organisation of specialists' work in the context of the hospital is that specialists and managers should accept the limitations of the 'integrated company' and of management participation. As discussed in paragraph 2.5.3, Dutch

hospitals may be regarded as integrated specialist companies. This does not mean interests are integrated as well, as was shown throughout this thesis. Specialists and managers have different interests, and different specialities have different interests as well. The care perspective, the client perspective and the control perspective by definition cannot blend. They complement each other. The concept of 'integration of specialists into the hospital organisation' is therefore a kind of contradiction in terms. Its present structure in Dutch hospitals, with specialists finances (partly) integrated in the hospital arrangements, and with specialists participating in management, is probably 'integration' at its best.

Specialists' participation in management does not make competing interests disappear. It seems to strengthen the control perspective without fundamentally hurting the care perspective, and specialists in general seem to value this.

The direction of integration, however, tends to be slightly away from the care perspective and into the control perspective. Specialist managers should therefore be invited to aim the direction of integration back into patient care as well. Of course they are very welcome to bridge a gap between specialists and management, but they should walk this bridge back and forth a lot. Think about the annual budget, and about policy plans, but try to start thinking about these matters from the care perspective and the client perspective. Take the initiative in clever 'agenda management' or try to start a discussion on process redesign. Specialist managers can not be expected to walk this bridge alone, though. Specialist participation in committees is intense, and this kind of participation should be valued as important means of involvement.

Some training in the features of the hospital management may be helpful for all specialists. In terms of priorities, however, some training in organising their own work and their own time is more important for specialists' day to day work than a training in hospital management in general.

Recommendations for specialists: how to work in a negotiated order

This category of considerations starts where the former category ends. The first recommendation for specialists who want to organise their own work and their own time is to accept and respect the hospital as a negotiated order and to learn to play the games of give-and-take, of diplomacy, of bargaining (Strauss 1978). Specialists should acknowledge the multitude of roles they play, and they should be aware of the different loyalties connected with these roles. Respecting the various interests, sometimes contradictory, is one of the rules of the game. Respecting other persons and parties having interests that may be different from one's own interests, is another rule. Balancing all interests, and sharing scarcity in the negotiated order should be a skill that is taught in specialist training, maybe even in physician training in general.

If persons and parties in hospital stress negotiation, in stead of order, they may capture each other in their attempts to get as much as possible, freezing all professional development. In fact, accepting the art of balancing will enhance the innovative potential of separate specialities and of co-operating specialities. Supporting specialities for example want to be recognised as autonomous professions. Following this need as much as possible might lead to a tendency to leave the hospital and to establish separate centres, for instance for radiology. In the long run, however, being separated from requesting specialities hampers the act of double inference (reasoning about the proper technique, and about the information that is relevant for the process of the requesting specialist), because the day to day contact with requesting colleagues will decrease.

Balancing the order, rather than wanting for the largest piece of the pie, will support professional development.

In balancing the order of day to day work, specialists are furthermore recommended not to surrender to the rhythm of the weekly schedule and the daily interruptions, but to take responsibility for their own work and agenda. Organising individual specialists' day to day work as a part of the collective organisation is complex, so it is not changed easily. The organisation of work processes, however, at the level of individuals and groups, deserves more attention and creativity than it usually gets. Specialists negotiate and grumble at logistics a lot, but careful evaluation of the organisation and logistics of their processes seems to be rare.

Careful evaluation of agenda management in specialists' work is rare as well.[6] Specialists are recommended to invite management to

help them organise their time, agenda and work. This may be considered unattractive or threatening at first, since it may reduce some of the complexity of specialists' work, which sometimes is an interesting factor. Having complex work that no one can really understand or reorganise helps in protecting self-control. The content of specialists' work in patient care, however, will remain its complexity of reasoning, decision making and technical skill. The organisation of specialists' work will support the content much better when process design and agenda management follow criteria that are brought up by the nature of reasoning, decision making and technical skill, and by the personal criteria of individual specialists.

Future specialists may be expected to gradually adopt the idea of specialists integrating and incorporating into the hospital organisation. Women support this view more often than men, and younger specialists support autonomy less strongly than older ones. Women more often work part-time and salaried than men. Their growing proportion will probably change the present dominance of fulltime and self-employed specialist practice. Women also want more involvement in decisions about the organisation of wards and outpatient departments than men. These trends are in line with the third recommendation for specialists, similar to the third recommendation for specialists and managers together: accept the wards and units of the department as the natural context of work. This is where the patients come. This is where specialist work starts. This is where nurses, assistants, and residents provide the workforce to co-operate with. Specialists should develop themselves as reliable fellow members of the department, trying to find common values and interests from both the care and client perspective. They should also try to convince the department workforce of these common values and interests instead of looking at management when being 'production pushers' might threaten being 'pals'.

The fourth recommendation for specialists is to develop reflective skills that will help individual specialists to stand up for their personal preferences and style. This will also improve the functioning of the peer group as a team of individuals who complement each other. Specialists, as a group, are not particularly known to be an oppressed population in society. Based on the factors discussed above, however, individual specialists may tend to feel victims of their situation. They need to learn how to balance being an individual and a member of a strong group. As discussed in Chapter 3, Schön (1983) puts the 'reflective practitioner' opposite the 'expert'. An expert is a professional with more or less static knowledge and skill, and without flexibility. A reflective practitioner is aware of new situations, adapts his or her attitude to different conditions, and evaluates his or her actions. In the interest of individual specialists' wellbeing, and in the interest of peer groups' functioning as teams of individuals, specialists should develop their reflective skills. Of course, this is easier said than done. It requires admitting being vulnerable as an individual, and opening up for peers to voice personal feelings and values.

Reflection should not only focus on adaptation and learning. It should focus on the characteristics of the own work processes as well, following for example the five-step model for professional work.

Changes in the composition or organisation of the peer group (a new member, a merger, a new kind of organisation) should be considered opportunities for evaluating the team and the room for individual differences and preferences, and for evaluating the own work processes. Even conflicts should be considered opportunities for introducing new kinds of communication among peers (Visser 2000).

Real effective quality systems in patient care should be based on measurements and instruments that support the workers' processes of learning, reflecting, and co-operating. Creating standards and guidelines results from learning and developing together (Broekhuis 2002). In short, reflective skill not only supports individual wellbeing, but it is also a condition for learning and improving in physician practice (Hemkes 1999). Introducing peer discussion and support groups, in specialist training

6 The composition of DTC's will be based partly on data about time per activity. So, information about time management should be available and may be processed in agenda management.

and in specialist practice, may endorse the development of reflective skills (Ventevogel et al. 2002).

Recommendations for managers: how to balance a negotiated order

Specialists grumbled about managers a lot, in the questionnaires as well as in the case studies. When asked whether they would like to 'take over the power' most specialists nevertheless decline. They do not want to fulfil the overall organisational tasks they expect managers to fulfil.

The case studies did not confirm the picture of managers making specialists' lives miserable, as is sometimes suggested in public discussion. Managers were complained about, but so were other persons and parties. In day to day negotiations, managers as negotiators came second, after colleagues in other specialities. Managers, nevertheless, sometimes seem to personify problems of scarcity, or the fact that logistics require such a lot of specialist attention.

This phenomenon seems to be reinforced by the absence of managers in daily specialist life. In the case studies, only ward co-ordinators were spontaneously met during working hours. Managers of higher levels were seen at formal meetings, for formal decision making, in their own rooms, and on their own floors.

Respondents whose peer group meet the board of directors regularly report positive feelings towards the hospital and hospital management more strongly than respondents who do not (paragraph 7.5.3). This suggests higher level managers' visibility makes a positive difference.

The overall organisation of specialist work in the Netherlands is going to change in the years to come. Aspects of competition will enter the hospital sector, which will make specialists and managers face major challenges of adaptation. Managers may stimulate competition by recognising the specialists' tendency to focus on their work in patient care and on the organisation of 'their shop'. Specialists like to build and maintain their practices, and expand them if possible. Managers need to acknowledge the physicians in managing and governing their own affairs to a great extent. At the same time they should make management support services available, such as information technology support, contracting support, marketing support, and quality management support, to accelerate efforts at implementing evidence based medicine (Shortell et al. 2001).

Managers should also accept and develop their role of capacity manager. Hospitals provide scarce resources that should be allocated. Managing allocation might be the core mission of hospital managers. This may seem less heroic than running a hospital. Still, managing allocation in a right way asks for visionary leaders who embrace patient care and their professionals on one hand and who are able to set priorities on the other.

A new style of leadership in hospital management should be based on inviting specialists to contribute to the collective ambition of the organisation, while management creates the conditions that make this possible (Vermaak and Weggeman 1999). In this respect, managers should develop themselves as 'supportive entrepreneurs'. They should find opportunities for improving the position of the organisation by supporting specialists' work, by inviting specialists to contribute to the organisation's ambition, and by co-operating with specialists in developing new areas of common interests, for example clever patient care logistics and evidence based practice and policy (Walshe and Rundall 2001).

If specialists accept the hospital as the negotiated order they work in, they need support in balancing the interests of all parties in the hospital. The negotiated order will be hard to balance now and then, and hospital managers are recommended to develop into reliable mediators for rebalancing the order when negotiation out-weighs order. They can only do so as 'supportive entrepreneurs' who act from the care and client perspective. If they act from the control perspective as such, they reinforce their personification of scarcity, and they will not be trusted in their support of the negotiated order.

The recommendations are summed up in **table 9.4**.

Table 9.4: Recommendations

Recommendations for specialists and managers: *how to organise work in a negotiated order*	Recommendations for specialists: *how to work in a negotiated order*	Recommendations for managers: *how to balance a negotiated order*
jointly develop the care perspective and the client perspective	accept and respect the hospital as a negotiated order and learn to play the games of give-and-take, of diplomacy, of bargaining	be visible in specialists' day to day work
respect the differences between specialities and categories of specialists	do not surrender to the rhythm of the weekly schedule and the daily interruptions, but take responsibility for your own work and agenda	recognise the physicians' needs to build, maintain, and expand practices; acknowledge physicians in managing and governing their own affairs; make management support services available to accelerate efforts at implementing evidence based medicine
respect and develop the natural specialists' context of the department	accept the wards and units of the department as the natural context of work	accept and develop the role of capacity manager
accept the limitations of the integrated company and of management participation	develop reflective skill to help individual specialists balance individuality and group membership, and to develop the peer group as a team	develop yourselves as supportive entrepreneurs, inviting specialists to contribute to the collective ambition, and mediating negotiations when order is threatened

9.3.4 Conclusion

This thesis decoded 'doctors' orders' as 'negotiated orders'. Whether working in a general hospital, a university hospital, a specialised clinic or a private practice, specialists will always work amidst various values and interests and amidst various persons and parties competing for jurisdiction. Order on one hand and negotiations on the other should balance each other to prevent hospitals from becoming arenas more than they already are. All persons and parties in the hospital should work on order through a continuous search for common values from the care perspective and from the client perspective. They should also accept and respect the differences between specialities, the multitude of interests and values in the hospital, the impossibility of integrating them, and the necessity of negotiating them. In accepting this, dialogue will gradually redefine negotiation in the 'doctors' orders'.

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Appendix 1

Codes for the analysis of the nature of specialist work in patient care

The data in the case studies were texts, reflecting observations, conversations and interviews. The summaries of all texts were analysed using Atlas/ti. Atlas/ti enables the researcher to identify quotations by coding them. Codes can help finding quotations back and they can also help finding relations and patterns in the data. Software like Atlas/ti opens up large sets of data for systematic analysis.

Codes for observations	explanation:
morning meeting	observation of plenary morning meeting
other meetings on patient care	observations of scheduled discussions with the department or multidisciplinary staff meetings
meeting in class / training	observations of scheduled educational meetings
ICU / CCU	observation on Intensive Care Unit or Cardiac Care Unit
wards	observation of rounds or other activities on an inpatient ward or on Casualty in radiology: activities on the department for radiology
OPD	observation consultation hours on outpatient department
OR or procedures	observation of surgery observation of other procedures (for instance inserting pacemakers, procedures in radiology or gastroenterology)
committee or meeting	observation of a meeting of a committee or a working group or other structures having a largely organisational agenda
partnership	observation of a meeting of the partnership or the specialist group
management	observation of specialist having a formal management function or activity
unscheduled observation	researcher meets one of the specialists of the case studies by accident
interview or conversation	interview or conversation with specialists or with a group of specialists
numbers	the numbers of each moment of observation: patients, minutes, interruptions (unscheduled moments), etcetera
obs: personell in care	observations and conversations with nurses, assistants, other non-medical workers in patient care
various	observations not covered by other codes, for instance: lunches, moments of desk work, moments of rounding off OPD hours

Codes for the nature of specialist work in patient care	quotations having this code are about:
Individual specialists	
[initials]	[all individual specialists were coded by their initials]
career	career decisions of individual specialists
motivations on establishing	the considerations and motivations about establishing practice by an individual specialist
secondary functions	secondary functions of specialists, in or outside hospital
being a specialist	remarks and reflections about being a specialist
Peer group	
history	history of the partnership or specialist group; specialists from the past, former mergers, etcetera
roles	tasks and roles of the members of the partnership or specialist group; both formal and informal roles and tasks
co-operation	atmosphere and co-operation within the partnership or specialist group
management and policy	management and policy within the partnership or specialist group
merger	merger of the two partnerships or specialist groups within the speciality
finances and output	money, fees, financial arrangements, funding, output
PR	PR-policy of partnership or specialist group
secretary	co-operation with the secretaries of the speciality
recruitment	finding and recruiting new specialists
Processes individual patient care	
individual specialist care	medical aspects of specialist care for individual patients
information and consent	information to individual patients and getting their consent for investigations and treatment
contact with individual patient	atmosphere and communication in specialist contacts with individual patients
individual organisation of contact	the organisation of the specialist - patient contacts on individual level
discussion or co-operation with colleague	discussion or co-operation with a specialist colleague, concerning an individual patient
contact with GP about individual patient	communication or remarks concerning GP or other worker in primary care, connected with an individual patient
fellowship	remarks or the refraining of remarks about a colleague in front of an individual patient
incident, complaint	complaints or complications or incidents with individual patients
Organisation of patient care	
organisation of contacts	the way the specialist - patient contact is being organised and prepared in general
organisation of information and consent	the organisation of information for patients in general and the way they consent
before and after	care process before and after specialist - patient contact
morning meeting and transfer of patient care	the organisation of the morning meeting and of other moments with transfer of patient care between physicians

Codes for the nature of specialist work in patient care

quotations having this code are about:

Organisation of patient care

capacity of supply	the organisation / capacity of the physicians and specialists workforce; for instance: schedules, planning of presence/absence, OPD-hours planned with other parties, absent colleagues, rescheduling procedures
logistics and capacity	connecting demand (patients), supply (care) and information within the hospital; for instance: logistics of patients, availability of hospital capacity
waiting	patients on waiting lists and patients waiting in hospital
distribution of focus of attention	the distribution of special area's of knowledge and skills within the speciality
knowledge management	availability and access of knowledge and information; the way specialists use evidence based medicine; the way specialists keep up to date
standard operating procedures	making or using guidelines, instructions, SOP's, etcetera
quality management	the way specialists control and improve their work
defensive medicine	careful practice, partly to prevent incidents and lawsuits
reporting, filing, correspondence	laying down information and communication about patient care; in writing or in computers
multidisciplinary working	the (organisation of) medical co-operation with other specialities and specialists
OPD-organisation	aspects of the organisation of the outpatient departments
organisation of wards	aspects of the organisation of wards for inpatients, radiology, OR and Casualty
ICU- and CCU organisation	aspects of the organisation of specialised wards
co-operation care personell	co-operation and communication with nurses, assistants and other non-medical employees in patient care
co-operation GP's and PC	co-operation and communication with general practitioners and other workers in primary care
co-operation with colleagues in other hospitals	co-operation and communication with colleagues in other hospitals
co-operation with pharmacies and suppliers	co-operation and communication with pharmacies and suppliers for getting drugs or materials for patient care
two location	the way specialists use the two locations of patient care in their hospital
paperwork	the paperwork in patient care: the forms, surveys, writing, 'bureaucracy'
work space (care)	space available for patient care
materials and investments	purchasing and using materials and equipment in patient care
rules and legislation	rules and legislation concerning (the organisation of) patient care

Other persons / parties in context

own speciality	co-operation or colleagues of the own speciality or about the speciality outside of the hospital
other specialists and specialities	colleagues of other specialities or other specialist groups
personell patient care	relation with nurses, assistants, and other employees in patient care
medical staff	medical staff, the organisation of all specialists working in a hospital
management	managers, management and staff departments in hospital
manager	[individual managers met in observations or interviews were coded by their initials]
non-medical departments	co-operation with non-medical employees, for instance technicians, purchasing, etcetera
hospital	the own hospital organisation
GP's and primary care	general practitioners and other parties in primary care
other hospitals	other hospitals in the region or in the country
region	regional developments or parties in the district
insurance company	insurance company
industry and pharmacy	pharmaceutical industry and its workers, pharmacies and pharmacists
medicine	medicine as an occupation and a profession
health care	health care, being the sector specialists work in; also: relations with organisations in health care
government and politicians	the government structure and policy and the political system and politicians
media	media: newspapers, television, internet
private	private life of specialists and members of their family

Management and organisation / organising work

speciality	the nature and characteristics of work in the speciality and developments in the speciality
tasks	tasks of specialists or dilemma's about tasks of specialists; considerations about tasks belonging to specialists or rather to other parties
responsibilities	responsibilities of specialists or dilemma's about responsibilities of specialists; considerations about responsibilities belonging to specialists or rather to other parties
interruptions	interruptions of activities: pagers, phonecalls, people dropping by
organising individual work	specialists organising their own work; daily routine and rhythm of specialist work
managerial tasks	managerial and organisational tasks of specialists, not being medical managers
management participation	formal management functions for specialists; work of the medical managers in the case studies
employment	differences between employment and self-employment
restructuring hospital	the new organisational structure of the hospital
work space	work space, not directly connected with patient care
management image	metafores, images and expectations concerning management and managers in general, usually in hospital
for profit business	profit companies and the comparison with the not for profit sector

Various

observed	interesting moments that do not connect with another code; these quotations often reflect jokes, jargon, atmosphere or behaviour
gender	differences between male and female specialists; increase of number of female physicians and specialists
Karen	the researcher: remarks, advices and questions from specialists or other people met during the observations

Appendix 2

Codes for the analysis of negotiations and jurisdictional claims

Specialists' roles	quotations having this code reflect specialists in their role of:	identification of this role when the quotation mostly connects with the relation between specialists and:	number of quotations
Roles defined by setting / relation in hospital			
			639
doctor	seeing and treating patients in the speciality or being representative of the patient and of patient care	patients	270
peer	being member or representative of a partnership or a speciality group, practising the same speciality and having a shared organisation	colleagues of the same speciality, organised in peer group	86
department member	being a member or representative of a department, co-operating with colleagues, residents, nurses and other workers on the wards and units of the speciality	other members of the wards and units of the speciality: colleagues, residents, nurses and other workers	228
staff member	being a member or representative of the specialist staff, which is the group of all specialists providing patient care in one hospital and being organised in the specialist staff organ in hospital	other specialist colleagues in the hospital	29
hospital member	being a member or representative of the hospital organisation	the hospital organisation or its workers	26

Roles defined by setting / relation outside hospital			number of quotations	
			131	
individual	the individual who needs to balance individual and private needs and expectations, and work related needs and expectations; sometimes being the representative of the private context or the personal needs	themselves or their private situation	94	
professional	being a member or representative of the profession of physicians and of the own speciality	the organisations of the profession or the speciality or its individual members	37	
Parties / negotiators				
patients			**60**	
colleagues			**215**	
specialist colleagues of the same speciality and/or of the same department			42	a2 249
partnership or speciality group			41	
specialist collaegues of other specialities or other specialist groups			99	
specialist staff or fellow members of the specialist staff			14	
residents and students			19	
other occupations			**81**	
nurses, other personell in care			63	
other employees hospital			18	
hospital organisation			**118**	
managers			81	
hospital organisation			37	
profession			**33**	
general practitioners and other workers in primary care			15	
profession			18	
society			**58**	
workers / parties from outside (for instance technicians and farmacists)			5	
other hospitals			19	
insurance companies			6	
other external parties, media, politics			28	

Nature of negotiations / tactics	quotations having this code reflect mechanisms in wich specialists:	number of quotations
Active coping: fight or attack other parties, aimed at expanding jurisdiction		**59**
expand		
fight	actively try to expand say, power or influence	50
argue	fight the parties in their context	3
	argue with parties in their context	6
Active coping: deal with issues or other parties, aimed at defending or holding jurisdiction		**539**
'organise':		
organise	deal with an issue by organising circumstances or arrangements	
plan and (re)schedule	[special kind of organising] deal with an issue by planning and (re)scheduling own activities	59
adopt (patients, tasks, issues)	appropriate or adopt a task, responsibility, patient etcetera	25
assign to others (patients, tasks, issues)	assign a task, responsibility, patient etcetera to another party	77
instruct, correct or supervise	tell others how to react or how to handle	36
be positive	try to look at the bright side in coping with the issue	42
		6
'choose or combine':		
choose /select	choose between activities or tasks or roles simultaneously requiring time and attention	
combine	try to combine activities or tasks or roles simultaneously requiring time and attention	45 42
'interact':		
demand or request	ask, demand or request favours or items with other parties	
negotiate	negotiate the issue at stake: give-and-take, bargain	38
reason	try to use reason and debating in discussing the issue	60
form a coalition / bonding	involve other parties in strengthening their own position	7
dissociate from	distinguish themselves from other parties by condemning them and dissociate from them	41
refuse	refuse to adopt a task, responsibility, patient etcetera	13
		24
'take the lead':	take initiative or take the lead in dealing with the issue in relations with other parties	
lead		
participate in management	formally participate in management and organisation	5
		19
Passive: flight or surrender, not specifically or actively aimed at jurisdiction		**163**
give in	give in to the situation and co-operate	
let go; ignore; give up	try to pretend the issue doesn't exist, ignore	53
wait	wait for solutions	11
grumble	show their frustration by mumbling and grumbling	15
		84

Issues	quotations having this code reflect issues about:	number of quotations
Individual specialists:		**23**
(job) satisfaction	happiness and satisfaction in specialist working	18
shifts, irregular working hours	working hours and duties	5
Patient care:		**129**
specialist care	content of knowledge, decision making, skills	59
service & quality for patients	specialists wanting to provide high quality service and care to their patients	13
patient and problem inclusion	accepting / adopting or assigning patients and problems	34
demand patients	requests and demands of patients that cause dilemma's: do they or don't they belong to the specialists responsibility	23
Logistics and processes:		**123**
patients or information logistics	patients and information being on the right time and place	87
capacity (hospital, other)	the use and availability of capacity in hospital; most issues reflect scarcity	23
supply physicians	the availability of specialists and residents; issues concerning schedules and absence	9
change of specialists	mutual transfers / new specialists	4
Tasks and responsibilities:		**131**
role/task combination	two or more roles or tasks requiring time and attention simultaneously	77
new or extra task or responsibility	tasks and responsibilities showing up and causing dilemma's about 'ownership'	39
responsibility	specialists having responsibilities in general	15
The organisation of work:		**169**
bureaucracy and paperwork	forms, rules, and other kinds of 'bureaucracy'	4
interruptions	the interruptions of ongoing activities	14
output and finance	output and finance causing considerations in specialist work	37
management & organisation	the specialist role in management & organisation; management & organisation causing dilemma's in specialist work	67
material and work space	work space to work in and materials to work with: purchasing, availability, use	34
rules and regulations	rules, regulations and legislation influencing specialist work	13
Relationships and positions:		**163**
colleagues	co-operation and communication with specialist colleagues	39
gender	being male or female; increasing numbers of female specialists	5
positioning in context	the specialist's or the specialists group's position in relations with the context	

Issues	quotations having this code reflect issues about:	number of quotations
External:		17
insurance	rules and regulations of insurance companies	1
external physician shortage	the shortage of physicians in general: problems in recruiting residents and specialists	8
future	future developments, unpredictability	8

Appendix 3

Quotations concerning the researcher

This code ('Karen') was only used when the quotations revealed information that was different from the standard dialogues between the researcher, the specialists who were being observed and the other people who were met.

Category	these quotations are about: (with some examples from the fieldnotes)	number of quotations
Specialists about the research		**7**
	- interested and enthusiastic reactions ("Important subject")	3
	- critical reactions ("Vague")	3
	- neutral reactions ("Kind of time measurement study?")	1
The researcher's role		**35**
	- researcher's 'double-role' in MCH ("Good that someone from the fourteenth flour has a look here" / "I know you will handle this discreetly")	6
	- researcher's roles of: researcher / observant / advisor / trainee ("Maybe you can advise us on that' / "What anatomical structure do you see here?")	7
	- moments in which the researcher was asked to stay outside ("I would prefer to meet this patient alone")	2
	- the researcher influencing the specialist's daily routine ("I like chatting with you, I'll work a bit harder in the afternoon" / "Usually I would dictate the letters in between OPD-patients." KK: "You can do that now! Just pretend I'm not here." "No, I don't mind, I'm not behind in dictating letters anyway.")	10
	- specialists reacting to the researcher taking notes ("What are you writing down?" / Two specialists talking about a misunderstanding: "Man, you're a moron. Now she [meaning KK] will get a wrong impression")	5
	- specialists asking personal questions ("What kind of career will you have after finishing the research?")	5
Other people		**8**
	- interactions patients - researcher ("Are you taking notes because you have to check things?")	3
	- other specialists, residents, nurses, etc. who ask or say something about the research or researcher ("Every specialist should just have his personal manager." / "I never knew specialists do so many other things besides surgery.")	5
Researcher's 'in between' thoughts and remarks		**10**
	- fieldnotes reflecting the researcher's thoughts and remarks about people or situations ("I do not feel very welcome here today" / "I'm very impressed with X [specialist], she is so committed to her patients")	10

Enquête formulier

Instituut Beleid & Management Gezondheidszorg
Erasmus MC

Afdeling Sociale Geneeskunde
AMC

MEDISCH SPECIALISTEN EN ORGANISATIE
vragenlijst voor medisch specialisten in algemene ziekenhuizen

Geachte collega,

In deze vragenlijst vragen wij uw mening over de organisatie van medisch werk, over uw werkomgeving en over de huidige én de door u gewenste vormen van betrokkenheid van specialisten bij beslissingen en overleg in het ziekenhuis. Uw mening wordt verwerkt in een promotieonderzoek naar de organisatie van medisch specialistisch werk binnen ziekenhuizen. Dit onderzoek wordt uitgevoerd door Karen Kruijthof, arts en bestuurskundige. De promotoren zijn mw. prof.dr. Pauline L. Meurs, Instituut Beleid & Management Gezondheidszorg, Erasmus Medisch Centrum en prof.dr. Niek S. Klazinga, afdeling Sociale Geneeskunde, Academisch Medisch Centrum.
Zoals u heeft gelezen in de bijgevoegde brief, zal de Orde van Medisch Specialisten mede op basis van de resultaten van dit vragenlijstonderzoek een visie ontwikkelen op de rol en positie van de medisch specialist in de ziekenhuiszorg van vandaag en morgen.
Wij weten dat medisch specialisten volle dagen hebben en dat zij veel invul-formulieren moeten verwerken. Ons onderzoek naar specialisten en organisatie kan echter alleen zinvol genoemd worden als het de daadwerkelijke ervaringen en meningen van medisch specialisten centraal stelt. Wij hebben daarom een representatieve steekproef van medisch specialisten samengesteld uit de gegevens van het nieuwste Geneeskundig Adresboek. U ontvangt deze vragenlijst omdat uw naam in deze aselecte steekproef is opgenomen.
Het invullen van de vragenlijst kost ongeveer een kwartier. Voor eventuele opmerkingen over de vragen of over de te formuleren beleidsvisie van de Orde van Medisch Specialisten is ruimte op de laatste bladzijde van deze lijst. Alle gegevens zijn anoniem en worden vertrouwelijk behandeld.
Ten behoeve van optimale informatie over uw meningen en ervaringen doen wij een dringend beroep op uw medewerking.
Wilt u zo vriendelijk zijn voor 14 februari 2003 de lijst retour te zenden?
U kunt hiervoor de bijgevoegde enveloppe gebruiken. Een postzegel is niet nodig.
De resultaten van deze enquête zullen op verschillende momenten worden gepresenteerd, onder meer via publicatie in Medisch Contact.
HARTELIJK BEDANKT VOOR UW MEDEWERKING!!!

Karen Kruijthof (tel. 070 - 3302866; kruijthof@bmg.eur.nl)
Pauline Meurs
Niek Klazinga

De vragen kunt u beantwoorden door een kruisje te zetten bij het antwoord dat u het meest van toepassing vindt of door een getal of korte tekst in te vullen binnen de aangegeven kaders. Deze vragenlijst wordt geautomatiseerd verwerkt. Daarom is het belangrijk dat de vragenlijst niet kreukt en dat u een zwarte of blauwe pen gebruikt (geen rode pen en geen viltstift).
Zet een duidelijk kruisje in het vakje van uw keuze (**het vakje niet helemaal inkleuren**!).
Bijvoorbeeld:
☐ ja ☒ nee

Alleen als u een antwoord wilt **veranderen**, moet u het juiste vakje helemaal inkleuren. In bovenstaand voorbeeld:
■ ja ☒ nee

ORGANISATORISCHE ASPECTEN VAN MEDISCH WERK

1. De onderstaande lijst bevat een aantal uitspraken over organisatorische aspecten van medisch werk in het algemeen. Wilt u aangeven in hoeverre u het met onderstaande **algemene** uitspraken eens of oneens bent?

	Helemaal eens	Eens	Niet eens/ oneens	Oneens	Helemaal oneens
Binnen een maatschap/vakgroep van medisch specialisten is gelijke zeggenschap van alle specialisten noodzakelijk.	❑	❑	❑	❑	❑
Binnen een maatschap/vakgroep van medisch specialisten is het noodzakelijk afspraken te maken over wie "de baas" is.	❑	❑	❑	❑	❑
De kwaliteit van het medisch handelen kan alleen door de medische beroepsgroep worden bewaakt.	❑	❑	❑	❑	❑
De medische kwaliteit van individuele patiëntenzorg wordt bedreigd door **organisatorische** overwegingen.	❑	❑	❑	❑	❑
De medische kwaliteit van individuele patiëntenzorg wordt bedreigd door **financiële** overwegingen.	❑	❑	❑	❑	❑
Door de onvoorspelbaarheid van medisch werk is het voor medisch specialisten moeilijk om vaste afspraken te maken over de inrichting van hun dagelijks werk.	❑	❑	❑	❑	❑
Wie binnen een maatschap/vakgroep een vakinhoudelijk aandachtsgebied heeft, behoort het laatste woord te hebben over de organisatie daarvan.	❑	❑	❑	❑	❑
Het functioneren van medisch specialisten behoort met behulp van periodieke functioneringsgesprekken geëvalueerd te worden.	❑	❑	❑	❑	❑
Voor multidisciplinaire patiëntenzorg behoort één van de betrokken specialisten eindverantwoordelijk te zijn.	❑	❑	❑	❑	❑

2. Medisch specialisten hebben in het ziekenhuis te maken met niet-medische managers en bestuurders. Wilt u aangeven in hoeverre u het met onderstaande **algemene** uitspraken over managers eens of oneens bent?

	Helemaal eens	Eens	Niet eens/ oneens	Oneens	Helemaal oneens
Managers moeten zich niet bezig houden met de medische beroepsuitoefening.	❑	❑	❑	❑	❑
Managers dienen condities te scheppen voor professionele medische beroepsuitoefening.	❑	❑	❑	❑	❑
Managers dienen actief ontwikkelingen in gang te zetten, ook op het terrein van de medische beroepsuitoefening.	❑	❑	❑	❑	❑

3. In veel ziekenhuizen worden medisch specialisten formeel betrokken bij organisatieprocessen in het ziekenhuis. Bijvoorbeeld doordat enkele specialisten "medisch manager" of "managementparticipant" worden, of doordat zij andere organisatorische functies vervullen. Wilt u aangeven in hoeverre u het met onderstaande **algemene** uitspraken eens of oneens bent?

	Helemaal eens	Eens	Niet eens/ oneens	Oneens	Helemaal oneens
Formele betrokkenheid van medisch specialisten bij de organisatie is noodzakelijk voor:					
- belangenbehartiging van medisch specialisten;	❑	❑	❑	❑	❑
- kostenbeheersing in het ziekenhuis;	❑	❑	❑	❑	❑
- optimale organisatie van de patiëntenzorg;	❑	❑	❑	❑	❑
- realiseren van door de medische staf gewenst beleid;	❑	❑	❑	❑	❑
Organisatorische functies bieden medisch specialisten interessante loopbaanperspectieven.	❑	❑	❑	❑	❑
Gezag op basis van medisch inhoudelijke deskundigheid is een voorwaarde voor het vervullen van de functie van medisch manager/managementparticipant.	❑	❑	❑	❑	❑
Een medisch manager/managementparticipant behoort condities te scheppen voor professionele medische beroepsuitoefening.	❑	❑	❑	❑	❑
Een medisch manager/managementparticipant behoort zich op te stellen als intermediair tussen maatschappen/vakgroepen en management/bestuur.	❑	❑	❑	❑	❑
Een medisch manager/managementparticipant behoort de specialisten van maatschappen/vakgroepen actief aan te sturen.	❑	❑	❑	❑	❑
Op termijn behoren medisch specialisten, zoals andere medewerkers in het ziekenhuis, ingebed te zijn in de ziekenhuishiërarchie.	❑	❑	❑	❑	❑
Verpleegkundigen behoren organisatorisch ondergeschikt te zijn aan medisch specialisten.	❑	❑	❑	❑	❑
Niet-medische managers behoren organisatorisch ondergeschikt te zijn aan medisch managers/ managementparticipanten.	❑	❑	❑	❑	❑
Maatschappen/vakgroepen worden als organisatievorm minder belangrijk wanneer medisch specialisten sterker in de ziekenhuisorganisatie worden opgenomen.	❑	❑	❑	❑	❑
De medische staf wordt als apart orgaan minder belangrijk wanneer medisch specialisten sterker in de ziekenhuisorganisatie worden opgenomen.	❑	❑	❑	❑	❑
Het is wenselijk dat medisch specialisten langzamerhand het beleid en beheer van het ziekenhuis van de niet-medische managers overnemen.	❑	❑	❑	❑	❑

Veel van de volgende vragen gaan over het ziekenhuis waar u werkt. Indien u in verschillende ziekenhuizen werkt:
het gaat steeds om het ziekenhuis waar u deze vragenlijst ontving.

UW DIRECTE WERKOMGEVING

4. Deze vraag gaat over uw directe werkomgeving. Geef aan in hoeverre u het eens of oneens bent met deze uitspraken over **uw werkomgeving**.

	Helemaal eens	Eens	Niet eens/ oneens	Oneens	Helemaal oneens
Ik voel me thuis in dit ziekenhuis.	❑	❑	❑	❑	❑
Ik ben tevreden met het functioneren van dit ziekenhuis.	❑	❑	❑	❑	❑
Ik voel me thuis bij deze maatschap/vakgroep.	❑	❑	❑	❑	❑
Ik ben tevreden met het functioneren van deze maatschap/vakgroep.	❑	❑	❑	❑	❑

5. Het gaat in deze vraag om uw mening over het management in uw ziekenhuis. "Het management" wordt ingedeeld in:

hoger management: raad van bestuur, diensthoofden, adjunct-directeuren, cluster- of divisiehoofden, centraal managementteam.

midden management: leidinggevenden van werkeenheden, afdelingen, functiegroepen, units.

Wilt u aangeven in welke mate u het eens of oneens bent met de volgende uitspraken over **het management in uw ziekenhuis**?

	Helemaal eens	Eens	Niet eens/ oneens	Oneens	Helemaal oneens
Het **hoger management** zet zich in dit ziekenhuis voldoende voor medisch specialisten in.	❑	❑	❑	❑	❑
De belangen van medisch specialisten worden door het **hoger management** van dit ziekenhuis serieus genomen.	❑	❑	❑	❑	❑
Het **midden management** zet zich in dit ziekenhuis voldoende voor medisch specialisten in.	❑	❑	❑	❑	❑
De belangen van medisch specialisten worden door het **midden management** van dit ziekenhuis serieus genomen.	❑	❑	❑	❑	❑

DE HUIDIGE SITUATIE

De vragen 6, 7 en 8 betreffen uw mening over de **huidige** situatie in uw ziekenhuis. In vraag 9 wordt gevraagd naar de door u **gewenste** situatie.

6. Medisch specialisten kunnen op de volgende manieren betrokken worden bij **besluitvorming** over verschillende onderwerpen:

geen betrokkenheid:	medisch specialisten worden niet systematisch betrokken bij de besluitvorming;
meepraten:	er is formeel overleg met medisch specialisten voordat het besluit wordt genomen door management/bestuur;
meebeslissen:	medisch specialisten beslissen mee met management/bestuur;
eindverantwoordelijkheid:	medisch specialisten nemen de uiteindelijke beslissing.

Kies per onderwerp de omschrijving die volgens u het meest van toepassing is op de **huidige** situatie.

	huidige rol medisch specialisten bij beslissingen in dit ziekenhuis			
Onderwerp van besluitvorming	geen betrok-kenheid	praten mee	beslissen mee	eind-verant-woordelijk
verdeling van ziekenhuisbudget	❑	❑	❑	❑
selectie nieuwe medisch specialist	❑	❑	❑	❑
nieuw multidisciplinair spreekuur	❑	❑	❑	❑
bedden-verdeling over specialismen	❑	❑	❑	❑
verdeling OK-tijd over specialismen	❑	❑	❑	❑
productie-afspraken met ziektekostenverzekeraars	❑	❑	❑	❑
inhoud ziekenhuis-beleidsplan	❑	❑	❑	❑
inrichting studenten- en co-assistentenonderwijs	❑	❑	❑	❑
inrichting medisch-specialistische opleidingen	❑	❑	❑	❑
inhoud protocollen voor medische behandeling en diagnostiek	❑	❑	❑	❑
inhoud protocollen voor verpleegkundige zorg	❑	❑	❑	❑
invoering electronisch patiëntendossier op polikliniek	❑	❑	❑	❑
problemen met disfunctionerende collega	❑	❑	❑	❑
medisch inhoudelijke samenwerking met de eerste lijn	❑	❑	❑	❑

Onderwerp van besluitvorming	huidige rol medisch specialisten bij beslissingen in dit ziekenhuis: geen betrokkenheid	praten mee	beslissen mee	eindverantwoordelijk
bezuinigingen op een verpleegafdeling	❑	❑	❑	❑
invoering multidisciplinair overleg op een verpleegafdeling	❑	❑	❑	❑
een opnamestop	❑	❑	❑	❑
selectie leidinggevende verpleegafdeling	❑	❑	❑	❑
selectie leidinggevende polikliniek	❑	❑	❑	❑
arbeidsvoorwaarden medisch specialisten	❑	❑	❑	❑
reorganisatie van het ziekenhuis	❑	❑	❑	❑
jaarlijks beleidsplan werkeenheid of unit	❑	❑	❑	❑
invoering functie nurse practitioners	❑	❑	❑	❑
inrichting en aankleding van wachtruimtes	❑	❑	❑	❑

7. Overleg tussen verschillende partijen in het ziekenhuis kan wel of niet gestructureerd zijn:

niet gestructureerd: het overleg vindt toevallig of ad hoc plaats;

wel gestructureerd: het overleg vindt volgens vaste afspraken plaats met een vaste groep deelnemers.

Kies per regel de omschrijving die het meest van toepassing is op de **huidige** situatie in dit ziekenhuis.

	is niet gestructureerd	heeft een vaste structuur	komt in dit ziekenhuis niet voor
Het overleg tussen mijn maatschap/vakgroep en het management van units of afdelingen:	❑	❑	❑
Het overleg tussen mijn maatschap/vakgroep en het management van cluster of divisie:	❑	❑	❑
Het overleg van onze maatschap/vakgroep onderling:	❑	❑	❑
Het overleg tussen mijn maatschap/vakgroep en de Raad van Bestuur/directie:	❑	❑	❑
Het overleg tussen onze plenaire medische staf en het stafbestuur:	❑	❑	❑
Het overleg tussen ons stafbestuur en de Raad van bestuur:	❑	❑	❑

8. In veel ziekenhuizen hebben enkele medisch specialisten een formele managementfunctie (*medisch manager* of *management/participant*), meestal in deeltijd en gezamenlijk met een verpleegkundig en/of organisatorisch manager.
Wat is de situatie in dit ziekenhuis? *(meerdere antwoorden mogelijk)*:

❑ geen specialisten met een formele managementfunctie;
❑ specialisten met een managementfunctie op het niveau van units, werkeenheden, afdelingen of functiegroepen;
❑ specialisten met een managementfunctie op het niveau van clusters of divisies;
❑ specialisten met een managementfunctie in de Raad van Bestuur/directie.

DE WENSELIJKE SITUATIE

De vorige vragen gingen over de huidige situatie in uw ziekenhuis. Hieronder wordt gevraagd wat volgens u **wenselijk** zou zijn.

8. Medisch specialisten kunnen op de volgende manieren betrokken worden bij besluitvorming over verschillende onderwerpen:

geen betrokkenheid:	medisch specialisten worden niet systematisch betrokken bij de besluitvorming;
mespraten:	er is formeel overleg met medisch specialisten voordat het besluit wordt genomen door management/bestuur;
meebeslissen:	medisch specialisten beslissen mee met management/bestuur;
eindverantwoordelijkheid:	medisch specialisten nemen de uiteindelijke beslissing.

Wilt u bij de volgende onderwerpen aangeven hoe volgens u medisch specialisten in dit ziekenhuis betrokken **zouden moeten worden** bij beslissingen?

	gewenste rol medisch specialisten bij beslissingen in dit ziekenhuis			
Onderwerp van besluitvorming	geen betrok-kenheid	praten mee	beslissen mee	eind-verant-woordelijk
verdeling van ziekenhuisbudget	❑	❑	❑	❑
selectie nieuwe medisch specialist	❑	❑	❑	❑
nieuw multidisciplinair spreekuur	❑	❑	❑	❑
bedden-verdeling over specialismen	❑	❑	❑	❑
verdeling OK-tijd over specialismen	❑	❑	❑	❑
productie-afspraken met ziektekostenverzekeraars	❑	❑	❑	❑
inhoud ziekenhuis-beleidsplan	❑	❑	❑	❑
inrichting studenten- en co-assistentenonderwijs	❑	❑	❑	❑
inrichting medisch-specialistische opleidingen	❑	❑	❑	❑

Onderwerp van besluitvorming	gewenste rol medisch specialisten bij beslissingen in dit ziekenhuis: geen betrokkenheid	praten mee	beslissen mee	eindverantwoordelijk
inhoud protocollen voor medische behandeling en diagnostiek	❑	❑	❑	❑
inhoud protocollen voor verpleegkundige zorg	❑	❑	❑	❑
invoering electronisch patiëntendossier op polikliniek	❑	❑	❑	❑
problemen met disfunctionerende collega	❑	❑	❑	❑
medisch inhoudelijke samenwerking met de eerste lijn	❑	❑	❑	❑
arbeidsvoorwaarden medisch specialisten	❑	❑	❑	❑
reorganisatie van het ziekenhuis	❑	❑	❑	❑
jaarlijks beleidsplan werkeenheid of unit	❑	❑	❑	❑
invoering functie nurse practitioners	❑	❑	❑	❑
inrichting en aankleding van wachtruimtes	❑	❑	❑	❑

DE VERDELING VAN UW TIJD IN HET ZIEKENHUIS

10. Werkt u fulltime of parttime in dit ziekenhuis (waar u deze vragenlijst ontving)?

❑ fulltime

❑ parttime, namelijk % *(percentage in kader invullen alstublieft)*

Indien u parttime in dit ziekenhuis werkt: werkt u daarnaast ook in een ander ziekenhuis/praktijk?

❑ ik werk alleen in dit ziekenhuis

❑ ik werk ook in een ander ziekenhuis/praktijk

11. Hoeveel uur bent u gemiddeld per week in dit ziekenhuis aanwezig?

Gemiddeld ben ik uren per week in dit ziekenhuis aanwezig *(hokjes invullen alstublieft)*

12. Hoe verdeelt u momenteel uw tijd in dit ziekenhuis en bent u daar tevreden over?

Geef met percentages aan hoe u **ongeveer** uw tijd verdeelt over onderstaande vijf onderwerpen, **dit mag een grove schatting zijn**.

Geef vervolgens per onderwerp aan of u er liever wat minder of meer tijd aan zou besteden, als dat mogelijk zou zijn.

Soort werkzaamheden	Schatting percentage	Ik vind dit precies goed	Ik zou hier liever wat minder tijd aan besteden	Ik zou hier liever wat meer tijd aan besteden
Directe patiëntenzorg (bijv. kliniek, dagbehandeling, polikliniek, OK)	%	❑	❑	❑
Activiteiten die uit directe patiëntenzorg voortkomen (bijv. brieven, patiëntenbesprekingen, overdracht)	%	❑	❑	❑
Opleiding en onderwijs (bijv. aan AGIO's, AGNIO's, co-assistenten, onderwijs-bijeenkomsten)	%	❑	❑	❑
Onderzoek, bij- en nascholing (bijv. bijhouden literatuur, bij- en nascholingsbijeenkomsten bijwonen, uitvoeren of begeleiden onderzoek)	%	❑	❑	❑
Organisatorische activiteiten (bijv. vergaderen, commissiewerk, rooster maken, management)	%	❑	❑	❑
	100 %			

13. Heeft u in het **verleden** één of meer van onderstaande activiteiten uitgevoerd; voert u **momenteel** één van de onderstaande activiteiten uit; of overweegt u in de **toekomst** één of meer van onderstaande activiteiten uit te gaan voeren? *(aankruisen indien van toepassing; meerdere antwoorden mogelijk per activiteit).*

Activiteit	Ik heb dit in het verleden gedaan	Ik doe dit momenteel	Ik denk er over dit in de toekomst te gaan doen
managementparticipant/ medisch manager	❑	❑	❑
voorzitter maatschap hoofd vakgroep	❑	❑	❑
opleider/plaatsvervangend opleider	❑	❑	❑
lid bestuur medische staf	❑	❑	❑
lid kernstaf	❑	❑	❑
lid commissie/werkgroep ziekenhuis	❑	❑	❑
lid commissie/werkgroep medische staf	❑	❑	❑
lid ondernemingsraad	❑	❑	❑
lid bestuur/werkgroep wetenschappelijke vereniging	❑	❑	❑
lid bestuur/werkgroep andere landelijke organisatie in gezondheidszorg/geneeskunde	❑	❑	❑
anders: *(binnen kader invullen alstublieft)*	❑	❑	❑

ALGEMENE INFORMATIE

14. Wat voor soort ziekenhuis is dit? *(één antwoord mogelijk).*

❑ topklinisch opleidingsziekenhuis (STZ-ziekenhuis)

❑ algemeen ziekenhuis met één of meer door de MSRC erkende medisch-specialistische opleidingen

❑ algemeen ziekenhuis zonder door de MSRC erkende medisch-specialistische opleidingen

❑ categoraal ziekenhuis

❑ anders, namelijk

(binnen kader invullen alstublieft)

15. Hoe groot is dit ziekenhuis?

Dit ziekenhuis heeft ongeveer bedden *(aantal bedden in de hokjes invullen alstublieft)*

De medische staf van dit ziekenhuis bestaat uit ongeveer specialisten *(aantal personen in medische staf invullen alstublieft).*

16. Heeft dit ziekenhuis verschillende locaties?

❑ het ziekenhuis heeft één locatie

❑ het ziekenhuis heeft twee locaties

❑ het ziekenhuis heeft drie of meer locaties

17. In een "dienstenstructuur" zijn organisatie-onderdelen ondergebracht in diensten zoals bijvoorbeeld verpleegkundige dienst, poliklinische dienst, medisch ondersteunende afdelingen, facilitaire dienst etc.
In een "gekantelde structuur" zijn organisatie-onderdelen ingericht rondom medische vakken of patiëntenprocessen.

Is dit ziekenhuis overwegend georganiseerd volgens een "dienstenstructuur", of is het overwegend georganiseerd volgens een zogenaamde "gekantelde structuur"?

❑ overwegend een "dienstenstructuur"

❑ overwegend een "gekantelde structuur"

❑ anders, namelijk *(binnen kader invullen alstublieft)*

18. Verzorgt uw maatschap of vakgroep een (deel van een) door de MSRC erkende medisch-specialistische opleiding?

❑ ja ❑ nee

19. Hoe groot is uw maatschap/vakgroep?

Mijn maatschap/vakgroep bestaat uit specialisten

(aantal personen in hokjes invullen alstublieft)

20. Maakt u deel uit van een stafmaatschap (alle medisch specialisten in het vrij beroep in één ziekenhuis in één maatschap)?

❑ ja ❑ nee

21. Maakt u deel uit van een maatschap/vakgroep in regionaal verband (stadsmaatschap, regiomaatschap of regionale vakgroep met specialisten die werkzaam zijn in verschillende ziekenhuizen)?

❑ ja ❑ nee

22. In welke provincie werkt u?

❑ Groningen	❑ Overijssel	❑ Utrecht	❑ Zeeland
❑ Friesland	❑ Flevoland	❑ Noord Holland	❑ Noord Brabant
❑ Drenthe	❑ Gelderland	❑ Zuid Holland	❑ Limburg

23. Bent u man of vrouw?

❑ man ❑ vrouw

24. Wat is uw leeftijd?

(uw leeftijd in kader invullen alstublieft)

25. Bent u lid van de Orde van Medisch Specialisten?

❑ ja ❑ nee

26. Hoeveel jaar werkt u in dit ziekenhuis?

(aantal jaren dat u in dit ziekenhuis werkt in kader invullen alstublieft)

27. Op welke wijze bent u aan dit ziekenhuis verbonden? *(één antwoord mogelijk)*

❑ als medisch specialist vrij beroepsbeoefenaar

❑ gedeeltelijk als medisch specialist vrij beroepsbeoefenaar, gedeeltelijk in dienst van dit ziekenhuis

❑ in dienst van dit ziekenhuis

❑ anders, namelijk *(binnen kader invullen alstublieft)*

28. Wat is uw medisch specialisme?

❑ allergologie
❑ anesthesiologie
❑ cardiologie
❑ cardiothoracale chirurgie
❑ dermatologie en venerologie
❑ gastro-enterologie
❑ gynaecologie & verloskunde
❑ heelkunde
❑ intensive care geneeskunde
❑ inwendige geneeskunde
❑ kaakchirurgie
❑ keel-, neus- en oorheelkunde
❑ kindergeneeskunde
❑ klinische chemie
❑ klinische genetica
❑ klinische geriatrie
❑ klinische neurofysiologie
❑ longziekten
❑ medische microbiologie
❑ neurochirurgie
❑ neurologie
❑ nucleaire geneeskunde
❑ oogheelkunde
❑ orthopedie
❑ pathologie
❑ plastische chirurgie
❑ psychiatrie
❑ radiologie
❑ radiotherapie
❑ reumatologie
❑ revalidatiegeneeskunde
❑ urologie
❑ anders, namelijk

(binnen kader invullen alstublieft)

TENSLOTTE

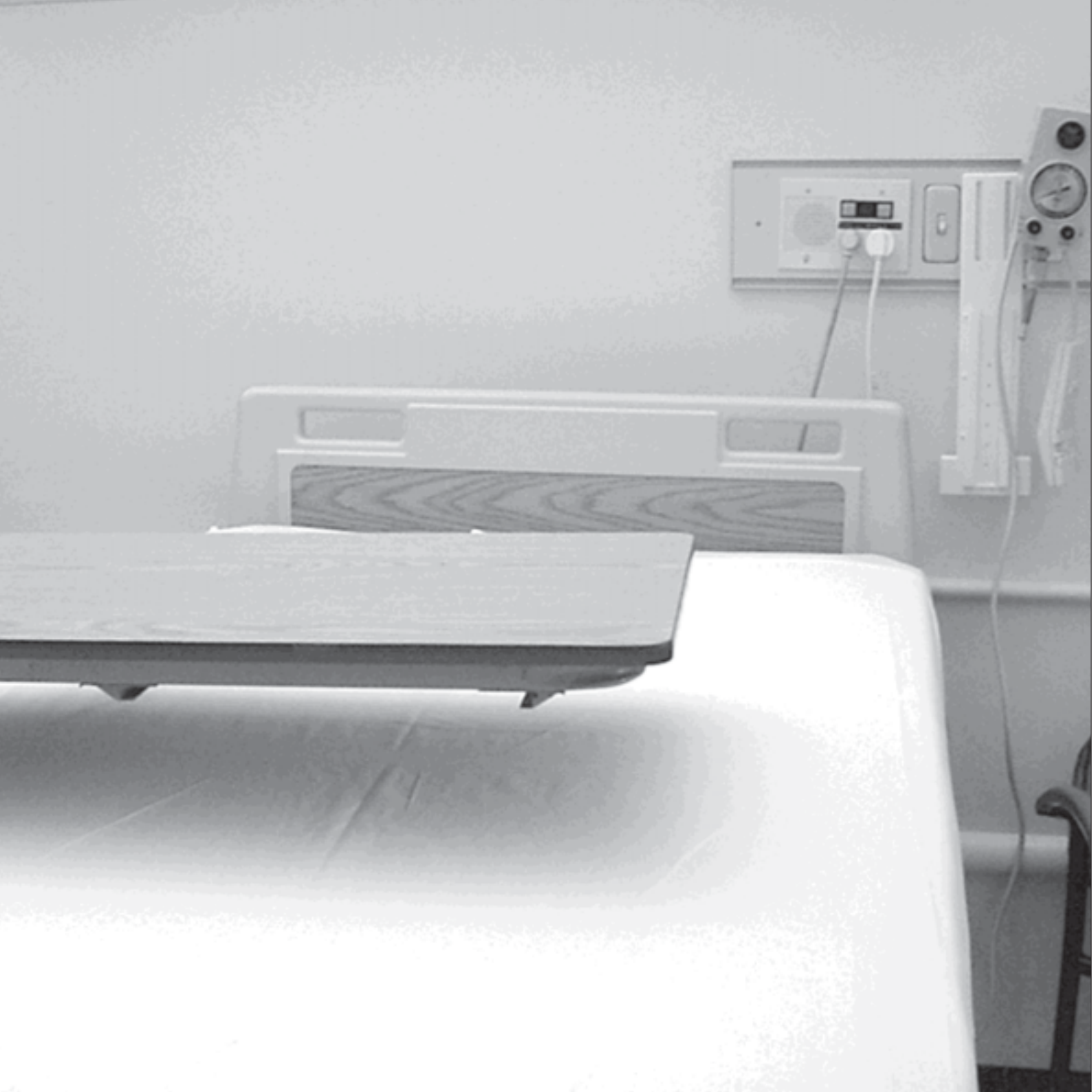
29. Wat is uw mening over deze stelling?

	Helemaal eens	Eens	Niet eens/ oneens	Oneens	Helemaal oneens
Ik vind het een goede ontwikkeling dat medisch specialisten in de ziekenhuisorganisatie integreren.	❑	❑	❑	❑	❑

30. Misschien wilt u naar aanleiding van deze **vragenlijst** nog aanvullende opmerkingen maken. U kunt uw reactie hier kwijt.

31. Misschien heeft u suggesties voor de **Orde van Medisch Specialisten** als het gaat om de rol en positie van de medisch specialist in de ziekenhuiszorg van vandaag en morgen. U kunt suggesties of opmerkingen hier kwijt.

HARTELIJK BEDANKT VOOR UW MEDEWERKING!!!



Dokterspraktijken

Het dagelijks werk van specialisten en hun aanspraken op zeggenschap in Nederlandse ziekenhuizen

Deel 1 Het onderzoek: achtergrond, theorieën en methoden

1. Papier en praktijk

Dit onderzoek gaat over het dagelijks werk van specialisten en over hun zeggenschap in het werk.[1] Andere studies over dit onderwerp gaan meestal over het management of over het beleid van ziekenhuizen. Dit onderzoek begint bij het 'echte werk' in de geneeskunde, de patiëntenzorg. De informatie komt direct uit dokterspraktijken.

Het idee voor het onderwerp komt wél uit management en beleid. Alle algemene Nederlandse ziekenhuizen krijgen sinds 1983 elk jaar een budget. Vóór die tijd waren de uitgaven van een ziekenhuis niet gelimiteerd. Om een eind te maken aan de stijgende kosten van ziekenhuizen werd er een budgetsysteem ingevoerd. Voor de medisch specialisten gold het budget niet. Zij werkten in de ziekenhuizen, maar ze waren daar over het algemeen niet in dienst. Hun werk werd betaald per verrichting, op basis van eigen overeenkomsten met ziektekostenverzekeraars. Het budget dwong managers van ziekenhuizen om activiteiten te beperken. Voor de specialisten was er geen reden om terughoudend te zijn. Zij bleven onveranderd een beroep doen op de activiteiten van het ziekenhuis - verpleging, apparatuur, bedden - ter ondersteuning van hun werk. Dit gaf in de ziekenhuizen veel problemen bij het verdelen van de budgetten.

Als oplossing voor de belangentegenstellingen adviseerde de 'Commissie Biesheuvel' in 1994 om de kosten van het werk van specialisten te integreren in het budget van het ziekenhuis. De commissie vond dat ziekenhuizen 'geïntegreerd medisch specialistische bedrijven' zijn, waar specialisten en anderen samen patiënten behandelen en verzorgen. De commissie pleitte ook voor deelname van specialisten in de leiding van afdelingen.

Er volgde een onrustige periode, waarin specialisten, ziekenhuizen, verzekeraars en de overheid het voortdurend met elkaar oneens waren over de uitwerking van de voorstellen. Uiteindelijk werd in 2000 de financiële en organisatorische 'integratie' van specialisten en het ziekenhuis vastgelegd in de 'Integratiewet'. In deze wet staat dat specialisten niet meer zelf afspraken maken met verzekeraars over behandelingen en vergoedingen. Dat doet het ziekenhuis. De raad van bestuur doet de onderhandelingen. Het ziekenhuis moet wel rekening houden met wat de specialisten nodig hebben voor hun patiëntenzorg, want zij zijn en blijven daarvoor verantwoordelijk. Specialisten, op hun beurt, moeten rekening houden met wat er is afgesproken over het budget.

De integratiewet en de documenten en regels die daarbij horen, vormen het 'kader' voor zeggenschap in het ziekenhuis. Dat is het papier. Maar wat is de praktijk? Wat willen specialisten te zeggen hebben in hun spreekkamer, op de afdeling of in het ziekenhuis? Waarover willen ze zeggenschap hebben in hun dagelijks werk?

Daarover gaat dit onderzoek. Eenenvijftig specialisten van zeven vakgebieden in twee ziekenhuizen deden eraan mee. Ze werden gevolgd in hun dagelijks werk. Bijna zevenhonderd specialisten vulden een vragenlijst in.

Artsen behoren tot een 'professie', een beroepsgroep met een exclusief werkveld, waar abstracte kennis en specialistische vaardigheden voor nodig zijn. Mensen die die kennis en vaardigheden niet hebben, kunnen niet zomaar beslissingen nemen over het werk in een professie. Daarom hebben professionals zelf relatief veel zeggenschap over hun eigen werk.

Specialisten zijn professionals die in ziekenhuizen werken. Ziekenhuizen vormen, net als andere organisaties, 'social orders'[2] die berusten op regels en afspraken die de personen en partijen in het ziekenhuis met elkaar maken. De vorming van zo'n 'order' is niet toevallig. Het is een

1 In het Engels wordt in het onderzoek de term 'jurisdiction' gebruikt. Deze term combineert begrippen als autonomie, bevoegdheid en 'recht van spreken'. Voor de leesbaarheid wordt in het Nederlands 'zeggenschap' gebruikt.

2 Het begrip 'order' ('social order' en 'negotiated order') is moeilijk in het Nederlands te vertalen. De term combineert begrippen als orde, rangorde, evenwicht, stelsel en systeem. Voor de zorgvuldigheid wordt 'negotiated order' niet vertaald.

proces waarin deelnemers proberen hun belangen te beschermen. Die belangen kunnen tegenstrijdig zijn, en ze kunnen veranderen. Daarom worden 'social orders' bepaald door voortdurende onderhandelingen. Het zijn 'negotiated orders'. Op elk moment in de tijd vormt de uitkomst van de onderhandelingen het begin van de volgende ronde.

Dit onderzoek gaat over de 'negotiated order' in het werk van specialisten. De onderzoeksvraag is: 'Wat is de aard van de onderhandelingen die de 'negotiated order' in het dagelijks werk van specialisten in ziekenhuizen bepalen, en welke aanspraken op zeggenschap liggen ten grondslag aan deze onderhandelingen?'

Voor de aard van de onderhandelingen is het 'wie', 'hoe' en 'wat' belangrijk.

Wie: de rollen van waaruit specialisten onderhandelen in hun dagelijks werk, en de mensen of partijen die zij in die onderhandelingen ontmoeten.

Hoe: de manier waarop specialisten onderhandelen.

Wat: de onderwerpen waar specialisten over onderhandelen.

De aanspraken op zeggenschap zijn niet vanzelf zichtbaar in de onderhandelingen. Om er achter te komen welke aanspraken ten grondslag liggen aan onderhandelingen, moeten eerst de onderwerpen worden onderzocht.

2. Verleden en heden

Specialismen ontstonden in Nederland tussen 1860 en 1930. Vóór die tijd waren er maar twee soorten artsen. De 'doctores medicinae' hadden aan de universiteit gestudeerd. Zij stelden diagnoses en schreven behandelingen en geneesmiddelen voor. De 'chirurgijns' hadden hun vaardigheden in de praktijk geleerd. Zij behandelden verwondingen en zweren en verwijderden stenen uit de blaas. Vanaf 1865 moest elke arts aan de universiteit zijn opgeleid. Daarna was er een snelle ontwikkeling van kennis en technologie. Er kwamen diagnostische mogelijkheden in radiologie, klinische chemie en pathologie. De kennis over bacteriën en infecties nam snel toe. Huisartsen bleven als algemeen arts werken. Uit de doctores medicinae kwamen 'beschouwende' specialisten voort, zoals internisten en cardiologen. De chirurgijns werden 'snijdende' specialisten. Voorbeelden daarvan zijn chirurgen en gynaecologen. De beschouwende en snijdende specialismen ontwikkelden zich doordat ze gebruik konden maken van nieuwe kennis en technieken - en die leidden tot een derde groep specialisten: 'ondersteuners', bijvoorbeeld anesthesiologen en radiologen.

De technologie werd vanaf het begin van de twintigste eeuw ondergebracht in ziekenhuizen. Daardoor veranderden de 'gasthuizen' in moderne behandelcentra, waar steeds meer specialisten gingen werken.

'Integratie' en 'participatie' zijn belangrijke woorden in de ziekenhuizen van nu. De integratiewet, ingevoerd in 2000, geeft de raad van bestuur van een ziekenhuis de verantwoordelijkheid te onderhandelen met zorgverzekeraars over de vergoedingen voor het werk van ziekenhuizen en specialisten samen. De specialisten hebben de taak om in het ziekenhuis na te gaan wat er nodig is voor goede patiëntenzorg en samen met de raad van bestuur regelingen af te spreken over bijvoorbeeld het medisch kwaliteitsbeleid, over het werk van specialisten, over hun 'participatie' in commissies en management, en over de continuïteit van zorg.

De meeste ziekenhuizen hadden tot de jaren negentig een 'centralistische' en 'hiërarchische' structuur. Elke leidinggevende kreeg instructies van een hogere leidinggevende, en elke leidinggevende moest aan die hogere leidinggevende verantwoording afleggen. Alle lijnen kwamen centraal bij elkaar, bij de directie. Door fusies en doordat het werk ingewikkelder werd, werden de ziekenhuizen daar te groot voor. Directies 'decentraliseerden' hun organisaties, en ze werden zelf 'raad van bestuur'. Raden van bestuur spreken nu met hun afdelingen af welke resultaten er moeten komen. Hoe die afdelingen dat doen, mogen ze nu meer zelf bepalen dan vroeger. In de meeste ziekenhuizen staat een afdeling onder

leiding van een manager en een 'medisch manager'. De medisch manager is een specialist die een dag of een dagdeel per week beschikbaar is voor organisatorische activiteiten, 'managementparticipatie'.

Nederlandse ziekenhuizen zijn 'geïntegreerd medisch specialistische bedrijven' geworden. De meeste specialisten werken niet in loondienst van het ziekenhuis - ze zijn 'vrij gevestigd' - maar de regelingen voor hun inkomsten zijn sinds de integratiewet wel onderdeel van ziekenhuisregelingen. Specialisten zijn ook bij de organisatie in het ziekenhuis betrokken, bijvoorbeeld door 'managementparticipatie' en in ziekenhuiscommissies. Dat wil niet zeggen dat de belangen van de verschillende partijen in het 'geïntegreerde bedrijf' vanzelfsprekend ook geïntegreerd zijn. De 'medische staf' - alle specialisten van één ziekenhuis samen - onderhandelt nog steeds met de raad van bestuur over de specialistenbelangen in het ziekenhuis. En voor onderhandelingen over de verdeling van de inkomsten hebben de 'vrijgevestigden' in één ziekenhuis meestal ook een eigen groep, bijvoorbeeld een 'koepelmaatschap'.

Hoe is het in het buitenland? Westerse landen hebben allemaal hun eigen organisatie van gezondheidszorg. In Nederland kunnen de meeste patiënten, behalve in noodgevallen, alleen naar een specialist als de huisarts hen verwijst. Dat is niet overal zo. De vrije vestiging van specialisten in ziekenhuizen is ook niet in elk land bekend. Het systeem waarin specialisten werken verschilt dus per land. Daarom zijn de resultaten van dit onderzoek niet zomaar ergens anders van toepassing. Maar overal wordt gezocht naar mogelijkheden om gezondheidszorg betaalbaar en toegankelijk te houden. Om dat mogelijk te maken zijn vaak veranderingen nodig, ook in de organisatie van ziekenhuizen. Zulke veranderingen beïnvloeden de 'negotiated order'. Als voorbeeld van een analyse van een 'negotiated order' kan dit onderzoek daarom wel voor andere landen betekenis hebben.

3. Theorieën

Omdat het onderzoek zich afspeelt in de praktijk van specialisten, moet eerst duidelijk worden wat het dagelijks werk van specialisten is. Patiëntenzorg is het belangrijkste. Daar besteden ze de meeste tijd aan in vergelijking met hun werk voor onderwijs of onderzoek, en ook in vergelijking met hun organisatorische activiteiten, zoals vergaderen, roosters maken en 'managementparticipatie'. Het eerste deel van het theoretisch kader is daarom een model met drie handelingen als afzonderlijke stappen in patiëntenzorg. 'Diagnosticeren' is de stap waarin het probleem van de patiënt wordt vertaald in medische kennis. De uitkomst daarvan is een diagnose, of ideeën over mogelijke diagnosen. 'Behandelen' is de stap waarin medische kennis wordt vertaald in mogelijke oplossingen voor het probleem van de patiënt. Soms bieden geneesmiddelen een oplossing, of leefregels. Soms moeten artsen of anderen, bijvoorbeeld verpleegkundigen of fysiotherapeuten, de behandeling uitvoeren. Operaties zijn de belangrijkste behandelingen in de snijdende specialismen. 'Redeneren' over diagnoses en behandeling, en over de specifieke patiënt en de algemene medische kennis, is de stap waarin alle handelingen en overwegingen bij elkaar komen.

In werkelijkheid zijn de drie stappen of handelingen steeds met elkaar verbonden. Ze hebben geen vaste volgorde, het zijn geen losse stappen in de tijd.

De dagelijkse organisatie van het werk in patiëntenzorg wordt in het onderzoek beschreven door na te gaan op welke plaatsen specialisten werken, hoe hun tijd in patiëntenzorg bepaald wordt, en met wie ze werken.

Er wordt door beschouwende, snijdende en ondersteunende specialisten niet op dezelfde manier gediagnosticeerd, behandeld en geredeneerd. De drie stappen uit het model zijn ook niet voor ieder vakgebied even belangrijk. Daarom is hun werk apart onderzocht.

Het tweede deel van het theoretisch kader gaat over de invulling van het 'wie', 'hoe' en 'wat' in de onderhandelingen die de 'negotiated order' in het werk van specialisten bepalen.

Eerst het 'wie'. Specialisten hebben in hun werk relaties met mensen of groepen om hen heen. Ze kunnen zeven verschillende rollen spelen, afhankelijk van de relatie waar het om gaat. De rol van dokter (1) spelen ze als ze inhoudelijk met patiëntenzorg bezig zijn, als ze direct contact hebben met patiënten, of als ze besprekingen hebben over patiënten. In hun rol van collega (2) werken ze samen met de specialisten van hetzelfde vakgebied. De meeste specialisten zijn niet in dienst van het ziekenhuis. Ze hebben dan samen met de collega's van één vakgebied een

maatschap, en ze verdelen in die maatschap de kosten die ze maken en de inkomsten die ze via het ziekenhuis ontvangen. Als artsen wel in loondienst zijn, hebben ze samen met de collega's van één vakgebied een vakgroep. Ook dan zorgen ze samen voor de organisatie van de patiëntenzorg.

Artsen in ziekenhuizen werken op patiëntenafdelingen en in poliklinieken waar ook anderen werken, verpleegkundigen, doktersassistentes, laboranten. In de rol van afdelingslid (3) hebben specialisten een relatie met die medewerkers, of ze vertegenwoordigen de belangen van de afdeling.

Alle specialisten in één ziekenhuis zijn lid van de medische staf. De medische staf vergadert met de raad van bestuur over onderwerpen die voor alle specialisten of voor het hele ziekenhuis belangrijk zijn. Dan hebben specialisten de rol van staflid (4). De meeste artsen werken in één ziekenhuis. In hun rol van ziekenhuislid (5) zitten ze bijvoorbeeld in een commissie.

Specialisten hebben ook een privé-leven. En ze zijn individuen die van elkaar verschillen in hun manier van werken. Dit bepaalt hun rol van individu (6). Vanuit die rol letten ze bijvoorbeeld op hun werktijden, en door die rol hebben ze verschillende stijlen van omgaan met hun patiënten. En tenslotte is elke arts lid van de medische professie. Specialisten van één vakgebied doen in hun rol van professional (7) bijvoorbeeld mee aan de ontwikkeling van landelijk kwaliteitsbeleid. Of ze vergaderen over nieuwe manieren om de gezondheidszorg te betalen.

Vanuit deze zeven rollen onderhandelen specialisten dagelijks met verschillende mensen en groepen. Soms moeten ze met zichzelf onderhandelen als twee rollen gelijktijdig tegenstrijdige eisen stellen, bijvoorbeeld wanneer ze als dokter het spreekuur rustig willen afronden, maar als individu op tijd thuis willen zijn.

Dan over het 'hoe' van onderhandelingen. Onderhandelingen kunnen klein of groot zijn, ze zijn doelgericht gestart of ze worden juist gevoerd zonder dat de deelnemers zich daar bewust van zijn. Ze gaan vaak samen met andere vormen van interactie, bijvoorbeeld dwang of overreding.

In het onderzoek is informatie verzameld over de verschillende soorten onderhandelingen in de verschillende rollen. Er zijn drie soorten tactieken in onderhandelingen, afhankelijk van de beoogde resultaten. 'Vechten of aanvallen' is nodig als je je belangen wilt verdedigen bij een aanval of als je ze wilt uitbreiden bij tegenstand. 'Verdedigen of behouden' is gericht op bescherming of op het voorkómen van schade. 'Vluchten of opgeven' betekent dat je het niet langer nodig vindt om in actie te komen, of dat je denkt dat het toch zinloos is.

Tenslotte het 'wat'. De aanspraken op zeggenschap zullen zelden direct zichtbaar zijn in onderhandelingen. Daarom is analyse van de onderwerpen van onderhandelingen nodig, om te ontdekken wat de onderliggende onderwerpen zijn waar specialisten zeggenschap over willen hebben.

Specialisten behoren tot de medische professie. Omdat professionals zelf veel zeggenschap hebben, moet de maatschappij er op kunnen vertrouwen dat professionals hun kennis zo goed mogelijk toepassen en dat ze werken in het belang van wie hun hulp of advies nodig heeft. Daarom stellen professionals strenge eisen aan hun opleidingen en daarom moeten ze zich aan bepaalde gedragsregels houden. Om te begrijpen waarom specialisten over bepaalde onderwerpen iets te zeggen willen hebben, is in het onderzoek gevraagd naar hun 'professionele oriëntatie'. Dit is het derde deel van het theoretisch kader. In hoeverre steunen specialisten het 'professioneel primaat', het uitgangspunt dat patiëntenzorg in het ziekenhuis altijd op de eerste plaats komt, vóór geld en efficiency? Hoe belangrijk is 'autonomie', de vrijheid om te beslissen over de inhoud en de organisatie van hun werk, en over de manier waarop de kwaliteit van het werk bewaakt wordt? Hoe belangrijk is 'egalitarisme', de onderlinge gelijkheid van specialisten in een groep? Voelen specialisten zich goed in hun werkomgeving? En verwachten ze dat hun onderlinge belangenbehartiging, bijvoorbeeld in de medische staf, zal blijven bestaan?

Ook is in het onderzoek gevraagd naar de oriëntatie op het ziekenhuis. Hoe betrokken voelen ze zich bij de organisatie en de besluitvorming in het ziekenhuis, en hoe betrokken willen ze zich voelen? Wat vinden ze van 'integreren' of 'participeren'? Welke rol moeten de specialisten spelen die ook manager zijn?

In elk ziekenhuis vormen de verhoudingen tussen zeggenschap van managers, zeggenschap van patiënten, en zeggenschap van specialisten een bepaald evenwicht. Dit onderzoek maakt dat evenwicht zichtbaar in het dagelijks werk van specialisten.

4. Methoden

Het onderzoek is 'exploratief'. In de verzamelde informatie is naar patronen en verbanden gezocht, zonder dat die vooraf in hypotheses zijn voorspeld. Daarbij zijn kwalitatieve methoden gebruikt, omdat die nuttig zijn voor diepgaand onderzoek bij enkele mensen of groepen. Voor een breder, maar oppervlakkiger beeld van het werk van specialisten zijn kwantitatieve methoden gebruikt. Die zijn geschikt voor het verzamelen van informatie bij veel verschillende mensen tegelijk.

De kwalitatieve methode is een 'meervoudige gevalstudie'. In zeven afzonderlijke specialistengroepen werd informatie verzameld over het dagelijks werk. De twee beschouwende vakgebieden in het onderzoek zijn interne geneeskunde en cardiologie. Er hebben drie snijdende groepen deelgenomen. Gynaecologie heeft in beide ziekenhuizen aan het onderzoek meegedaan, en heelkunde in één ziekenhuis. De ondersteunende vakgebieden zijn anesthesiologie en radiologie.

In totaal werden 51 specialisten tenminste één dagdeel gevolgd. Samen is dat bijna 300 uur met observaties. Aanvullend zijn er 40 afzonderlijke interviews gehouden met specialisten. Schriftelijke bronnen zijn in de loop van elke studie verzameld en geanalyseerd (instructies, roosters, protocollen, agenda's en stukken uit maatschapsvergaderingen). De aantekeningen van observaties en interviews zijn verwerkt in een computerprogramma voor kwalitatieve analyses, 'Atlas/ti'.

De kwantitatieve benadering is een landelijk vragenlijstonderzoek onder een steekproef van 2000 specialisten in algemene ziekenhuizen. De respons is 34%. De vragenlijsten zijn verwerkt in een computerprogramma voor kwantitatieve analyses, 'SPSS'.

De samenstelling van de responsgroep komt bijna helemaal overeen met de samenstelling van de populatie, voor zover het ging om specialisme en geslacht. Er is geen onderzoek gedaan onder de mensen die de vragenlijst niet hebben ingevuld. Daarom zou het toch kunnen dat de meningen van de deelnemers anders zijn dan die van de specialisten die geen reactie hebben gegeven.

De onderzoeker is zelf arts en bestuurskundige. Ze werkt als beleidsmedewerker in één van de deelnemende ziekenhuizen. Deze combinaties van rollen en functies heeft voordelen en nadelen. Er zijn verschillende maatregelen genomen om de nadelen te beperken en voor iedereen duidelijk te maken wanneer welke rol of functie aan de orde was. De onderzoeker heeft ook een dagboek bijgehouden waarin zij haar eigen rol kritisch volgt.

Door deze maatregelen zijn de voordelen van de verschillende rollen en functies versterkt en waren de onderzoeksomstandigheden gunstig voor het verzamelen van zoveel mogelijk informatie.

Deel 2 Resultaten

5. Het werk in patiëntenzorg

Om onderhandelingen in de 'negotiated order' in het werk van specialisten te kunnen begrijpen, is eerst het belangrijkste werk van specialisten nader onderzocht: de patiëntenzorg. Specialisten besteden het grootste deel van hun tijd aan patiëntenzorg. Tachtig procent, zeggen ze in het vragenlijstonderzoek. Ze verdelen dat over 65% direct contact met de patiënt en 15% activiteiten die met patiëntenzorg te maken hebben, bijvoorbeeld besprekingen en administratie.

In de zeven deelnemende specialistengroepen werd dieper ingegaan op het diagnosticeren, behandelen en redeneren in de verschillende specialismen.

In beschouwende vakgebieden is redeneren vooral argumenteren. Het verband tussen diagnostiek en behandeling wordt steeds zoveel mogelijk gelegd in een sluitend betoog, een verhaal.

In de snijdende vakgebieden worden vooral besluiten genomen. Elke toepassing van chirurgie in diagnostiek of in de behandeling van een patiënt moet voortkomen uit een duidelijke beslissing.

Voor de ondersteunende disciplines is verbindingen leggen heel belangrijk in de momenten van redeneren. Ondersteuners leggen een verbinding tussen aanvraag en uitvoering. Radiologen beoordelen de aanvraag van de hoofdbehandelaar, om te beslissen wat er radiologisch moet gebeuren. Anesthesiologen beoordelen welke anesthesie het beste past bij de operatie. Daarna geven ondersteuners aan wat de aanvragers verder moeten doen, of waar ze op moeten letten. De radiologen maken een verslag van hun bevindingen dat past bij wat aanvragers willen weten. Anesthesiologen geven na de narcose instructies, bijvoorbeeld over wat er moet gebeuren als de patiënt misselijk wordt. Ondersteuners moeten steeds 'dubbel denken': vanuit hun eigen vakgebied en vanuit de vakgebieden van de aanvragers.

Artsen organiseren de tijden en de plaats van hun werk in roosters. In de beschouwende vakken laten de roosters vooral poliklinische spreekuren zien, visites op de afdeling en de supervisie van arts-assistenten. In de snijdende vakken zijn de belangrijkste onderdelen de operatiekamer, de poliklinische spreekuren, de visites op de afdeling en de supervisie van arts-assistenten. In de ondersteunende specialismen zijn de roosters gebaseerd op de onderlinge verdeling van ruimtes of apparatuur.

Met welke mensen werken specialisten? In alle vakgebieden staan patiënten bovenaan. Daarna komen de collega's uit het eigen vak, de specialisten uit andere vakken, en de verpleegkundigen en andere medewerkers in de patiëntenzorg.

In de beschouwende vakken wordt de arts-patiënt relatie sterker dan in de andere vakken bepaald door een vorm van wederzijds eigendom tussen dokter en patiënt. Patiënten hebben het over 'mijn dokter' en artsen hebben het over 'mijn patiënt'. Dat doen de meeste artsen. De meeste artsen hechten ook belang aan de relatie met 'hun patiënt'. Maar in de beschouwende vakken weegt dat zwaarder dan in de andere vakken. De relaties die beschouwende specialisten met patiënten hebben zijn vaker langdurig omdat er meer chronische patiënten zijn. De aard van de ziektebeelden en het belang van 'het verhaal' leiden ook tot gesprekken die over andere onderwerpen gaan dan alleen over het lichamelijk functioneren.

In de samenwerking tussen beschouwende collega's is het gezamenlijk opbouwen van een betoog van belang. De collega's helpen elkaar met het vinden van argumenten. Dat geldt ook voor de samenwerking met verpleegkundigen op de afdeling. De specialisten vragen de verpleegkundigen om informatie te verzamelen die nodig zou kunnen zijn voor het vervolg van diagnostiek en behandeling.

In de snijdende vakken wordt 'eigendom' in de arts-patiënt-relatie vooral bepaald door wie de patiënt geopereerd heeft. In het contact met de patiënt moet informatie worden verzameld die nodig is voor de beslissing over eventueel opereren. Gesprekken worden meer dan in de beschouwende vakken bepaald worden door feiten. De samenwerking tussen snijdende collega's onderling is vooral gezamenlijke besluitvorming. De specialisten toetsen elkaars redenering die wel of niet leidt tot de beslissing om chirurgisch te handelen. Samenwerking met verpleegkundigen is ook meer gezamenlijke besluitvorming dan in de andere vakken, waardoor discussies en gesprekken zakelijker zijn.

In de ondersteunende vakken hebben de specialisten meestal geen 'eigen' patiënten. Een uitzondering in het onderzoek zijn de patiënten die naar de 'pijnpoli' van de anesthesiologen komen. De andere patiënten zijn van de hoofdbehandelaar, die de patiënt verwijst voor aanvullend onderzoek of voor ondersteuning van de behandeling. Ondersteunende specialisten hebben meer communicatie over de patiënt met de hoofdbehandelaar dan met de patiënt zelf. Het leggen van verbindingen met de patiëntenzorg van de aanvragers werkt door in de onderlinge samenwerking van ondersteunende collega's. Samen moeten ze diensten verlenen aan de aanvragers en ze moeten beschikbaar zijn voor de aanvragers. Hier is dan ook, in vergelijking met de andere vakgebieden, de minste ruimte voor individuele variatie in de technische uitvoering van het werk. Doordat de apparatuur geconcentreerd is op één of enkele afdelingen, zijn de meeste collega's vaak bij elkaar in de buurt. Laboranten en assistenten zijn ook altijd dichtbij. Zij voeren vooral taken uit in het proces van de specialisten. Complexere technieken doen specialisten zelf. De voorbereidingen, de bewaking en de eenvoudiger technieken doen laboranten of assistenten.

Alle specialisten blijken zich veel bezig te houden met logistiek. Vele malen per dag gaan ze na of de planning van patiënten nog klopt, of het werk goed verdeeld is over de specialisten en arts-assistenten, of er genoeg bedden zijn, of de informatie die nodig is wel beschikbaar is. Waar ze dan op letten, verschilt per vakgebied.

Het gaat de beschouwende specialisten vooral om de contacten met individuele patiënten. Op welk moment moet een patiënt terugkomen? Welke informatie moet dan bekend zijn? Welke dokter moet die patiënt spreken? De snijdende specialisten letten vooral op de patiëntenstromen. Gaan er wel genoeg patiënten naar huis vandaag? Kunnen de nieuwe patiënten worden opgenomen? Zijn er bedden beschikbaar? Is er ruimte op de operatiekamers?

In de logistiek van de ondersteunende vakgebieden staat de afstemming met aanvragers centraal. Wanneer zijn er spreekuren van aanvragers die veel mensen doorsturen? Wanneer moet de informatie bekend zijn? Of, voor anesthesiologen, om welke ingreep gaat het en welke vormen van anesthesie zijn dan geschikt?

6. Onderhandelingen in patiëntenzorg

Als specialisten de rol van dokter spelen in hun patiëntenzorg zijn ze bezig met individuele patiënten, of met de belangen van hun patiëntenpopulatie in het algemeen. Als ze de rol van afdelingslid spelen, werken ze in hun patiëntenzorg samen met verpleegkundigen, doktersassistentes, laboranten, arts-assistenten. Specialisten onderhandelen in hun werk in patiëntenzorg vanuit deze twee rollen.

Beschouwende specialisten doen in hun patiëntenzorg aan 'toegangsbewaking'. Zij willen iets te zeggen hebben over de toegang van patiënten en over de problemen waar patiënten mee komen. Het gaat in hun vakken vooral om 'argumenteren'. Medisch inhoudelijk moet het verhaal over elke patiënt kloppen. Daarom moeten de specialisten er bij een nieuwe patiënt op letten dat het verhaal wel aansluit bij hun specialisme. Als het probleem van de patiënt nog niet helemaal duidelijk is, kan de keuze voor het juiste specialisme moeilijk zijn. Specialisten van verschillende vakgebieden onderhandelen dan met elkaar over waar de patiënt het beste terecht kan. Patiënten willen soms ook problemen aan de orde stellen die wel met hun gezondheid te maken hebben, maar niet met het vakgebied van de specialist. Dan onderhandelen arts en patiënt er over. Vaak vinden de specialisten dat zo'n probleem beter met de huisarts kan worden besproken.

Snijdende specialisten doen aan 'verkeersleiding' in hun patiëntenzorg. Meestal wordt één patiënt maar één keer geopereerd. Omdat opereren de essentie van het vakgebied is, moet er geen stagnatie van de patiëntenstroom zijn. Veel onderhandelingen van snijdende specialisten gaan dan ook over opnames en ontslag, over de beschikbaarheid van operatiekamers en bedden, en over de informatie die nodig is in de patiëntenzorg, zoals dossiers, laboratoriumuitslagen of röntgenfoto's. Ze onderhandelen bijvoorbeeld met managers en medewerkers van het opnamebureau. Snijdende specialisten willen iets te zeggen hebben over de logistiek van de patiëntenstromen en over ziekenhuiscapaciteit, omdat ze willen blijven opereren.

In de onderhandelingen in de patiëntenzorg doen ondersteunende specialisten aan 'positiebewaking'. Hun werk ondersteunt de patiëntenzorg van de specialisten die de aanvragen doen. Die hebben de neiging het ondersteunende werk vanzelfsprekend te vinden en soms weinig rekening te houden met de specialistische kennis die

daarvoor nodig is. Ondersteunende specialisten bewaken in de relatie met de aanvragers hun positie en de exclusiviteit van hun werk. Ze willen iets te zeggen hebben over hun eigen patiëntenzorg, en over de exclusieve toepassing van kennis, technieken en apparatuur waarin zij de verbinding leggen tussen hun eigen vakgebied en patiëntenzorg van de aanvrager.

Specialisten steunen het principe van het 'professioneel primaat': ze vinden dat patiëntenzorg in het ziekenhuis altijd op de eerste plaats moet komen. Vóór geld en efficiency. Dat blijkt uit het vragenlijstonderzoek. Ze vinden dat de kwaliteit van hun patiëntenzorg bedreigd wordt doordat ze te veel rekening moeten houden met financiële en organisatorische overwegingen. Als het gaat om autonomie, vinden specialisten dat hun beroepsgroep zelf de kwaliteit van patiëntenzorg moet bewaken. Managers in het ziekenhuis moeten zich niet inhoudelijk bemoeien met de medische beroepsuitoefening. Ze kunnen misschien wel initiatief nemen om af en toe iets aan patiëntenzorg te veranderen.

7. Onderhandelingen in het ziekenhuis

Specialisten spelen in het ziekenhuis de rollen van collega, lid van de afdeling, van de staf en van het ziekenhuis. Er zijn specialisten die óók de rol van 'medisch manager' hebben. In de drie groepen specialismen zijn er, als het om die rollen gaat, accentverschillen in de onderhandelingen. Maar de overeenkomsten zijn groter dan in de onderhandelingen in de patiëntenzorg. In elke rol gaan de onderhandelingen over het organiseren van werk en over het bevestigen of verbeteren van posities en relaties. De rollen van collega en lid van de afdeling zijn het belangrijkste voor het evenwicht in het dagelijks werk van specialisten.

De rol van collega is belangrijk omdat specialisten van één vakgebied niet zonder elkaar kunnen werken. Solo praktijken komen niet meer voor. Specialisten letten op elkaar in de patiëntenzorg en ze vullen elkaar aan in besprekingen over individuele patiënten. Ze verdelen ook verschillende aandachtsgebieden in het specialisme. Voor de organisatie van het werk hebben ze elkaar ook nodig. Ze verdelen diensten en taken in onderwijs en onderzoek, of in de organisatie.

In hun onderlinge relaties willen individuele collega's iets te zeggen hebben over de manier waarop het werk wordt georganiseerd, en over de manier waarop ze samenwerken. Maar het evenwicht in de groep staat ten dienste van het gezamenlijke belang. Het gaat niet om de individuele collega. 'Harde' belangen, bijvoorbeeld de verdeling van het inkomen over de collega's, worden wel besproken. Maar over minder concrete onderwerpen, zoals de stijl van patiëntenzorg of de manier van met elkaar omgaan, praten specialisten weinig met elkaar. Omdat collega's intensief samenwerken zonder veel ruimte voor het uitspreken van individuele voorkeuren of meningen, ontstaan er irritaties. Bijna elke specialistengroep kent vroeg of laat een periode waarin onderlinge verhoudingen gespannen of slecht zijn.

In de groep collega's hoort iedereen even veel waard te zijn. De specialisten geven in het vragenlijstonderzoek aan dat ze 'egalitarisme' belangrijk vinden. Alle groepsleden moeten dezelfde mate van zeggenschap hebben. De meeste specialisten zeggen zich thuis te voelen in hun groep collega's.

De collega's komen samen op voor hun belangen in relaties met andere specialistengroepen en managers. De onderhandelingen gaan dan over de positie van de groep in het ziekenhuis, over geld en over de aantallen patiënten die gezien en behandeld worden, de 'productie'.

De zeven specialistengroepen in dit onderzoek werken in ziekenhuizen die recent zijn gefuseerd. De relatie met de collega-specialistengroep in 'het andere ziekenhuis' moet nog in evenwicht komen. Verder letten de collega's op hun positie ten opzichte van het management, ten opzichte van andere specialistengroepen en ten opzichte van andere ziekenhuizen of specialistengroepen in de regio.

De specialisten hebben het vaak over hun 'eigen winkel', als ze het hebben over hun groep collega's van één vakgebied. Samen willen zij het voor het zeggen hebben in hun 'winkel'. Zij willen beslissen over de inhoud van het werk in de patiëntenzorg, over de financiën, en over de organisatie van het werk.

De rol van afdelingslid is belangrijk omdat het werk pas echt begint op afdelingen, in poliklinieken en in operatiekamers. Specialisten onderhandelen over de organisatie van het werk op de afdeling. Ze willen een erkende rol spelen in het management. Ze onderhandelen ook over de verdeling van taken tussen hen en anderen op

de afdeling en over 'ruimte en spullen', kamers, apparatuur en instrumenten. In de onderhandelingen hebben de specialisten te maken met managers, en ook met medisch managers als die er zijn, met collega's, en met andere specialistengroepen. In de enquête geven ze aan meer betrokken te willen worden bij beslissingen over de organisatie van de afdeling. Vooral beschouwende specialisten willen zeggenschap over de gang van zaken op de afdeling. Specialisten in snijdende vakken willen dat het duidelijk is dat de specialist de baas is in de patiëntenzorg. Zij hebben minder dan anderen behoefte aan invloed op het afdelingsbeleid. De ondersteunende specialisten zijn tevredener over hun invloed op de afdeling dan de anderen.

Als lid van de afdeling onderhandelen specialisten ook over hun positie ten opzichte van de medewerkers. De specialisten zijn niet hun 'gelijken', ze staan in sociaal en functioneel opzicht hoger. Het gaat er niet om dat specialisten zomaar iets te zeggen willen hebben over de mensen op de afdeling. Het gaat er om dat het in de patiëntenzorg duidelijk moet zijn dat de specialist de leiding heeft. In het vragenlijstonderzoek vinden veel specialisten dat zij de baas horen te zijn in de patiëntenzorg. Ze vinden niet dat ze zonder meer de baas horen te zijn van iedereen in het ziekenhuis.

Specialisten voeren ook onderhandelingen over de afdeling. Bijvoorbeeld als het gaat over reorganisaties of verbouwingen, waar specialisten met managers over praten. Ze onderhandelen bij een fusie ook met collega's en managers van de overeenkomstige afdeling in 'het andere ziekenhuis'.

Specialisten letten in hun rol van afdelingslid vooral op de belangen die ze als dokter en collega hebben. Ze willen iets over de afdeling te zeggen hebben, omdat ze daar als dokter en als collega werken. De belangen die ze behartigen hebben bijvoorbeeld te maken met de logistiek en inhoud van de patiëntenzorg, of met 'productie' en de organisatie van het werk van de groep collega's.

Specialisten onderhandelen in hun dagelijks werk weinig als staflid of als ziekenhuislid. Natuurlijk maken ze deel uit van de medische staf en van het ziekenhuis. Maar deze rollen krijgen alleen een eigen vorm wanneer specialisten bijzondere functies hebben, bijvoorbeeld in het stafbestuur, een stafcommissie, of in een ziekenhuiscommissie.

In de enquête geeft 20% van de respondenten aan medisch manager te zijn. In de observaties waren er maar vier medisch managers. Zij onderhandelen over hun positie in relaties met managers, specialisten en specialistengroepen. Ze onderhandelen ook over de organisatie van werk.

Als manager moeten ze leren omgaan met de schaarse middelen in het ziekenhuis en daarom proberen ze ook hun collega's ervan te overtuigen dat ze soms op een andere, efficiëntere manier moeten werken. In onderhandelingen met 'echte' managers proberen medisch managers de patiëntenzorg te beschermen en te voorkómen dat de financiële druk te groot wordt.

De medisch managers lijken hun onderhandelingen te baseren op een 'hybride' grondslag. In hun relatie met managers willen ze iets te zeggen hebben over de organisatie van patiëntenzorg, waarbij ze de patiëntenzorg proberen te beschermen of verbeteren. Wanneer ze hun collega's 'managen', willen ze iets te zeggen hebben over de organisatie van specialistenwerk. Daarbij wijzen ze op schaarste, of op het belang van het ziekenhuis als geheel.

8. De specialist als individu en als professional

Specialisten hebben ook een privé-leven. In het ziekenhuis onderhandelen ze daar vooral met zichzelf over. Ze wegen hun persoonlijk belang, bijvoorbeeld dat ze op tijd thuis zijn, dan af tegen de verplichtingen vanuit andere rollen, vooral die van dokter en die van collega. Wanneer ze met zichzelf onderhandelen zoeken ze naar mogelijkheden waarbij ze niet voor één van de rollen hoeven te kiezen. Als ze op tijd naar huis willen gaan én ze hebben een maatschapsvergadering, dan gaan ze bijvoorbeeld wat eerder weg bij die vergadering. Als dat niet kan, laten ze de belangen die ze als dokter of collega hebben meestal voorgaan.

Specialisten hebben hun eigen ideeën over onderlinge relaties in de groep. Ze hebben persoonlijke voorkeuren voor de stijl van samenwerken en de taakverdeling met collega's. Toch - dat kwam al eerder aan de orde - onderhandelen ze daar weinig over. Ze vinden het zo belangrijk om onderlinge relaties goed te houden, dat ze onderhandelingen over persoonlijke voorkeuren liever vermijden. Het is ook niet gebruikelijk om persoonlijke ambities te bespreken, of loopbaanwensen.

Specialisten willen als individu graag iets te zeggen hebben over de inrichting van het dagelijks werk, over de relaties met collega's en over de individuele loopbaan. Maar de onderhandelingen daarover zijn bescheiden, omdat ze vinden dat de groep belangrijker is dan het individu.

Vrouwen en jongere specialisten zijn de specialisten van de toekomst. Uit de enquête blijkt dat zij autonomie minder belangrijk vinden dan mannen en oudere specialisten. En dat vrouwen vaker van zichzelf vinden dat ze als 'gewone medewerker' moeten meedoen in het ziekenhuis. Vijf procent van de groep specialisten ouder dan 50 jaar is vrouw. In de jongste groep, tot en met 40 jaar, is dat 40%. Omdat zij vaker in deeltijd en in loondienst werken, zal in de toekomst de voltijds werkende, vrij gevestigde specialist minder vaak voorkomen dan nu. In de oudere specialistengroepen werkt 80% in vrije vestiging. In de jongste groep is dat iets meer dan 60%.

Specialisten werken in de Nederlandse gezondheidszorg. Ze zijn lid van de medische professie, de beroepsgroep van artsen. En ze zijn lid van hun eigen specialisme. Op deze drie niveaus spelen ze een rol als professional.

Aan echte onderhandelingen over de Nederlandse gezondheidszorg nemen specialisten alleen deel als ze een formele rol hebben in een landelijke organisatie. Die onderhandelingen spelen zich buiten het ziekenhuis af. Ze zijn niet onderzocht in de observaties. Specialisten praten er wel over in het ziekenhuis. Er komt een nieuw financieringssysteem dat gebaseerd is op Diagnose Behandel Combinaties. De meeste specialisten hebben daar weinig vertrouwen in. Ze mopperen er over.

Als professional zijn specialisten ook vertegenwoordigers van de medische beroepsgroep in Nederland. Ze willen samen iets te zeggen hebben over hun werk en daar hebben ze maatschappelijk en juridisch ruimte voor nodig. Daarom hebben ze bijvoorbeeld hun eigen normen in ontmoetingen met niet-specialisten. Specialisten vinden het goed dat ze wat meer tot 'gewone mensen' gerekend gaan worden, maar dat moet, vinden ze, niet worden overdreven. Om als dokter enig overwicht te hebben, moet de maatschappij óók blijven opkijken tegen specialisten.

De rol van lid van één bepaald specialisme wordt buiten het ziekenhuis ingevuld als een specialist actief is in een wetenschappelijke vereniging. Ook dat is in het onderzoek niet geobserveerd. In het vragenlijstonderzoek zijn specialisten die actief zijn in een wetenschappelijke vereniging wat minder 'traditioneel' in hun 'professionele oriëntatie' dan anderen. Ze vinden 'autonomie' en 'egalitarisme' minder belangrijk en ze vinden vaker dat specialisten 'gewoon' mee moeten doen met de rest van het ziekenhuis.

In het ziekenhuis zorgen wetenschappelijke en technische, maar ook maatschappelijke ontwikkelingen ervoor dat patiëntenzorg verandert en dat de verdeling ervan tussen verschillende vakgebieden verandert. Daardoor voeren medische vakgebieden 'onderhandelingen' met elkaar. In de beschouwende vakken zeggen specialisten bijvoorbeeld dat ze ervaren dat de grens met de huisartsgeneeskunde verschuift. Patiënten hebben in toenemende mate psychosociale problemen, naast hun lichamelijke problemen of als gedeeltelijke oorzaak van die lichamelijke problemen.

Alle specialismen ontwikkelen hun kennis en kunde. Ondersteunende specialismen ontwikkelen nieuwe aandachtsgebieden in de patiëntenzorg, bijvoorbeeld pijnbestrijding en intensive care geneeskunde in de anaesthesiologie. Of ze gaan hun kennis en vaardigheden toepassen op de patiëntenzorg van andere specialismen. Echoscopische diagnostiek in de radiologie is bijvoorbeeld een belangrijke aanvulling op de diagnostiek van beschouwende vakgebieden. Sommige radiologen denken dat zij de diagnostiek van beschouwende vakgebieden grotendeels zouden kunnen overnemen. Radiologen kunnen ook onder röntgendoorlichting vernauwingen of obstructies in bloedvaten en ingewanden behandelen, bijvoorbeeld door een 'stent' te plaatsen. Operaties zijn dan niet meer nodig, en daarmee komen ze op het terrein van snijdende vakken.

Het gaat in deze verschuivingen meestal niet om letterlijke onderhandelingen tussen artsen van verschillende vakgebieden. Al kunnen specialisten zich wel in strijdbare termen over andere vakken uitspreken. Specialisten willen, als professional in hun eigen vak, iets te zeggen hebben over de toepassing van hun kennis en kunde, zo mogelijk ook als het gaat om patiënten en problemen die ergens anders 'horen'. Alleen is in de beschouwende vakken de 'toegangsbewaking' belangrijker dan het 'overnemen' van huisartsgeneeskundige patiëntenzorg. Er wordt dan ook veel gemopperd over de psychosomatische problematiek in de spreekkamer van de specialist.

Deel 3 Conclusie en discussie

9. Conclusies en discussie

Specialisten zijn vooral dokter en collega. Deze rollen zijn het meest bepalend voor de 'negotiated order' in hun werk. Ze onderhandelen omdat ze als dokter iets te zeggen willen hebben over de patiëntenzorg en over de logistiek van patiëntenzorg. Als collega's gaat het ze om de organisatie van de 'winkel' die ze samen hebben.

Specialisten zijn op hun hoede als het gaat om hun positie in verschillende relaties. Als de mogelijkheid zich voordoet, proberen ze in onderhandelingen hun positie ten opzichte van hun omgeving te verbeteren. Deze mogelijkheden kunnen zich onverwacht voordoen. Het is belangrijk om steeds te weten wat de uitgangspositie is in de verschillende relaties, omdat specialisten op elk moment klaar moeten staan om hun positie te verdedigen of te verbeteren.

De 'negotiated order' verdient een nieuw concept als aanvulling: de 'negotiated position'. 'Negotiated order' is de uitkomst van alle onderhandelingen in een groep of in een organisatie. De 'negotiated position' is de uitkomst voor één persoon of partij daarin. Deze uitkomst is tegelijk het begin van nieuwe onderhandelingen.

Nu kan worden vastgesteld wat in het dagelijks werk van specialisten de verhouding is tussen wat managers te zeggen hebben, wat patiënten te zeggen hebben, en wat specialisten te zeggen hebben. In hun dagelijkse werk hebben specialisten het overwegend zelf voor het zeggen. De achtergrond van het werk wordt voor een deel bepaald door 'het management', bijvoorbeeld omdat het management de 'eigenaar' is van de organisatiestructuur van het ziekenhuis en van regels voor beleid en financiële beslissingen. Maar 'het management' bestaat niet alleen uit managers, want ook het stafbestuur is bijvoorbeeld betrokken bij beslissingen over het ziekenhuis. Medisch managers zijn betrokken bij beslissingen over afdelingen. En 70% van de deelnemers aan het vragenlijstonderzoek zit in een ziekenhuiscommissie.

In hoeverre hebben patiënten iets te zeggen? Zij zijn niet als 'georganiseerde' groep zichtbaar in het werk van specialisten. Individuele patiënten onderhandelen wel met de specialisten, over hun afspraken, over hun behandeling of over de problemen die ze aan de orde kunnen stellen.

Het onderzoek laat zien dat het eigenlijk niet voldoende is om te weten wíe het voor het zeggen heeft. Op z'n minst moet óók duidelijk zijn welke criteria de deelnemers gebruiken. Streven ze naar goede patiëntenzorg, naar tevreden klanten, of naar een efficiënte organisatie? En op welke manier doen ze dat? Volgen de verschillende deelnemers dezelfde waarden? Sluiten ze contracten met elkaar af? Of is er gewoon iemand de baas? Vervolgonderzoek naar zeggenschap in ziekenhuizen zou van deze modelmatige combinaties gebruik moeten maken.

Vervolgstudies kunnen op verschillende manieren een aanvulling geven op dit onderzoek. De andere partijen in de onderhandelingen zouden bijvoorbeeld gevolgd kunnen worden. Of de patiënten zouden gevolgd kunnen worden - voor een andere benadering van het werk in ziekenhuizen. Een systematische vergelijking is in deze studie alleen op het niveau van de groepen specialismen gedaan: beschouwend, snijdend en ondersteunend. Ander onderzoek zou ziekenhuizen kunnen vergelijken, of verschillende vakgebieden binnen de beschouwende, snijdende en ondersteunende specialismen. En uit dit onderzoek kunnen verschillende hypotheses gehaald worden, die getoetst kunnen worden.

'Plezier in het werk' was niet het onderwerp van dit onderzoek. Toch kan voorzichtig worden geconcludeerd dat specialisten zwaar werk hebben en dat grofweg één op de tien daar op één of andere manier last van heeft. Dat heeft met veel verschillende dingen te maken. Dit onderzoek laat drie oorzaken zien: de aard van het werk, de continue onderhandelingen en het belang van de groep.

Ten eerste is het werk van specialisten, vooral in patiëntenzorg, veeleisend en 'gulzig', en het wordt in toenemende mate gestandaardiseerd. Specialisten willen zoveel mogelijk hun eigen werk organiseren. Daarom zijn ze op elk moment beschikbaar in al hun rollen. Wie niet naar de afzonderlijke rollen kijkt, maar naar het dagelijks werk van specialisten als geheel, ziet dat de rollen zich niet laten inroosteren. Daarom is het werk van specialisten gefragmenteerd. 'Serieel' zien ze verschillende patiënten

achter elkaar, en doen ze verschillende activiteiten. 'Parallel' werken ze aan veel tegelijk. Dat betekent dat specialisten tijdens een ontmoeting met patiënt X een vraag kunnen krijgen over patiënt Y, of gebeld kunnen worden over een vergadering met maatschap Z. Specialisten hebben daarom op een dag veel 'seriële en parallelle schakelingen'. Alleen dagdelen met operaties of andere relatief langer durende activiteiten kunnen perioden met meer concentratie geven, als de 'pieper' wordt beantwoord door iemand anders. 'Zelf-management' ontaardt op dagelijks niveau nog wel eens in 'geleefd worden' door het rooster, de spreekuurschema's en de pieper. De houding van overgave aan het ritme van de dag is een houding die op termijn het persoonlijke gevoel van controle kan ondermijnen.

Ten tweede is het ziekenhuis een soort arena waarin specialisten elkaar en andere partijen in de gaten houden om het verlies van hun positie te voorkómen. De belangen van de verschillende partijen in het 'geïntegreerd medisch specialistisch bedrijf' zijn niet geïntegreerd. Specialisten komen vooral elkaar tegen in dagelijkse onderhandelingen, met managers op de tweede plaats. Dat er dagelijks onderhandelingen nodig zijn, kan individuele specialisten het gevoel geven dat ze bedreigd worden.

Ten derde is de groep in de geneeskunde erg belangrijk. Collega's hebben elkaar nodig voor patiëntenzorg en voor zakelijke belangen. Hun inkomen wordt bepaald door formules en afhankelijkheden, en de regels daarvoor zijn sinds de jaren tachtig aan het veranderen. Externe onzekerheid over het inkomen maakt de groep weer belangrijker voor de gezamenlijke belangen. De belangrijke rol van de groep kan specialisten langzamerhand het gevoel geven dat ze er individueel niet zo veel toe doen.

Dit onderzoek leidt tot een aantal aanbevelingen waardoor het werk van specialisten zou kunnen veranderen, en waardoor het misschien minder zwaar zou worden. De eerste aanbevelingen zijn voor specialisten en managers samen. Daarna volgen aanbevelingen voor specialisten en tenslotte voor ziekenhuismanagers.

Hoe moet je in een 'negotiated order' het werk organiseren? Dat moeten specialisten en managers samen doen. Het is duidelijk dat contracten en documenten niet bepalen dat dat goed gaat. Het lijkt erop dat gemeenschappelijke waarden weinig ontwikkeld zijn. Het ziekenhuis is er voor de patiëntenzorg en voor de patiënt. De criteria voor beslissingen van artsen en managers, maar ook van anderen in het ziekenhuis, moeten daarom in de eerste plaats gebaseerd zijn op een idee van wat goede patiëntenzorg is, en van wat patiënten willen. Criteria voor een goede, efficiënte organisatie moeten daar een afgeleide van zijn.

De patiëntenzorg verschilt per soort specialisme. Verschillen die er zijn, moeten worden gerespecteerd. De organisatie van patiëntenzorg zou geen eenheidsworst moeten zijn. Verschillende soorten specialisten hebben ook verschillende manieren waarop ze deelnemen aan de organisatie. Daar moet aandacht voor zijn, want die verschillende manieren hebben te maken met wat er nodig is voor de patiëntenzorg. Snijdende specialisten willen bijvoorbeeld dat hun patiëntenstromen op gang blijven. Ze hebben er minder behoefte aan om zich bezig te houden met de algemene organisatie van de afdeling. Het heeft dan ook geen zin om ze zonder meer daartoe te dwingen. Als hun betrokkenheid toch nodig is, zullen managers specialisten duidelijk moeten maken waarom.

Verschillende soorten specialisten hebben ook verschillende soorten 'blinde vlekken'. Door de kenmerken van hun patiëntenzorg hebben ze voorkeuren voor onderwerpen en voor manieren van communiceren. Managers en specialisten moeten elkaar wijzen op patronen die tot 'blinde vlekken' leiden. En ze moeten elkaar motiveren om van die patronen af te wijken, omdat dat beter is voor de samenwerking.

Specialisten lijken een natuurlijke ruimte te hebben op het niveau van de afdeling. Daar wordt hun werk uitgevoerd. De rol van afdelingslid verdient versterking. Specialisten en managers moeten proberen om vanuit de afdeling te werken aan de organisatie van het werk van specialisten. 'Evidence based medicine', waarin artsen hun beslissingen in patiëntenzorg zoveel mogelijk proberen te baseren op

bewijzen van effectiviteit, moet door de afdeling als geheel worden aangepakt. De komst van nieuwe functies in de patiëntenzorg, zoals 'nurse practitioners' en 'physician assistants' moet worden gekoppeld aan beslissingen over taakverschuivingen van artsen naar verpleegkundigen. De projecten in veel ziekenhuizen, om patiëntenzorg zo te organiseren dat patiënten sneller en zo mogelijk beter geholpen worden, horen gebaseerd te zijn op medisch inhoudelijke en organisatorische argumenten. Als dit per vakgebied op maat wordt aangepakt, kunnen specialisten zeker meer bij de organisatie betrokken zijn, zonder dat het hen meer tijd kost.

De waarde van 'het geïntegreerd medisch specialistisch bedrijf' is beperkt. Specialisten zijn tot op zekere hoogte geïntegreerd in het ziekenhuis. Hun inkomen wordt door het ziekenhuis verstrekt en ze nemen deel aan het management. Maar de belangen zijn niet geïntegreerd. Dat kan ook niet. De criteria voor goede patiëntenzorg, tevreden klanten en een efficiënte organisatie zullen in ziekenhuizen altijd náást elkaar bestaan. 'Integratie van specialisten in de ziekenhuisorganisatie' houdt een tegenstrijdigheid in.

Managementparticipatie lijkt door de specialisten in het onderzoek gesteund te worden. Medisch managers combineren de criteria van goede patiëntenzorg en efficiënt organiseren en daarom zijn ze belangrijk voor het werken in de 'negotiated order'. Maar managementkrachten lijken sterker aan medisch managers te trekken dan krachten vanuit de patiëntenzorg. Het zou goed zijn als medisch managers zich ook in de andere richting ontwikkelen, door zich te buigen over het werk in de patiëntenzorg, en initiatief te nemen tot onderzoek naar dagindeling en tijdsbesteding, en door te praten over andere manieren om patiëntenzorg te organiseren. Zij hoeven dat niet alleen te doen. Specialisten nemen op grote schaal deel aan commissies, en deze betrokkenheid lijkt wel eens onvoldoende gezien te worden.

Enige training in hoe ziekenhuismanagement werkt is misschien handig voor specialisten. Maar als ze moeten kiezen, kunnen ze zich beter verdiepen in het organiseren van hun eigen werk en tijd.

Hoe moeten specialisten werken in de 'negotiated order' van het ziekenhuis? Als zij zich, zoals net aanbevolen, willen verdiepen in de organisatie van hun eigen werk en tijd, zullen ze het evenwichtsspel van het ziekenhuis moeten leren spelen. Het spel van 'geven-en-nemen', van diplomatieke betrekkingen, het spel van afdingen. Ze kunnen niet inzetten op 'de grootste helft', want als iedereen dat doet houdt iedereen elkaar gevangen. Ze moeten inzetten op het evenwicht, met de onderhandeling als bescheiden middel om dat te bereiken. Dat zou ook voor medisch inhoudelijke ontwikkelingen gunstiger zijn dan 'het onderste uit de kan' willen.

In het evenwicht van dagelijks werk moeten specialisten zich niet overgeven aan het ritme van het spreekuur en de pieper. Hun werk en hun tijd verdienen dat ze er verantwoordelijkheid voor nemen. Het is niet makkelijk om het werk anders te organiseren. Maar er over mopperen lost zeker niks op. Zorgvuldig onderzoek van de logistiek van patiëntenzorg is zeldzaam. Het is misschien ook voor specialisten niet aantrekkelijk om daar hulp bij te vragen. Het feit dat niemand de organisatie van je werk begrijpt is natuurlijk wel interessant. Het helpt in elk geval om het zelf voor het zeggen te hebben - en te houden. Toch zou een betere indeling de inhoud van het werk niet van zijn complexiteit ontdoen. Integendeel. Een betere organisatie kan ruimte creëren voor nieuwe ontwikkelingen.

De specialisten van de toekomst zullen het evenwichtsspel misschien makkelijker spelen dan de specialisten van nu. Vrouwen en jonge specialisten, ook mannen, vinden 'autonomie' minder belangrijk dan mannen en oudere specialisten. Vrouwen gaan er ook vaker vanuit dat specialisten 'gewoon' in de organisatie van het ziekenhuis mee horen te doen. Ze werken vaker in deeltijd, en ze zullen daarom misschien ook minder de neiging hebben om hun energie aan onderhandelingen of positieverbetering te besteden. Vrouwen willen, meer dan mannen, invloed op het niveau van de afdeling. Dit sluit aan bij wat eerder al aan de orde kwam. Specialisten zouden de afdeling moeten accepteren als hun natuurlijke omgeving voor werk. Daar komen de patiënten. Daar begint het werk, en daar moeten dokters leren hun werk te delen met de anderen van de afdeling. Verschillende verantwoordelijkheden, gezamenlijke waarden.

In de groep van collega's mag de gezamenlijkheid juist wel wat minder belangrijk gevonden worden. De groep is zo dominant dat het individu verstikt raakt. De groep zou als 'team' aan kracht winnen wanneer er meer ruimte zou zijn voor individuele ontwikkeling. Gezamenlijke reflectie op het werk, de samenwerking en op het individueel functioneren is relatief onderontwikkeld in vergelijking met gezamenlijke belangenbehartiging. Vormen van intervisie, in de fase van opleiding en daarna, kunnen hier verandering in brengen.

Hoe kunnen managers de 'negotiated order' in balans helpen houden? Specialisten zitten in hun dagelijks werk vaker elkáár dwars dan dat ze worden dwarsgezeten door managers. Eigenlijk zijn managers, zeker die van hoger niveau, nauwelijks te zien in het dagelijks werk. Zij ontmoeten de specialisten alleen op formele momenten van besluitvorming, bijna nooit spontaan. Mede daardoor lijken zij beschouwd te worden als de personificatie van schaarste en andere problemen. Er wordt veel over hen gemopperd. Maar er wordt ook over andere dingen veel gemopperd. In het vragenlijstonderzoek waren specialisten positiever over het ziekenhuis als ze de raad van bestuur frequent ontmoetten en spraken. Om het evenwicht in het ziekenhuis te bewaren of te verbeteren wordt leden van raden van bestuur en andere managers daarom aangeraden zich te laten zien in het dagelijks leven van specialisten. Leer de 'negotiated order' van het dagelijks werk eens kennen.

Het nieuwe financieringsstelsel daagt managers en specialisten uit zich samen te onderscheiden van concurrenten. Managers kunnen het competitiegevoel versterken door te erkennen dat specialisten hun eigen zaakjes willen regelen en zo mogelijk hun praktijken willen uitbreiden. Daarbij hebben de artsen wel advies nodig bij het zaken doen, bij het organiseren van werk, en bij het afsluiten van contracten.

Managers en leidinggevenden in ziekenhuizen moeten accepteren dat ze schaarste en voorraden 'managen'. Dat lijkt misschien minder interessant dan 'een ziekenhuis aansturen'. Toch zijn er daarvoor leiders nodig die patiëntenzorg en professionals kunnen koesteren en met visie prioriteiten kunnen stellen, zeker wanneer de schaarste straks gecombineerd wordt met 'gereguleerde concurrentie'.

Specialisten moeten door deze leiders worden uitgenodigd om mee te doen aan de ambities van de organisatie. In ruil voor concrete steun.

Managers en leidinggevenden horen betrouwbare bemiddelaars te zijn, die het evenwichtsspel goed kunnen spelen. Als specialisten en anderen hun onderhandelingen uit de hand laten lopen, moeten de leiders hen kunnen helpen de balans weer te vinden.

Managers kunnen dit alleen maar als ze zich ontwikkelen tot 'dienstbare ondernemers' die de concurrentiepositie van het ziekenhuis verbeteren door te streven naar goede patiëntenzorg en tevreden klanten. Als ze efficiency belangrijker vinden, zullen de andere partijen geen vertrouwen in hen hebben.

De verschillende partijen in ziekenhuizen moeten proberen te zoeken naar gemeenschappelijke waarden. Uiteindelijk werkt iedereen ten dienste van de zorgprocessen en van de individuele patiënten. Daarbij moeten mensen wel accepteren en respecteren dat er verschillen zijn tussen specialismen, en dat verschillende belangen en waarden in het ziekenhuis een rol spelen. Volledige integratie daarvan is niet mogelijk en onderhandelingen zullen altijd noodzakelijk blijven. Wanneer dat geaccepteerd wordt, kunnen onderhandelingen langzamerhand dialogen worden.

Dankwoord in vijf adviezen

Ik vond het leuk om promotieonderzoek te doen. Is mijn plezier over te dragen aan mensen die overwegen om het ook te doen, of die er nog mee bezig zijn? Vast niet helemaal. Maar nu ik kan terugkijken, kan ik wel aangeven waarom het voor mij leuk was en bleef. Door dat in vijf adviezen te beschrijven hoop ik anderen ideeën te geven over hoe je promoveren leuk maakt en houdt. Er zijn veel mensen die daar een rol in spelen. Ik vertel hier wie voor mij belangrijk waren. Dit dankwoord is voor hen en voor al diegenen die ik niet bij naam noem, maar die wel bleven vragen hoe het met mij en met mijn onderzoek ging.

1 Sta stil bij het of, waarom en hoe

Wilde ik echt onderzoek gaan doen? Hoe dan? Matteke Winkel was de eerste die mij uitnodigde om dat eens te bespreken. Haar advies: zoek advies! Benader verstandige mensen en vraag ze om mee te denken. Vraag elk van hen altijd om namen van mensen die je bij de volgende stap kunnen adviseren. Op die manier begon ik met een serie bezoeken en telefoongesprekken, waarin Nico Arts en Mebius Kramer belangrijke rollen speelden. Met de eerste nam ik de beslissing om inderdaad onderzoek te gaan doen. Met de tweede om óók bij het Medisch Centrum Haaglanden (MCH) te blijven werken. In het MCH gingen Corrie Bastiaanssen, Arnoud Boesten en Henk Schippers daarmee akkoord. Een topklinisch opleidingsziekenhuis, vonden zij, moet ook ruimte creëren voor onderzoek naar de organisatie van werk. Ik vind het jammer dat Henk niet meemaakt dat het onderzoek nu af is.

Arnoud Boesten en Peter Van der Meer, mijn 'MCH-bazen', hebben mij consequent de ruimte gegeven. Zij zijn mijn topklinische opleiders.

2 Zoek passende promotoren en omgeving

Op zoek naar een promotor vond ik stiekem dat potentiële promotoren ook bij mij moesten solliciteren. Zo werkt het niet formeel, maar zo zou je het als promovendus of AIO wel moeten doen. Het is jouw onderzoek.

De oratie van Pauline Meurs, 'Nobele wilden', had ik met veel plezier gelezen. Bovendien zou het Instituut Beleid en Management Gezondheidszorg (iBMG) waarschijnlijk een goede omgeving voor mij zijn. De 'wederzijdse sollicitatie' met Pauline verliep goed. Zij werd mijn promotor, en daar ben ik nog steeds trots op.

Het iBMG, in het bijzonder de sectie Bestuurs- en organisatiewetenschappen onder leiding van Robbert Huijsman, was inderdaad een goede plek om een begin te maken met mijn onderzoek. Ik kon er deelnemen aan de sectiebesprekingen en de 'promoclub', waarin Isabelle, Wendy, Michel, Jan en Luuk de 'harde kern' vormden. Annemiek en ik bespraken onderzoeksavonturen en werkten samen aan een hoofdstuk over specialisten en ziekenhuizen. Marianne verzorgde de correspondentie in de fase van afronding.

Toen het 'medisch' materiaal in mijn werkaantekeningen toenam, vroeg Pauline of Niek Klazinga als promotor mee wilde gaan doen. Hij wilde gelukkig tijd maken. Pauline en Niek, mijn promotoren-duo, vormden voor mij een prachtige combinatie van kennis, enthousiasme en motivatie. Het tweede 'academisch netwerk' bij Niek in het AMC was mooi meegenomen: Thomas, Kiki, Lidwien, Sylvia, Tineke, Hedwig, Yolande, en de ontmoetingen met het Instituut voor Ziekenhuiswetenschappen in Leuven.

3 Verbind motivatie aan onderwerp en aanpak

Promotieonderzoek is intensief en nauwelijks aan vaste tijden gebonden. Dat blijft leuk als je van je onderwerp houdt en als je het belangrijk vindt. Het moet 'van jou' zijn, niet van iets of iemand anders.

Ik hou ervan om na te denken over 'het echte werk' in de geneeskunde, de patiëntenzorg. Daarom wilde ik in mijn onderzoek samenwerken met medisch specialisten. Zonder de 51 specialisten die ik volgde in het Medisch Centrum Haaglanden en in het Vlietland Ziekenhuis, en zonder de tientallen anderen die ik daarbij ontmoette, had ik dit boek niet kunnen schrijven. Het zien van hun dagelijks werk bevestigde keer op keer mijn motivatie voor het onderzoek.

Alle deelnemers aan het landelijke vragenlijstonderzoek hielpen mij ook.

Wat mijn motivatie verder steunde was de houding van veel anderen in beide ziekenhuizen. Gert de Bey en Lucas Elting, de raad van bestuur van het Vlietland Ziekenhuis, waren vanaf het begin geïnteresseerd en positief. De stafbesturen van de twee ziekenhuizen (in het bijzonder de voorzitters Roel Veldhuizen, Gerard Croll, Han Spierenburg en Marcel van den Aardweg) stimuleerden hun stafleden om mee te werken aan mijn onderzoek. Verder kreeg ik van Marjan, Thomas, Paul, Yvonne en Coby hulp bij het verzamelen van achtergrondmateriaal, documenten, mondelinge informatie en literatuur.

4 Vraag advies en steun

Je kunt niet alles alleen doen. Promotoren zijn essentiële adviseurs, maar je hebt ook een promo-team nodig van mensen die je op onderdelen ondersteunen. Mijn team: voor de statistiek: Cok Ouwerkerk; voor het benaderen van specialisten in Nederland: Gerlof Meijer en Bart-Jeroen Heesen (Orde van Medisch Specialisten); voor het voorbereiden en regelen van een enorme verzending: Annemarie van Sliedregt; voor het Engels: Simon Bignell; voor de vormgeving en uitvoering van het boek: Hein van Putten; en voor het vervolmaken en overdenken van alles: mijn liefste paranimfen Petra de Koning en Stephany Kruijthof, naast me op 10 juni maar vooral nabij in mijn leven.

5 Koester de mensen om je heen

Er is meer in het leven dan het onderzoek. De mensen om je heen helpen je om frustraties te relativeren en successen te vieren. Koester hun belangstelling, vriendschap en liefde.

Mijn collega's en de specialisten waar ik mee samenwerkte namen af en toe mijn MCH-werk over en bléven geïnteresseerd in mijn onderzoek. Ik sla er veel over en noem Marieke, Jaco, Anneke, Michiel, Jan Willem, Marjolein, Edith, Anika, Marco, René, Melanie, Hendrik, Joep, Belinda, Sandra en Alexandra.

Mijn intervisiegroep - Stella, Peter, Jelle en Barend - zal altijd kritisch van mij houden.

Mijn ouders, familie en vrienden, ze zijn er voor me: Henny en Dirk, Theo en Elly, Stephany, Hans, Petra, Marie-Louise, Hein, Hanneke en iedereen die ik niet bij naam noem. Tante Wies en Oom Dré stuurden in mijn laatste schrijf-kwartaal elke week een bemoedigende kaart.

Tenslotte, Peter, jij bent mijn waypoint home.
Dankjewel voor jou.

Karen Kruijthof, 19 maart 2005

Curriculum Vitae

Karen Kruijthof (20 June 1967) attended the 'Christelijk Gymnasium' in Utrecht from 1979 to 1985. She studied Medicine at the Free University in Amsterdam, which she combined with Public Administration and Public Policy Studies.

As a student she fulfilled various secondary functions in committees. She was a student member of the Board of the Medical Faculty of the Free University and she was also a student adviser of the Dutch Survey Board of Medical Faculties (1992, Landelijke Visitatiecommissie Geneeskunde en Gezondheidswetenschappen).

In 1992 she graduated as a Master of Public Administration and in 1994 as a Medical Doctor.

Between 1994 and 1996 she worked in the 'Westfries Gasthuis' in Hoorn, as a resident (not in specialist training) in surgery. This was a special resident function, since it was established by the nursing department of the hospital, as part of a project for new ways for physicians and nurses to work together. The surgeons were her supervisors in patient care, the head of the floor was her supervisor for matters of organisation and co-operation.

When this project ended at the end of 1996, she chose to leave individual patient care and started working as a member of the management support staff in the 'Westeinde Ziekenhuis' in The Hague. Since the merger with 'Ziekenhuis Antoniushove' in Leidschendam in 1998 the hospital is called 'Medisch Centrum Haaglanden'.

Within the 'Medisch Centrum Haaglanden', Karen Kruijthof is currently one of the advisors to the hospital board. She also supports the specialist staff, for example by assisting the committee that writes the specialist policy plan.

Since February 2000 she has combined her work in the hospital with being a research fellow at the Institute of Health Policy and Management at the Erasmus Medical Centre in Rotterdam, on a 'zero budget labour contract'. She joins the Section for Policy and Organisational Sciences.

She also attends the meetings of the research group 'Physician Management Integration' at the Department of Social Medicine in the Academic Medical Centre in Amsterdam, and its shared meetings with researchers of the Centre for Research on Health Services and Nursing Management in Leuven, Belgium.

During the research period she co-operated with the Order of Medical Specialists in its policy project for specialists' role and position in the hospital organisation.

Karen Kruijthof is a member of the Society of Dutch Female Physicians and she chaired the editorial board of its journal between 1998 and 2001. Since 1997 she is an editor of the The Hague Journal for Public Health (Epidemiologisch Bulletin, GGD Den Haag), and since 2004 she is a member of the Advisory Board of 'Medisch Contact', the journal of the Royal Dutch Medical Association.

She joins a peer discussion and support group since the beginning of her internships in 1992.

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Dokterspraktijken

Het dagelijks werk van specialisten en hun aanspraken op zeggenschap in Nederlandse ziekenhuizen

Nederlandse samenvatting van het proefschrift

Doctors' Orders

Specialists' Day to Day Work and their jurisdictional Claims in Dutch Hospitals

Karen Kruijthof, 2005

Deel 1 Het onderzoek: achtergrond, theorieën en methoden

1. Papier en praktijk

Dit onderzoek gaat over het dagelijks werk van specialisten en over hun zeggenschap in het werk.[1] Andere studies over dit onderwerp gaan meestal over het management of over het beleid van ziekenhuizen. Dit onderzoek begint bij het 'echte werk' in de geneeskunde, de patiëntenzorg. De informatie komt direct uit dokterspraktijken.

Het idee voor het onderwerp komt wél uit management en beleid. Alle algemene Nederlandse ziekenhuizen krijgen sinds 1983 elk jaar een budget. Vóór die tijd waren de uitgaven van een ziekenhuis niet gelimiteerd. Om een eind te maken aan de stijgende kosten van ziekenhuizen werd er een budgetsysteem ingevoerd. Voor de medisch specialisten gold het budget niet. Zij werkten in de ziekenhuizen, maar ze waren daar over het algemeen niet in dienst. Hun werk werd betaald per verrichting, op basis van eigen overeenkomsten met ziektekostenverzekeraars. Het budget dwong managers van ziekenhuizen om activiteiten te beperken. Voor de specialisten was er geen reden om terughoudend te zijn. Zij bleven onveranderd een beroep doen op de activiteiten van het ziekenhuis - verpleging, apparatuur, bedden - ter ondersteuning van hun werk. Dit gaf in de ziekenhuizen veel problemen bij het verdelen van de budgetten.

Als oplossing voor de belangentegenstellingen adviseerde de 'Commissie Biesheuvel' in 1994 om de kosten van het werk van specialisten te integreren in het budget van het ziekenhuis. De commissie vond dat ziekenhuizen 'geïntegreerd medisch specialistische bedrijven' zijn, waar specialisten en anderen samen patiënten behandelen en verzorgen. De commissie pleitte ook voor deelname van specialisten in de leiding van afdelingen.

Er volgde een onrustige periode, waarin specialisten, ziekenhuizen, verzekeraars en de overheid het voortdurend met elkaar oneens waren over de uitwerking van de voorstellen. Uiteindelijk werd in 2000 de financiële en organisatorische 'integratie' van specialisten en het ziekenhuis vastgelegd in de 'Integratiewet'. In deze wet staat dat specialisten niet meer zelf afspraken maken met verzekeraars over behandelingen en vergoedingen. Dat doet het ziekenhuis. De raad van bestuur doet de onderhandelingen. Het ziekenhuis moet wel rekening houden met wat de specialisten nodig hebben voor hun patiëntenzorg, want zij zijn en blijven daarvoor verantwoordelijk. Specialisten, op hun beurt, moeten rekening houden met wat er is afgesproken over het budget.

De integratiewet en de documenten en regels die daarbij horen, vormen het 'kader' voor zeggenschap in het ziekenhuis. Dat is het papier. Maar wat is de praktijk? Wat willen specialisten te zeggen hebben in hun spreekkamer, op de afdeling of in het ziekenhuis? Waarover willen ze zeggenschap hebben in hun dagelijks werk?

Daarover gaat dit onderzoek. Eenenvijftig specialisten van zeven vakgebieden in twee ziekenhuizen deden eraan mee. Ze werden gevolgd in hun dagelijks werk. Bijna zevenhonderd specialisten vulden een vragenlijst in.

Artsen behoren tot een 'professie', een beroepsgroep met een exclusief werkveld, waar abstracte kennis en specialistische vaardigheden voor nodig zijn. Mensen die die kennis en vaardigheden niet hebben, kunnen niet zomaar beslissingen nemen over het werk in een professie. Daarom hebben professionals zelf relatief veel zeggenschap over hun eigen werk.

Specialisten zijn professionals die in ziekenhuizen werken. Ziekenhuizen vormen, net als andere organisaties, 'social orders'[2] die berusten op regels en afspraken die de personen en partijen in het ziekenhuis met elkaar maken. De vorming van zo'n 'order' is niet toevallig. Het is een

1 In het Engels wordt in het onderzoek de term 'jurisdiction' gebruikt. Deze term combineert begrippen als autonomie, bevoegdheid en 'recht van spreken'. Voor de leesbaarheid wordt in het Nederlands 'zeggenschap' gebruikt.

2 Het begrip 'order' ('social order' en 'negotiated order') is moeilijk in het Nederlands te vertalen. De term combineert begrippen als orde, rangorde, evenwicht, stelsel en systeem. Voor de zorgvuldigheid wordt 'negotiated order' niet vertaald.

proces waarin deelnemers proberen hun belangen te beschermen. Die belangen kunnen tegenstrijdig zijn, en ze kunnen veranderen. Daarom worden 'social orders' bepaald door voortdurende onderhandelingen. Het zijn 'negotiated orders'. Op elk moment in de tijd vormt de uitkomst van de onderhandelingen het begin van de volgende ronde.

Dit onderzoek gaat over de 'negotiated order' in het werk van specialisten. De onderzoeksvraag is: 'Wat is de aard van de onderhandelingen die de 'negotiated order' in het dagelijks werk van specialisten in ziekenhuizen bepalen, en welke aanspraken op zeggenschap liggen ten grondslag aan deze onderhandelingen?'

Voor de aard van de onderhandelingen is het 'wie', 'hoe' en 'wat' belangrijk.

Wie: de rollen van waaruit specialisten onderhandelen in hun dagelijks werk, en de mensen of partijen die zij in die onderhandelingen ontmoeten.

Hoe: de manier waarop specialisten onderhandelen.

Wat: de onderwerpen waar specialisten over onderhandelen.

De aanspraken op zeggenschap zijn niet vanzelf zichtbaar in de onderhandelingen. Om er achter te komen welke aanspraken ten grondslag liggen aan onderhandelingen, moeten eerst de onderwerpen worden onderzocht.

2. Verleden en heden

Specialismen ontstonden in Nederland tussen 1860 en 1930. Vóór die tijd waren er maar twee soorten artsen. De 'doctores medicinae' hadden aan de universiteit gestudeerd. Zij stelden diagnoses en schreven behandelingen en geneesmiddelen voor. De 'chirurgijns' hadden hun vaardigheden in de praktijk geleerd. Zij behandelden verwondingen en zweren en verwijderden stenen uit de blaas. Vanaf 1865 moest elke arts aan de universiteit zijn opgeleid. Daarna was er een snelle ontwikkeling van kennis en technologie. Er kwamen diagnostische mogelijkheden in radiologie, klinische chemie en pathologie. De kennis over bacteriën en infecties nam snel toe. Huisartsen bleven als algemeen arts werken. Uit de doctores medicinae kwamen 'beschouwende' specialisten voort, zoals internisten en cardiologen. De chirurgijns werden 'snijdende' specialisten. Voorbeelden daarvan zijn chirurgen en gynaecologen. De beschouwende en snijdende specialismen ontwikkelden zich doordat ze gebruik konden maken van nieuwe kennis en technieken - en die leidden tot een derde groep specialisten: 'ondersteuners', bijvoorbeeld anesthesiologen en radiologen.

De technologie werd vanaf het begin van de twintigste eeuw ondergebracht in ziekenhuizen. Daardoor veranderden de 'gasthuizen' in moderne behandelcentra, waar steeds meer specialisten gingen werken.

'Integratie' en 'participatie' zijn belangrijke woorden in de ziekenhuizen van nu. De integratiewet, ingevoerd in 2000, geeft de raad van bestuur van een ziekenhuis de verantwoordelijkheid te onderhandelen met zorgverzekeraars over de vergoedingen voor het werk van ziekenhuizen en specialisten samen. De specialisten hebben de taak om in het ziekenhuis na te gaan wat er nodig is voor goede patiëntenzorg en samen met de raad van bestuur regelingen af te spreken over bijvoorbeeld het medisch kwaliteitsbeleid, over het werk van specialisten, over hun 'participatie' in commissies en management, en over de continuïteit van zorg.

De meeste ziekenhuizen hadden tot de jaren negentig een 'centralistische' en 'hiërarchische' structuur. Elke leidinggevende kreeg instructies van een hogere leidinggevende, en elke leidinggevende moest aan die hogere leidinggevende verantwoording afleggen. Alle lijnen kwamen centraal bij elkaar, bij de directie. Door fusies en doordat het werk ingewikkelder werd, werden de ziekenhuizen daar te groot voor. Directies 'decentraliseerden' hun organisaties, en ze werden zelf 'raad van bestuur'. Raden van bestuur spreken nu met hun afdelingen af welke resultaten er moeten komen. Hoe die afdelingen dat doen, mogen ze nu meer zelf bepalen dan vroeger. In de meeste ziekenhuizen staat een afdeling onder

leiding van een manager en een 'medisch manager'. De medisch manager is een specialist die een dag of een dagdeel per week beschikbaar is voor organisatorische activiteiten, 'managementparticipatie'.

Nederlandse ziekenhuizen zijn 'geïntegreerd medisch specialistische bedrijven' geworden. De meeste specialisten werken niet in loondienst van het ziekenhuis - ze zijn 'vrij gevestigd' - maar de regelingen voor hun inkomsten zijn sinds de integratiewet wel onderdeel van ziekenhuisregelingen. Specialisten zijn ook bij de organisatie in het ziekenhuis betrokken, bijvoorbeeld door 'managementparticipatie' en in ziekenhuiscommissies. Dat wil niet zeggen dat de belangen van de verschillende partijen in het 'geïntegreerde bedrijf' vanzelfsprekend ook geïntegreerd zijn. De 'medische staf' - alle specialisten van één ziekenhuis samen - onderhandelt nog steeds met de raad van bestuur over de specialistenbelangen in het ziekenhuis. En voor onderhandelingen over de verdeling van de inkomsten hebben de 'vrijgevestigden' in één ziekenhuis meestal ook een eigen groep, bijvoorbeeld een 'koepelmaatschap'.

Hoe is het in het buitenland? Westerse landen hebben allemaal hun eigen organisatie van gezondheidszorg. In Nederland kunnen de meeste patiënten, behalve in noodgevallen, alleen naar een specialist als de huisarts hen verwijst. Dat is niet overal zo. De vrije vestiging van specialisten in ziekenhuizen is ook niet in elk land bekend. Het systeem waarin specialisten werken verschilt dus per land. Daarom zijn de resultaten van dit onderzoek niet zomaar ergens anders van toepassing. Maar overal wordt gezocht naar mogelijkheden om gezondheidszorg betaalbaar en toegankelijk te houden. Om dat mogelijk te maken zijn vaak veranderingen nodig, ook in de organisatie van ziekenhuizen. Zulke veranderingen beïnvloeden de 'negotiated order'. Als voorbeeld van een analyse van een 'negotiated order' kan dit onderzoek daarom wel voor andere landen betekenis hebben.

3. Theorieën

Omdat het onderzoek zich afspeelt in de praktijk van specialisten, moet eerst duidelijk worden wat het dagelijks werk van specialisten is. Patiëntenzorg is het belangrijkste. Daar besteden ze de meeste tijd aan in vergelijking met hun werk voor onderwijs of onderzoek, en ook in vergelijking met hun organisatorische activiteiten, zoals vergaderen, roosters maken en 'managementparticipatie'. Het eerste deel van het theoretisch kader is daarom een model met drie handelingen als afzonderlijke stappen in patiëntenzorg. 'Diagnosticeren' is de stap waarin het probleem van de patiënt wordt vertaald in medische kennis. De uitkomst daarvan is een diagnose, of ideeën over mogelijke diagnosen. 'Behandelen' is de stap waarin medische kennis wordt vertaald in mogelijke oplossingen voor het probleem van de patiënt. Soms bieden geneesmiddelen een oplossing, of leefregels. Soms moeten artsen of anderen, bijvoorbeeld verpleegkundigen of fysiotherapeuten, de behandeling uitvoeren. Operaties zijn de belangrijkste behandelingen in de snijdende specialismen. 'Redeneren' over diagnoses en behandeling, en over de specifieke patiënt en de algemene medische kennis, is de stap waarin alle handelingen en overwegingen bij elkaar komen.

In werkelijkheid zijn de drie stappen of handelingen steeds met elkaar verbonden. Ze hebben geen vaste volgorde, het zijn geen losse stappen in de tijd.

De dagelijkse organisatie van het werk in patiëntenzorg wordt in het onderzoek beschreven door na te gaan op welke plaatsen specialisten werken, hoe hun tijd in patiëntenzorg bepaald wordt, en met wie ze werken.

Er wordt door beschouwende, snijdende en ondersteunende specialisten niet op dezelfde manier gediagnosticeerd, behandeld en geredeneerd. De drie stappen uit het model zijn ook niet voor ieder vakgebied even belangrijk. Daarom is hun werk apart onderzocht.

Het tweede deel van het theoretisch kader gaat over de invulling van het 'wie', 'hoe' en 'wat' in de onderhandelingen die de 'negotiated order' in het werk van specialisten bepalen.

Eerst het 'wie'. Specialisten hebben in hun werk relaties met mensen of groepen om hen heen. Ze kunnen zeven verschillende rollen spelen, afhankelijk van de relatie waar het om gaat. De rol van dokter (1) spelen ze als ze inhoudelijk met patiëntenzorg bezig zijn, als ze direct contact hebben met patiënten, of als ze besprekingen hebben over patiënten. In hun rol van collega (2) werken ze samen met de specialisten van hetzelfde vakgebied. De meeste specialisten zijn niet in dienst van het ziekenhuis. Ze hebben dan samen met de collega's van één vakgebied een

maatschap, en ze verdelen in die maatschap de kosten die ze maken en de inkomsten die ze via het ziekenhuis ontvangen. Als artsen wel in loondienst zijn, hebben ze samen met de collega's van één vakgebied een vakgroep. Ook dan zorgen ze samen voor de organisatie van de patiëntenzorg.

Artsen in ziekenhuizen werken op patiëntenafdelingen en in poliklinieken waar ook anderen werken, verpleegkundigen, doktersassistentes, laboranten. In de rol van afdelingslid (3) hebben specialisten een relatie met die medewerkers, of ze vertegenwoordigen de belangen van de afdeling.

Alle specialisten in één ziekenhuis zijn lid van de medische staf. De medische staf vergadert met de raad van bestuur over onderwerpen die voor alle specialisten of voor het hele ziekenhuis belangrijk zijn. Dan hebben specialisten de rol van staflid (4). De meeste artsen werken in één ziekenhuis. In hun rol van ziekenhuislid (5) zitten ze bijvoorbeeld in een commissie.

Specialisten hebben ook een privé-leven. En ze zijn individuen die van elkaar verschillen in hun manier van werken. Dit bepaalt hun rol van individu (6). Vanuit die rol letten ze bijvoorbeeld op hun werktijden, en door die rol hebben ze verschillende stijlen van omgaan met hun patiënten. En tenslotte is elke arts lid van de medische professie. Specialisten van één vakgebied doen in hun rol van professional (7) bijvoorbeeld mee aan de ontwikkeling van landelijk kwaliteitsbeleid. Of ze vergaderen over nieuwe manieren om de gezondheidszorg te betalen.

Vanuit deze zeven rollen onderhandelen specialisten dagelijks met verschillende mensen en groepen. Soms moeten ze met zichzelf onderhandelen als twee rollen gelijktijdig tegenstrijdige eisen stellen, bijvoorbeeld wanneer ze als dokter het spreekuur rustig willen afronden, maar als individu op tijd thuis willen zijn.

Dan over het 'hoe' van onderhandelingen. Onderhandelingen kunnen klein of groot zijn, ze zijn doelgericht gestart of ze worden juist gevoerd zonder dat de deelnemers zich daar bewust van zijn. Ze gaan vaak samen met andere vormen van interactie, bijvoorbeeld dwang of overreding.

In het onderzoek is informatie verzameld over de verschillende soorten onderhandelingen in de verschillende rollen. Er zijn drie soorten tactieken in onderhandelingen, afhankelijk van de beoogde resultaten. 'Vechten of aanvallen' is nodig als je je belangen wilt verdedigen bij een aanval of als je ze wilt uitbreiden bij tegenstand. 'Verdedigen of behouden' is gericht op bescherming of op het voorkómen van schade. 'Vluchten of opgeven' betekent dat je het niet langer nodig vindt om in actie te komen, of dat je denkt dat het toch zinloos is.

Tenslotte het 'wat'. De aanspraken op zeggenschap zullen zelden direct zichtbaar zijn in onderhandelingen. Daarom is analyse van de onderwerpen van onderhandelingen nodig, om te ontdekken wat de onderliggende onderwerpen zijn waar specialisten zeggenschap over willen hebben.

Specialisten behoren tot de medische professie. Omdat professionals zelf veel zeggenschap hebben, moet de maatschappij er op kunnen vertrouwen dat professionals hun kennis zo goed mogelijk toepassen en dat ze werken in het belang van wie hun hulp of advies nodig heeft. Daarom stellen professionals strenge eisen aan hun opleidingen en daarom moeten ze zich aan bepaalde gedragsregels houden. Om te begrijpen waarom specialisten over bepaalde onderwerpen iets te zeggen willen hebben, is in het onderzoek gevraagd naar hun 'professionele oriëntatie'. Dit is het derde deel van het theoretisch kader. In hoeverre steunen specialisten het 'professioneel primaat', het uitgangspunt dat patiëntenzorg in het ziekenhuis altijd op de eerste plaats komt, vóór geld en efficiency? Hoe belangrijk is 'autonomie', de vrijheid om te beslissen over de inhoud en de organisatie van hun werk, en over de manier waarop de kwaliteit van het werk bewaakt wordt? Hoe belangrijk is 'egalitarisme', de onderlinge gelijkheid van specialisten in een groep? Voelen specialisten zich goed in hun werkomgeving? En verwachten ze dat hun onderlinge belangenbehartiging, bijvoorbeeld in de medische staf, zal blijven bestaan?

Ook is in het onderzoek gevraagd naar de oriëntatie op het ziekenhuis. Hoe betrokken voelen ze zich bij de organisatie en de besluitvorming in het ziekenhuis, en hoe betrokken willen ze zich voelen? Wat vinden ze van 'integreren' of 'participeren'? Welke rol moeten de specialisten spelen die ook manager zijn?

In elk ziekenhuis vormen de verhoudingen tussen zeggenschap van managers, zeggenschap van patiënten, en zeggenschap van specialisten een bepaald evenwicht. Dit onderzoek maakt dat evenwicht zichtbaar in het dagelijks werk van specialisten.

4. Methoden

Het onderzoek is 'exploratief'. In de verzamelde informatie is naar patronen en verbanden gezocht, zonder dat die vooraf in hypotheses zijn voorspeld. Daarbij zijn kwalitatieve methoden gebruikt, omdat die nuttig zijn voor diepgaand onderzoek bij enkele mensen of groepen. Voor een breder, maar oppervlakkiger beeld van het werk van specialisten zijn kwantitatieve methoden gebruikt. Die zijn geschikt voor het verzamelen van informatie bij veel verschillende mensen tegelijk.

De kwalitatieve methode is een 'meervoudige gevalstudie'. In zeven afzonderlijke specialistengroepen werd informatie verzameld over het dagelijks werk. De twee beschouwende vakgebieden in het onderzoek zijn interne geneeskunde en cardiologie. Er hebben drie snijdende groepen deelgenomen. Gynaecologie heeft in beide ziekenhuizen aan het onderzoek meegedaan, en heelkunde in één ziekenhuis. De ondersteunende vakgebieden zijn anesthesiologie en radiologie.

In totaal werden 51 specialisten tenminste één dagdeel gevolgd. Samen is dat bijna 300 uur met observaties. Aanvullend zijn er 40 afzonderlijke interviews gehouden met specialisten. Schriftelijke bronnen zijn in de loop van elke studie verzameld en geanalyseerd (instructies, roosters, protocollen, agenda's en stukken uit maatschapsvergaderingen). De aantekeningen van observaties en interviews zijn verwerkt in een computerprogramma voor kwalitatieve analyses, 'Atlas/ti'.

De kwantitatieve benadering is een landelijk vragenlijstonderzoek onder een steekproef van 2000 specialisten in algemene ziekenhuizen. De respons is 34%. De vragenlijsten zijn verwerkt in een computerprogramma voor kwantitatieve analyses, 'SPSS'.

De samenstelling van de responsgroep komt bijna helemaal overeen met de samenstelling van de populatie, voor zover het ging om specialisme en geslacht. Er is geen onderzoek gedaan onder de mensen die de vragenlijst niet hebben ingevuld. Daarom zou het toch kunnen dat de meningen van de deelnemers anders zijn dan die van de specialisten die geen reactie hebben gegeven.

De onderzoeker is zelf arts en bestuurskundige. Ze werkt als beleidsmedewerker in één van de deelnemende ziekenhuizen. Deze combinaties van rollen en functies heeft voordelen en nadelen. Er zijn verschillende maatregelen genomen om de nadelen te beperken en voor iedereen duidelijk te maken wanneer welke rol of functie aan de orde was. De onderzoeker heeft ook een dagboek bijgehouden waarin zij haar eigen rol kritisch volgt.

Door deze maatregelen zijn de voordelen van de verschillende rollen en functies versterkt en waren de onderzoeksomstandigheden gunstig voor het verzamelen van zoveel mogelijk informatie.

Deel 2 Resultaten

5. Het werk in patiëntenzorg

Om onderhandelingen in de 'negotiated order' in het werk van specialisten te kunnen begrijpen, is eerst het belangrijkste werk van specialisten nader onderzocht: de patiëntenzorg. Specialisten besteden het grootste deel van hun tijd aan patiëntenzorg. Tachtig procent, zeggen ze in het vragenlijstonderzoek. Ze verdelen dat over 65% direct contact met de patiënt en 15% activiteiten die met patiëntenzorg te maken hebben, bijvoorbeeld besprekingen en administratie.

In de zeven deelnemende specialistengroepen werd dieper ingegaan op het diagnosticeren, behandelen en redeneren in de verschillende specialismen.

In beschouwende vakgebieden is redeneren vooral argumenteren. Het verband tussen diagnostiek en behandeling wordt steeds zoveel mogelijk gelegd in een sluitend betoog, een verhaal.

In de snijdende vakgebieden worden vooral besluiten genomen. Elke toepassing van chirurgie in diagnostiek of in de behandeling van een patiënt moet voortkomen uit een duidelijke beslissing.

Voor de ondersteunende disciplines is verbindingen leggen heel belangrijk in de momenten van redeneren. Ondersteuners leggen een verbinding tussen aanvraag en uitvoering. Radiologen beoordelen de aanvraag van de hoofdbehandelaar, om te beslissen wat er radiologisch moet gebeuren. Anesthesiologen beoordelen welke anesthesie het beste past bij de operatie. Daarna geven ondersteuners aan wat de aanvragers verder moeten doen, of waar ze op moeten letten. De radiologen maken een verslag van hun bevindingen dat past bij wat aanvragers willen weten. Anesthesiologen geven na de narcose instructies, bijvoorbeeld over wat er moet gebeuren als de patiënt misselijk wordt. Ondersteuners moeten steeds 'dubbel denken': vanuit hun eigen vakgebied en vanuit de vakgebieden van de aanvragers.

Artsen organiseren de tijden en de plaats van hun werk in roosters. In de beschouwende vakken laten de roosters vooral poliklinische spreekuren zien, visites op de afdeling en de supervisie van arts-assistenten. In de snijdende vakken zijn de belangrijkste onderdelen de operatiekamer, de poliklinische spreekuren, de visites op de afdeling en de supervisie van arts-assistenten. In de ondersteunende specialismen zijn de roosters gebaseerd op de onderlinge verdeling van ruimtes of apparatuur.

Met welke mensen werken specialisten? In alle vakgebieden staan patiënten bovenaan. Daarna komen de collega's uit het eigen vak, de specialisten uit andere vakken, en de verpleegkundigen en andere medewerkers in de patiëntenzorg.

In de beschouwende vakken wordt de arts-patiënt relatie sterker dan in de andere vakken bepaald door een vorm van wederzijds eigendom tussen dokter en patiënt. Patiënten hebben het over 'mijn dokter' en artsen hebben het over 'mijn patiënt'. Dat doen de meeste artsen. De meeste artsen hechten ook belang aan de relatie met 'hun patiënt'. Maar in de beschouwende vakken weegt dat zwaarder dan in de andere vakken. De relaties die beschouwende specialisten met patiënten hebben zijn vaker langdurig omdat er meer chronische patiënten zijn. De aard van de ziektebeelden en het belang van 'het verhaal' leiden ook tot gesprekken die over andere onderwerpen gaan dan alleen over het lichamelijk functioneren.

In de samenwerking tussen beschouwende collega's is het gezamenlijk opbouwen van een betoog van belang. De collega's helpen elkaar met het vinden van argumenten. Dat geldt ook voor de samenwerking met verpleegkundigen op de afdeling. De specialisten vragen de verpleegkundigen om informatie te verzamelen die nodig zou kunnen zijn voor het vervolg van diagnostiek en behandeling.

In de snijdende vakken wordt 'eigendom' in de arts-patiënt-relatie vooral bepaald door wie de patiënt geopereerd heeft. In het contact met de patiënt moet informatie worden verzameld die nodig is voor de beslissing over eventueel opereren. Gesprekken worden meer dan in de beschouwende vakken bepaald worden door feiten. De samenwerking tussen snijdende collega's onderling is vooral gezamenlijke besluitvorming. De specialisten toetsen elkaars redenering die wel of niet leidt tot de beslissing om chirurgisch te handelen. Samenwerking met verpleegkundigen is ook meer gezamenlijke besluitvorming dan in de andere vakken, waardoor discussies en gesprekken zakelijker zijn.

In de ondersteunende vakken hebben de specialisten meestal geen 'eigen' patiënten. Een uitzondering in het onderzoek zijn de patiënten die naar de 'pijnpoli' van de anesthesiologen komen. De andere patiënten zijn van de hoofdbehandelaar, die de patiënt verwijst voor aanvullend onderzoek of voor ondersteuning van de behandeling. Ondersteunende specialisten hebben meer communicatie over de patiënt met de hoofdbehandelaar dan met de patiënt zelf. Het leggen van verbindingen met de patiëntenzorg van de aanvragers werkt door in de onderlinge samenwerking van ondersteunende collega's. Samen moeten ze diensten verlenen aan de aanvragers en ze moeten beschikbaar zijn voor de aanvragers. Hier is dan ook, in vergelijking met de andere vakgebieden, de minste ruimte voor individuele variatie in de technische uitvoering van het werk. Doordat de apparatuur geconcentreerd is op één of enkele afdelingen, zijn de meeste collega's vaak bij elkaar in de buurt. Laboranten en assistenten zijn ook altijd dichtbij. Zij voeren vooral taken uit in het proces van de specialisten. Complexere technieken doen specialisten zelf. De voorbereidingen, de bewaking en de eenvoudiger technieken doen laboranten of assistenten.

Alle specialisten blijken zich veel bezig te houden met logistiek. Vele malen per dag gaan ze na of de planning van patiënten nog klopt, of het werk goed verdeeld is over de specialisten en arts-assistenten, of er genoeg bedden zijn, of de informatie die nodig is wel beschikbaar is. Waar ze dan op letten, verschilt per vakgebied.

Het gaat de beschouwende specialisten vooral om de contacten met individuele patiënten. Op welk moment moet een patiënt terugkomen? Welke informatie moet dan bekend zijn? Welke dokter moet die patiënt spreken? De snijdende specialisten letten vooral op de patiëntenstromen. Gaan er wel genoeg patiënten naar huis vandaag? Kunnen de nieuwe patiënten worden opgenomen? Zijn er bedden beschikbaar? Is er ruimte op de operatiekamers?

In de logistiek van de ondersteunende vakgebieden staat de afstemming met aanvragers centraal. Wanneer zijn er spreekuren van aanvragers die veel mensen doorsturen? Wanneer moet de informatie bekend zijn? Of, voor anesthesiologen, om welke ingreep gaat het en welke vormen van anesthesie zijn dan geschikt?

6. Onderhandelingen in patiëntenzorg

Als specialisten de rol van dokter spelen in hun patiëntenzorg zijn ze bezig met individuele patiënten, of met de belangen van hun patiëntenpopulatie in het algemeen. Als ze de rol van afdelingslid spelen, werken ze in hun patiëntenzorg samen met verpleegkundigen, doktersassistentes, laboranten, arts-assistenten. Specialisten onderhandelen in hun werk in patiëntenzorg vanuit deze twee rollen.

Beschouwende specialisten doen in hun patiëntenzorg aan 'toegangsbewaking'. Zij willen iets te zeggen hebben over de toegang van patiënten en over de problemen waar patiënten mee komen. Het gaat in hun vakken vooral om 'argumenteren'. Medisch inhoudelijk moet het verhaal over elke patiënt kloppen. Daarom moeten de specialisten er bij een nieuwe patiënt op letten dat het verhaal wel aansluit bij hun specialisme. Als het probleem van de patiënt nog niet helemaal duidelijk is, kan de keuze voor het juiste specialisme moeilijk zijn. Specialisten van verschillende vakgebieden onderhandelen dan met elkaar over waar de patiënt het beste terecht kan. Patiënten willen soms ook problemen aan de orde stellen die wel met hun gezondheid te maken hebben, maar niet met het vakgebied van de specialist. Dan onderhandelen arts en patiënt er over. Vaak vinden de specialisten dat zo'n probleem beter met de huisarts kan worden besproken.

Snijdende specialisten doen aan 'verkeersleiding' in hun patiëntenzorg. Meestal wordt één patiënt maar één keer geopereerd. Omdat opereren de essentie van het vakgebied is, moet er geen stagnatie van de patiëntenstroom zijn. Veel onderhandelingen van snijdende specialisten gaan dan ook over opnames en ontslag, over de beschikbaarheid van operatiekamers en bedden, en over de informatie die nodig is in de patiëntenzorg, zoals dossiers, laboratoriumuitslagen of röntgenfoto's. Ze onderhandelen bijvoorbeeld met managers en medewerkers van het opnamebureau. Snijdende specialisten willen iets te zeggen hebben over de logistiek van de patiëntenstromen en over ziekenhuiscapaciteit, omdat ze willen blijven opereren.

In de onderhandelingen in de patiëntenzorg doen ondersteunende specialisten aan 'positiebewaking'. Hun werk ondersteunt de patiëntenzorg van de specialisten die de aanvragen doen. Die hebben de neiging het ondersteunende werk vanzelfsprekend te vinden en soms weinig rekening te houden met de specialistische kennis die

daarvoor nodig is. Ondersteunende specialisten bewaken in de relatie met de aanvragers hun positie en de exclusiviteit van hun werk. Ze willen iets te zeggen hebben over hun eigen patiëntenzorg, en over de exclusieve toepassing van kennis, technieken en apparatuur waarin zij de verbinding leggen tussen hun eigen vakgebied en patiëntenzorg van de aanvrager.

Specialisten steunen het principe van het 'professioneel primaat': ze vinden dat patiëntenzorg in het ziekenhuis altijd op de eerste plaats moet komen. Vóór geld en efficiency. Dat blijkt uit het vragenlijstonderzoek. Ze vinden dat de kwaliteit van hun patiëntenzorg bedreigd wordt doordat ze te veel rekening moeten houden met financiële en organisatorische overwegingen. Als het gaat om autonomie, vinden specialisten dat hun beroepsgroep zelf de kwaliteit van patiëntenzorg moet bewaken. Managers in het ziekenhuis moeten zich niet inhoudelijk bemoeien met de medische beroepsuitoefening. Ze kunnen misschien wel initiatief nemen om af en toe iets aan patiëntenzorg te veranderen.

7. Onderhandelingen in het ziekenhuis

Specialisten spelen in het ziekenhuis de rollen van collega, lid van de afdeling, van de staf en van het ziekenhuis. Er zijn specialisten die óók de rol van 'medisch manager' hebben. In de drie groepen specialismen zijn er, als het om die rollen gaat, accentverschillen in de onderhandelingen. Maar de overeenkomsten zijn groter dan in de onderhandelingen in de patiëntenzorg. In elke rol gaan de onderhandelingen over het organiseren van werk en over het bevestigen of verbeteren van posities en relaties. De rollen van collega en lid van de afdeling zijn het belangrijkste voor het evenwicht in het dagelijks werk van specialisten.

De rol van collega is belangrijk omdat specialisten van één vakgebied niet zonder elkaar kunnen werken. Solo praktijken komen niet meer voor. Specialisten letten op elkaar in de patiëntenzorg en ze vullen elkaar aan in besprekingen over individuele patiënten. Ze verdelen ook verschillende aandachtsgebieden in het specialisme. Voor de organisatie van het werk hebben ze elkaar ook nodig. Ze verdelen diensten en taken in onderwijs en onderzoek, of in de organisatie.

In hun onderlinge relaties willen individuele collega's iets te zeggen hebben over de manier waarop het werk wordt georganiseerd, en over de manier waarop ze samenwerken. Maar het evenwicht in de groep staat ten dienste van het gezamenlijke belang. Het gaat niet om de individuele collega. 'Harde' belangen, bijvoorbeeld de verdeling van het inkomen over de collega's, worden wel besproken. Maar over minder concrete onderwerpen, zoals de stijl van patiëntenzorg of de manier van met elkaar omgaan, praten specialisten weinig met elkaar. Omdat collega's intensief samenwerken zonder veel ruimte voor het uitspreken van individuele voorkeuren of meningen, ontstaan er irritaties. Bijna elke specialistengroep kent vroeg of laat een periode waarin onderlinge verhoudingen gespannen of slecht zijn.

In de groep collega's hoort iedereen even veel waard te zijn. De specialisten geven in het vragenlijstonderzoek aan dat ze 'egalitarisme' belangrijk vinden. Alle groepsleden moeten dezelfde mate van zeggenschap hebben. De meeste specialisten zeggen zich thuis te voelen in hun groep collega's.

De collega's komen samen op voor hun belangen in relaties met andere specialistengroepen en managers. De onderhandelingen gaan dan over de positie van de groep in het ziekenhuis, over geld en over de aantallen patiënten die gezien en behandeld worden, de 'productie'.

De zeven specialistengroepen in dit onderzoek werken in ziekenhuizen die recent zijn gefuseerd. De relatie met de collega-specialistengroep in 'het andere ziekenhuis' moet nog in evenwicht komen. Verder letten de collega's op hun positie ten opzichte van het management, ten opzichte van andere specialistengroepen en ten opzichte van andere ziekenhuizen of specialistengroepen in de regio.

De specialisten hebben het vaak over hun 'eigen winkel', als ze het hebben over hun groep collega's van één vakgebied. Samen willen zij het voor het zeggen hebben in hun 'winkel'. Zij willen beslissen over de inhoud van het werk in de patiëntenzorg, over de financiën, en over de organisatie van het werk.

De rol van afdelingslid is belangrijk omdat het werk pas echt begint op afdelingen, in poliklinieken en in operatiekamers. Specialisten onderhandelen over de organisatie van het werk op de afdeling. Ze willen een erkende rol spelen in het management. Ze onderhandelen ook over de verdeling van taken tussen hen en anderen op

de afdeling en over 'ruimte en spullen', kamers, apparatuur en instrumenten. In de onderhandelingen hebben de specialisten te maken met managers, en ook met medisch managers als die er zijn, met collega's, en met andere specialistengroepen. In de enquête geven ze aan meer betrokken te willen worden bij beslissingen over de organisatie van de afdeling. Vooral beschouwende specialisten willen zeggenschap over de gang van zaken op de afdeling. Specialisten in snijdende vakken willen dat het duidelijk is dat de specialist de baas is in de patiëntenzorg. Zij hebben minder dan anderen behoefte aan invloed op het afdelingsbeleid. De ondersteunende specialisten zijn tevredener over hun invloed op de afdeling dan de anderen.

Als lid van de afdeling onderhandelen specialisten ook over hun positie ten opzichte van de medewerkers. De specialisten zijn niet hun 'gelijken', ze staan in sociaal en functioneel opzicht hoger. Het gaat er niet om dat specialisten zomaar iets te zeggen willen hebben over de mensen op de afdeling. Het gaat er om dat het in de patiëntenzorg duidelijk moet zijn dat de specialist de leiding heeft. In het vragenlijstonderzoek vinden veel specialisten dat zij de baas horen te zijn in de patiëntenzorg. Ze vinden niet dat ze zonder meer de baas horen te zijn van iedereen in het ziekenhuis.

Specialisten voeren ook onderhandelingen over de afdeling. Bijvoorbeeld als het gaat over reorganisaties of verbouwingen, waar specialisten met managers over praten. Ze onderhandelen bij een fusie ook met collega's en managers van de overeenkomstige afdeling in 'het andere ziekenhuis'.

Specialisten letten in hun rol van afdelingslid vooral op de belangen die ze als dokter en collega hebben. Ze willen iets over de afdeling te zeggen hebben, omdat ze daar als dokter en als collega werken. De belangen die ze behartigen hebben bijvoorbeeld te maken met de logistiek en inhoud van de patiëntenzorg, of met 'productie' en de organisatie van het werk van de groep collega's.

Specialisten onderhandelen in hun dagelijks werk weinig als staflid of als ziekenhuislid. Natuurlijk maken ze deel uit van de medische staf en van het ziekenhuis. Maar deze rollen krijgen alleen een eigen vorm wanneer specialisten bijzondere functies hebben, bijvoorbeeld in het stafbestuur, een stafcommissie, of in een ziekenhuiscommissie.

In de enquête geeft 20% van de respondenten aan medisch manager te zijn. In de observaties waren er maar vier medisch managers. Zij onderhandelen over hun positie in relaties met managers, specialisten en specialistengroepen. Ze onderhandelen ook over de organisatie van werk.

Als manager moeten ze leren omgaan met de schaarse middelen in het ziekenhuis en daarom proberen ze ook hun collega's ervan te overtuigen dat ze soms op een andere, efficiëntere manier moeten werken. In onderhandelingen met 'echte' managers proberen medisch managers de patiëntenzorg te beschermen en te voorkómen dat de financiële druk te groot wordt.

De medisch managers lijken hun onderhandelingen te baseren op een 'hybride' grondslag. In hun relatie met managers willen ze iets te zeggen hebben over de organisatie van patiëntenzorg, waarbij ze de patiëntenzorg proberen te beschermen of verbeteren. Wanneer ze hun collega's 'managen', willen ze iets te zeggen hebben over de organisatie van specialistenwerk. Daarbij wijzen ze op schaarste, of op het belang van het ziekenhuis als geheel.

8. De specialist als individu en als professional

Specialisten hebben ook een privé-leven. In het ziekenhuis onderhandelen ze daar vooral met zichzelf over. Ze wegen hun persoonlijk belang, bijvoorbeeld dat ze op tijd thuis zijn, dan af tegen de verplichtingen vanuit andere rollen, vooral die van dokter en die van collega. Wanneer ze met zichzelf onderhandelen zoeken ze naar mogelijkheden waarbij ze niet voor één van de rollen hoeven te kiezen. Als ze op tijd naar huis willen gaan én ze hebben een maatschapsvergadering, dan gaan ze bijvoorbeeld wat eerder weg bij die vergadering. Als dat niet kan, laten ze de belangen die ze als dokter of collega hebben meestal voorgaan.

Specialisten hebben hun eigen ideeën over onderlinge relaties in de groep. Ze hebben persoonlijke voorkeuren voor de stijl van samenwerken en de taakverdeling met collega's. Toch - dat kwam al eerder aan de orde - onderhandelen ze daar weinig over. Ze vinden het zo belangrijk om onderlinge relaties goed te houden, dat ze onderhandelingen over persoonlijke voorkeuren liever vermijden. Het is ook niet gebruikelijk om persoonlijke ambities te bespreken, of loopbaanwensen.

Specialisten willen als individu graag iets te zeggen hebben over de inrichting van het dagelijks werk, over de relaties met collega's en over de individuele loopbaan. Maar de onderhandelingen daarover zijn bescheiden, omdat ze vinden dat de groep belangrijker is dan het individu.

Vrouwen en jongere specialisten zijn de specialisten van de toekomst. Uit de enquête blijkt dat zij autonomie minder belangrijk vinden dan mannen en oudere specialisten. En dat vrouwen vaker van zichzelf vinden dat ze als 'gewone medewerker' moeten meedoen in het ziekenhuis. Vijf procent van de groep specialisten ouder dan 50 jaar is vrouw. In de jongste groep, tot en met 40 jaar, is dat 40%. Omdat zij vaker in deeltijd en in loondienst werken, zal in de toekomst de voltijds werkende, vrij gevestigde specialist minder vaak voorkomen dan nu. In de oudere specialistengroepen werkt 80% in vrije vestiging. In de jongste groep is dat iets meer dan 60%.

Specialisten werken in de Nederlandse gezondheidszorg. Ze zijn lid van de medische professie, de beroepsgroep van artsen. En ze zijn lid van hun eigen specialisme. Op deze drie niveaus spelen ze een rol als professional.

Aan echte onderhandelingen over de Nederlandse gezondheidszorg nemen specialisten alleen deel als ze een formele rol hebben in een landelijke organisatie. Die onderhandelingen spelen zich buiten het ziekenhuis af. Ze zijn niet onderzocht in de observaties. Specialisten praten er wel over in het ziekenhuis. Er komt een nieuw financieringssysteem dat gebaseerd is op Diagnose Behandel Combinaties. De meeste specialisten hebben daar weinig vertrouwen in. Ze mopperen er over.

Als professional zijn specialisten ook vertegenwoordigers van de medische beroepsgroep in Nederland. Ze willen samen iets te zeggen hebben over hun werk en daar hebben ze maatschappelijk en juridisch ruimte voor nodig. Daarom hebben ze bijvoorbeeld hun eigen normen in ontmoetingen met niet-specialisten. Specialisten vinden het goed dat ze wat meer tot 'gewone mensen' gerekend gaan worden, maar dat moet, vinden ze, niet worden overdreven. Om als dokter enig overwicht te hebben, moet de maatschappij óók blijven opkijken tegen specialisten.

De rol van lid van één bepaald specialisme wordt buiten het ziekenhuis ingevuld als een specialist actief is in een wetenschappelijke vereniging. Ook dat is in het onderzoek niet geobserveerd. In het vragenlijstonderzoek zijn specialisten die actief zijn in een wetenschappelijke vereniging wat minder 'traditioneel' in hun 'professionele oriëntatie' dan anderen. Ze vinden 'autonomie' en 'egalitarisme' minder belangrijk en ze vinden vaker dat specialisten 'gewoon' mee moeten doen met de rest van het ziekenhuis.

In het ziekenhuis zorgen wetenschappelijke en technische, maar ook maatschappelijke ontwikkelingen ervoor dat patiëntenzorg verandert en dat de verdeling ervan tussen verschillende vakgebieden verandert. Daardoor voeren medische vakgebieden 'onderhandelingen' met elkaar. In de beschouwende vakken zeggen specialisten bijvoorbeeld dat ze ervaren dat de grens met de huisartsgeneeskunde verschuift. Patiënten hebben in toenemende mate psychosociale problemen, naast hun lichamelijke problemen of als gedeeltelijke oorzaak van die lichamelijke problemen.

Alle specialismen ontwikkelen hun kennis en kunde. Ondersteunende specialismen ontwikkelen nieuwe aandachtsgebieden in de patiëntenzorg, bijvoorbeeld pijnbestrijding en intensive care geneeskunde in de anaesthesiologie. Of ze gaan hun kennis en vaardigheden toepassen op de patiëntenzorg van andere specialismen. Echoscopische diagnostiek in de radiologie is bijvoorbeeld een belangrijke aanvulling op de diagnostiek van beschouwende vakgebieden. Sommige radiologen denken dat zij de diagnostiek van beschouwende vakgebieden grotendeels zouden kunnen overnemen. Radiologen kunnen ook onder röntgendoorlichting vernauwingen of obstructies in bloedvaten en ingewanden behandelen, bijvoorbeeld door een 'stent' te plaatsen. Operaties zijn dan niet meer nodig, en daarmee komen ze op het terrein van snijdende vakken.

Het gaat in deze verschuivingen meestal niet om letterlijke onderhandelingen tussen artsen van verschillende vakgebieden. Al kunnen specialisten zich wel in strijdbare termen over andere vakken uitspreken. Specialisten willen, als professional in hun eigen vak, iets te zeggen hebben over de toepassing van hun kennis en kunde, zo mogelijk ook als het gaat om patiënten en problemen die ergens anders 'horen'. Alleen is in de beschouwende vakken de 'toegangsbewaking' belangrijker dan het 'overnemen' van huisartsgeneeskundige patiëntenzorg. Er wordt dan ook veel gemopperd over de psychosomatische problematiek in de spreekkamer van de specialist.

Deel 3 Conclusie en discussie

9. Conclusies en discussie

Specialisten zijn vooral dokter en collega. Deze rollen zijn het meest bepalend voor de 'negotiated order' in hun werk. Ze onderhandelen omdat ze als dokter iets te zeggen willen hebben over de patiëntenzorg en over de logistiek van patiëntenzorg. Als collega's gaat het ze om de organisatie van de 'winkel' die ze samen hebben.

Specialisten zijn op hun hoede als het gaat om hun positie in verschillende relaties. Als de mogelijkheid zich voordoet, proberen ze in onderhandelingen hun positie ten opzichte van hun omgeving te verbeteren. Deze mogelijkheden kunnen zich onverwacht voordoen. Het is belangrijk om steeds te weten wat de uitgangspositie is in de verschillende relaties, omdat specialisten op elk moment klaar moeten staan om hun positie te verdedigen of te verbeteren.

De 'negotiated order' verdient een nieuw concept als aanvulling: de 'negotiated position'. 'Negotiated order' is de uitkomst van alle onderhandelingen in een groep of in een organisatie. De 'negotiated position' is de uitkomst voor één persoon of partij daarin. Deze uitkomst is tegelijk het begin van nieuwe onderhandelingen.

Nu kan worden vastgesteld wat in het dagelijks werk van specialisten de verhouding is tussen wat managers te zeggen hebben, wat patiënten te zeggen hebben, en wat specialisten te zeggen hebben. In hun dagelijkse werk hebben specialisten het overwegend zelf voor het zeggen. De achtergrond van het werk wordt voor een deel bepaald door 'het management', bijvoorbeeld omdat het management de 'eigenaar' is van de organisatiestructuur van het ziekenhuis en van regels voor beleid en financiële beslissingen. Maar 'het management' bestaat niet alleen uit managers, want ook het stafbestuur is bijvoorbeeld betrokken bij beslissingen over het ziekenhuis. Medisch managers zijn betrokken bij beslissingen over afdelingen. En 70% van de deelnemers aan het vragenlijstonderzoek zit in een ziekenhuiscommissie.

In hoeverre hebben patiënten iets te zeggen? Zij zijn niet als 'georganiseerde' groep zichtbaar in het werk van specialisten. Individuele patiënten onderhandelen wel met de specialisten, over hun afspraken, over hun behandeling of over de problemen die ze aan de orde kunnen stellen.

Het onderzoek laat zien dat het eigenlijk niet voldoende is om te weten wíe het voor het zeggen heeft. Op z'n minst moet óók duidelijk zijn welke criteria de deelnemers gebruiken. Streven ze naar goede patiëntenzorg, naar tevreden klanten, of naar een efficiënte organisatie? En op welke manier doen ze dat? Volgen de verschillende deelnemers dezelfde waarden? Sluiten ze contracten met elkaar af? Of is er gewoon iemand de baas? Vervolgonderzoek naar zeggenschap in ziekenhuizen zou van deze modelmatige combinaties gebruik moeten maken.

Vervolgstudies kunnen op verschillende manieren een aanvulling geven op dit onderzoek. De andere partijen in de onderhandelingen zouden bijvoorbeeld gevolgd kunnen worden. Of de patiënten zouden gevolgd kunnen worden - voor een andere benadering van het werk in ziekenhuizen. Een systematische vergelijking is in deze studie alleen op het niveau van de groepen specialismen gedaan: beschouwend, snijdend en ondersteunend. Ander onderzoek zou ziekenhuizen kunnen vergelijken, of verschillende vakgebieden binnen de beschouwende, snijdende en ondersteunende specialismen. En uit dit onderzoek kunnen verschillende hypotheses gehaald worden, die getoetst kunnen worden.

'Plezier in het werk' was niet het onderwerp van dit onderzoek. Toch kan voorzichtig worden geconcludeerd dat specialisten zwaar werk hebben en dat grofweg één op de tien daar op één of andere manier last van heeft. Dat heeft met veel verschillende dingen te maken. Dit onderzoek laat drie oorzaken zien: de aard van het werk, de continue onderhandelingen en het belang van de groep.

Ten eerste is het werk van specialisten, vooral in patiëntenzorg, veeleisend en 'gulzig', en het wordt in toenemende mate gestandaardiseerd. Specialisten willen zoveel mogelijk hun eigen werk organiseren. Daarom zijn ze op elk moment beschikbaar in al hun rollen. Wie niet naar de afzonderlijke rollen kijkt, maar naar het dagelijks werk van specialisten als geheel, ziet dat de rollen zich niet laten inroosteren. Daarom is het werk van specialisten gefragmenteerd. 'Serieel' zien ze verschillende patiënten

achter elkaar, en doen ze verschillende activiteiten. 'Parallel' werken ze aan veel tegelijk. Dat betekent dat specialisten tijdens een ontmoeting met patiënt X een vraag kunnen krijgen over patiënt Y, of gebeld kunnen worden over een vergadering met maatschap Z. Specialisten hebben daarom op een dag veel 'seriële en parallelle schakelingen'. Alleen dagdelen met operaties of andere relatief langer durende activiteiten kunnen perioden met meer concentratie geven, als de 'pieper' wordt beantwoord door iemand anders. 'Zelf-management' ontaardt op dagelijks niveau nog wel eens in 'geleefd worden' door het rooster, de spreekuurschema's en de pieper. De houding van overgave aan het ritme van de dag is een houding die op termijn het persoonlijke gevoel van controle kan ondermijnen.

Ten tweede is het ziekenhuis een soort arena waarin specialisten elkaar en andere partijen in de gaten houden om het verlies van hun positie te voorkómen. De belangen van de verschillende partijen in het 'geïntegreerd medisch specialistisch bedrijf' zijn niet geïntegreerd. Specialisten komen vooral elkaar tegen in dagelijkse onderhandelingen, met managers op de tweede plaats. Dat er dagelijks onderhandelingen nodig zijn, kan individuele specialisten het gevoel geven dat ze bedreigd worden.

Ten derde is de groep in de geneeskunde erg belangrijk. Collega's hebben elkaar nodig voor patiëntenzorg en voor zakelijke belangen. Hun inkomen wordt bepaald door formules en afhankelijkheden, en de regels daarvoor zijn sinds de jaren tachtig aan het veranderen. Externe onzekerheid over het inkomen maakt de groep weer belangrijker voor de gezamenlijke belangen. De belangrijke rol van de groep kan specialisten langzamerhand het gevoel geven dat ze er individueel niet zo veel toe doen.

Dit onderzoek leidt tot een aantal aanbevelingen waardoor het werk van specialisten zou kunnen veranderen, en waardoor het misschien minder zwaar zou worden. De eerste aanbevelingen zijn voor specialisten en managers samen. Daarna volgen aanbevelingen voor specialisten en tenslotte voor ziekenhuismanagers.

Hoe moet je in een 'negotiated order' het werk organiseren? Dat moeten specialisten en managers samen doen. Het is duidelijk dat contracten en documenten niet bepalen dat dat goed gaat. Het lijkt erop dat gemeenschappelijke waarden weinig ontwikkeld zijn. Het ziekenhuis is er voor de patiëntenzorg en voor de patiënt. De criteria voor beslissingen van artsen en managers, maar ook van anderen in het ziekenhuis, moeten daarom in de eerste plaats gebaseerd zijn op een idee van wat goede patiëntenzorg is, en van wat patiënten willen. Criteria voor een goede, efficiënte organisatie moeten daar een afgeleide van zijn.

De patiëntenzorg verschilt per soort specialisme. Verschillen die er zijn, moeten worden gerespecteerd. De organisatie van patiëntenzorg zou geen eenheidsworst moeten zijn. Verschillende soorten specialisten hebben ook verschillende manieren waarop ze deelnemen aan de organisatie. Daar moet aandacht voor zijn, want die verschillende manieren hebben te maken met wat er nodig is voor de patiëntenzorg. Snijdende specialisten willen bijvoorbeeld dat hun patiëntenstromen op gang blijven. Ze hebben er minder behoefte aan om zich bezig te houden met de algemene organisatie van de afdeling. Het heeft dan ook geen zin om ze zonder meer daartoe te dwingen. Als hun betrokkenheid toch nodig is, zullen managers specialisten duidelijk moeten maken waarom.

Verschillende soorten specialisten hebben ook verschillende soorten 'blinde vlekken'. Door de kenmerken van hun patiëntenzorg hebben ze voorkeuren voor onderwerpen en voor manieren van communiceren. Managers en specialisten moeten elkaar wijzen op patronen die tot 'blinde vlekken' leiden. En ze moeten elkaar motiveren om van die patronen af te wijken, omdat dat beter is voor de samenwerking.

Specialisten lijken een natuurlijke ruimte te hebben op het niveau van de afdeling. Daar wordt hun werk uitgevoerd. De rol van afdelingslid verdient versterking. Specialisten en managers moeten proberen om vanuit de afdeling te werken aan de organisatie van het werk van specialisten. 'Evidence based medicine', waarin artsen hun beslissingen in patiëntenzorg zoveel mogelijk proberen te baseren op

bewijzen van effectiviteit, moet door de afdeling als geheel worden aangepakt. De komst van nieuwe functies in de patiëntenzorg, zoals 'nurse practitioners' en 'physician assistants' moet worden gekoppeld aan beslissingen over taakverschuivingen van artsen naar verpleegkundigen. De projecten in veel ziekenhuizen, om patiëntenzorg zo te organiseren dat patiënten sneller en zo mogelijk beter geholpen worden, horen gebaseerd te zijn op medisch inhoudelijke en organisatorische argumenten. Als dit per vakgebied op maat wordt aangepakt, kunnen specialisten zeker meer bij de organisatie betrokken zijn, zonder dat het hen meer tijd kost.

De waarde van 'het geïntegreerd medisch specialistisch bedrijf' is beperkt. Specialisten zijn tot op zekere hoogte geïntegreerd in het ziekenhuis. Hun inkomen wordt door het ziekenhuis verstrekt en ze nemen deel aan het management. Maar de belangen zijn niet geïntegreerd. Dat kan ook niet. De criteria voor goede patiëntenzorg, tevreden klanten en een efficiënte organisatie zullen in ziekenhuizen altijd náást elkaar bestaan. 'Integratie van specialisten in de ziekenhuisorganisatie' houdt een tegenstrijdigheid in.

Managementparticipatie lijkt door de specialisten in het onderzoek gesteund te worden. Medisch managers combineren de criteria van goede patiëntenzorg en efficiënt organiseren en daarom zijn ze belangrijk voor het werken in de 'negotiated order'. Maar managementkrachten lijken sterker aan medisch managers te trekken dan krachten vanuit de patiëntenzorg. Het zou goed zijn als medisch managers zich ook in de andere richting ontwikkelen, door zich te buigen over het werk in de patiëntenzorg, en initiatief te nemen tot onderzoek naar dagindeling en tijdsbesteding, en door te praten over andere manieren om patiëntenzorg te organiseren. Zij hoeven dat niet alleen te doen. Specialisten nemen op grote schaal deel aan commissies, en deze betrokkenheid lijkt wel eens onvoldoende gezien te worden.

Enige training in hoe ziekenhuismanagement werkt is misschien handig voor specialisten. Maar als ze moeten kiezen, kunnen ze zich beter verdiepen in het organiseren van hun eigen werk en tijd.

Hoe moeten specialisten werken in de 'negotiated order' van het ziekenhuis? Als zij zich, zoals net aanbevolen, willen verdiepen in de organisatie van hun eigen werk en tijd, zullen ze het evenwichtsspel van het ziekenhuis moeten leren spelen. Het spel van 'geven-en-nemen', van diplomatieke betrekkingen, het spel van afdingen. Ze kunnen niet inzetten op 'de grootste helft', want als iedereen dat doet houdt iedereen elkaar gevangen. Ze moeten inzetten op het evenwicht, met de onderhandeling als bescheiden middel om dat te bereiken. Dat zou ook voor medisch inhoudelijke ontwikkelingen gunstiger zijn dan 'het onderste uit de kan' willen.

In het evenwicht van dagelijks werk moeten specialisten zich niet overgeven aan het ritme van het spreekuur en de pieper. Hun werk en hun tijd verdienen dat ze er verantwoordelijkheid voor nemen. Het is niet makkelijk om het werk anders te organiseren. Maar er over mopperen lost zeker niks op. Zorgvuldig onderzoek van de logistiek van patiëntenzorg is zeldzaam. Het is misschien ook voor specialisten niet aantrekkelijk om daar hulp bij te vragen. Het feit dat niemand de organisatie van je werk begrijpt is natuurlijk wel interessant. Het helpt in elk geval om het zelf voor het zeggen te hebben - en te houden. Toch zou een betere indeling de inhoud van het werk niet van zijn complexiteit ontdoen. Integendeel. Een betere organisatie kan ruimte creëren voor nieuwe ontwikkelingen.

De specialisten van de toekomst zullen het evenwichtsspel misschien makkelijker spelen dan de specialisten van nu. Vrouwen en jonge specialisten, ook mannen, vinden 'autonomie' minder belangrijk dan mannen en oudere specialisten. Vrouwen gaan er ook vaker vanuit dat specialisten 'gewoon' in de organisatie van het ziekenhuis mee horen te doen. Ze werken vaker in deeltijd, en ze zullen daarom misschien ook minder de neiging hebben om hun energie aan onderhandelingen of positieverbetering te besteden. Vrouwen willen, meer dan mannen, invloed op het niveau van de afdeling. Dit sluit aan bij wat eerder al aan de orde kwam. Specialisten zouden de afdeling moeten accepteren als hun natuurlijke omgeving voor werk. Daar komen de patiënten. Daar begint het werk, en daar moeten dokters leren hun werk te delen met de anderen van de afdeling. Verschillende verantwoordelijkheden, gezamenlijke waarden.

In de groep van collega's mag de gezamenlijkheid juist wel wat minder belangrijk gevonden worden. De groep is zo dominant dat het individu verstikt raakt. De groep zou als 'team' aan kracht winnen wanneer er meer ruimte zou zijn voor individuele ontwikkeling. Gezamenlijke reflectie op het werk, de samenwerking en op het individueel functioneren is relatief onderontwikkeld in vergelijking met gezamenlijke belangenbehartiging. Vormen van intervisie, in de fase van opleiding en daarna, kunnen hier verandering in brengen.

Hoe kunnen managers de 'negotiated order' in balans helpen houden? Specialisten zitten in hun dagelijks werk vaker elkáár dwars dan dat ze worden dwarsgezeten door managers. Eigenlijk zijn managers, zeker die van hoger niveau, nauwelijks te zien in het dagelijks werk. Zij ontmoeten de specialisten alleen op formele momenten van besluitvorming, bijna nooit spontaan. Mede daardoor lijken zij beschouwd te worden als de personificatie van schaarste en andere problemen. Er wordt veel over hen gemopperd. Maar er wordt ook over andere dingen veel gemopperd. In het vragenlijstonderzoek waren specialisten positiever over het ziekenhuis als ze de raad van bestuur frequent ontmoetten en spraken. Om het evenwicht in het ziekenhuis te bewaren of te verbeteren wordt leden van raden van bestuur en andere managers daarom aangeraden zich te laten zien in het dagelijks leven van specialisten. Leer de 'negotiated order' van het dagelijks werk eens kennen.

Het nieuwe financieringsstelsel daagt managers en specialisten uit zich samen te onderscheiden van concurrenten. Managers kunnen het competitiegevoel versterken door te erkennen dat specialisten hun eigen zaakjes willen regelen en zo mogelijk hun praktijken willen uitbreiden. Daarbij hebben de artsen wel advies nodig bij het zaken doen, bij het organiseren van werk, en bij het afsluiten van contracten.

Managers en leidinggevenden in ziekenhuizen moeten accepteren dat ze schaarste en voorraden 'managen'. Dat lijkt misschien minder interessant dan 'een ziekenhuis aansturen'. Toch zijn er daarvoor leiders nodig die patiëntenzorg en professionals kunnen koesteren en met visie prioriteiten kunnen stellen, zeker wanneer de schaarste straks gecombineerd wordt met 'gereguleerde concurrentie'.

Specialisten moeten door deze leiders worden uitgenodigd om mee te doen aan de ambities van de organisatie. In ruil voor concrete steun.

Managers en leidinggevenden horen betrouwbare bemiddelaars te zijn, die het evenwichtsspel goed kunnen spelen. Als specialisten en anderen hun onderhandelingen uit de hand laten lopen, moeten de leiders hen kunnen helpen de balans weer te vinden.

Managers kunnen dit alleen maar als ze zich ontwikkelen tot 'dienstbare ondernemers' die de concurrentiepositie van het ziekenhuis verbeteren door te streven naar goede patiëntenzorg en tevreden klanten. Als ze efficiency belangrijker vinden, zullen de andere partijen geen vertrouwen in hen hebben.

De verschillende partijen in ziekenhuizen moeten proberen te zoeken naar gemeenschappelijke waarden. Uiteindelijk werkt iedereen ten dienste van de zorgprocessen en van de individuele patiënten. Daarbij moeten mensen wel accepteren en respecteren dat er verschillen zijn tussen specialismen, en dat verschillende belangen en waarden in het ziekenhuis een rol spelen. Volledige integratie daarvan is niet mogelijk en onderhandelingen zullen altijd noodzakelijk blijven. Wanneer dat geaccepteerd wordt, kunnen onderhandelingen langzamerhand dialogen worden.

Curriculum Vitae

Karen Kruijthof (1967) ging van 1979 tot 1985 naar het Christelijk Gymnasium in Utrecht. Ze studeerde geneeskunde en bestuurskunde aan de Vrije Universiteit in Amsterdam. Als student was ze onder andere lid van het bestuur van de Faculteit Geneeskunde van de Vrije Universiteit en van de eerste Landelijke Visitatiecommissie voor Geneeskunde en Gezondheidswetenschappen. In 1992 rondde zij bestuurskunde af (doctoraal-examen) en in 1994 geneeskunde (arts-examen).

Tussen 1994 en 1996 werkte ze in het Westfries Gasthuis in Hoorn, als arts-assistent heelkunde (niet-in-opleiding). Dit was een bijzonder assistentschap omdat de functie was ontworpen door de verplegingsdienst, als onderdeel van een kwaliteitsproject. De chirurgen waren verantwoordelijk voor de supervisie in de patiëntenzorg, het etagehoofd was haar organisatorisch leidinggevende.

Toen dit project eindigde in 1996, koos zij ervoor de individuele geneeskunde te verlaten en werd zij stafmedewerker in het Westeinde Ziekenhuis in Den Haag - na de fusie met het Ziekenhuis Antoniushove het Medisch Centrum Haaglanden.

In het Medisch Centrum Haaglanden is Karen Kruijthof nu één van de adviseurs van de Raad van Bestuur en werkt ze onder andere samen met de medische staf als secretaris van de Commissie Medisch Beleidsplan.

Van 2000 tot 2005 combineerde ze het werk in het ziekenhuis met een nul-aanstelling als promovendus aan het Instituut Beleid en Management Gezondheidszorg van het Erasmus Medisch Centrum in Rotterdam. Ze maakte daar deel uit van de sectie Bestuurs- en Organisatie-wetenschappen. Ook bezocht zij de bijeenkomsten van de onderzoeksgroep 'Physician Management Integration' van de afdeling Sociale Geneeskunde van het Academisch Medisch Centrum in Amsterdam, en de gezamenlijke vergaderingen met onderzoekers van het Centrum voor Ziekenhuis- en Verplegingswetenschap in Leuven, België.

Als onderzoeker hield ze tweemaal een voordracht in parallelsessies van de jaarlijkse conferentie van de 'European Health Management Association' en werkte ze samen met de Orde van Medisch Specialisten in het beleidsproject 'De Medisch Specialist in Perspectief'.

Karen Kruijthof is lid van de Vereniging van Nederlandse Vrouwelijke Artsen en ze was tussen 1998 en 2001 redactievoorzitter van het tijdschrift van de vereniging. Sinds 1997 is ze lid van de redactie van het Epidemiologisch Bulletin, Tijdschrift voor Volksgezondheid en Onderzoek in Den Haag (GGD Den Haag), en sinds 2004 maakt ze deel uit van de Raad van Advies van het tijdschrift Medisch Contact.

Vanaf haar co-assistentschappen in 1992 neemt zij deel aan intervisie in SPG-verband ('Steunende Procesgerichte Groep').

Stellingen behorende bij het proefschrift

Doctors' orders

1. In hun dagelijks werk zijn medisch specialisten in de eerste plaats dokter en in de tweede plaats collega: ze onderhandelen vooral over de patiëntenzorg en over de onderlinge organisatie van werk en zakelijke belangen.
   Dit proefschrift.

2. Omdat medisch specialisten van verschillende vakgebieden verschillende organisatorische voorkeuren hebben, kunnen medische staven niet tot krachtige consensus komen over prioriteiten en werkwijzen in het ziekenhuis.
   Dit proefschrift.

3. Groepsmacht en onderlinge afhankelijkheid belemmeren leden van een vakgroep of maatschap individuele wensen en voorkeuren te benoemen.
   Dit proefschrift.

4. De rol en positie van medisch specialisten in de ziekenhuisorganisatie zal in de nabije toekomst vooral worden bepaald door de afname van vrije vestiging, de afname van de behoefte aan autonomie en de toename van werken in deeltijd.
   Dit proefschrift.

5. Medisch specialisten moeten zich realiseren dat ze alleen vaker kunnen meebeslissen over beleid en organisatie in het ziekenhuis als ze daar ook meer tijd en aandacht aan willen besteden.
   Dit proefschrift.

6. Om bij artsen het vermogen te versterken tot organisatie van en reflectie op het eigen handelen, moet intervisie onderdeel uitmaken van medische opleidingen.

7. Integratie is tweerichtingsverkeer; waar van medisch specialisten 'managementparticipatie' wordt verlangd, behoort van managers 'patiëntenzorgparticipatie' verlangd te worden.

8. Voor goede prestaties is een cyclus van 'vertrouwen en verantwoording' waardevoller dan een cyclus van 'planning en control'.

9. Grote steden combineren structuur, diversiteit en chaos; dit maakt medewerkers van binnenstadsziekenhuizen systematisch veelzijdig.

10. Temps staat in het ziekenhuis voor de tijd van roosters, spreekuurschema's, het tellen van een hartfrequentie; durée staat voor de tijd van luisteren, begrijpen, het kloppen van een hart; doelmatige én goede patiëntenzorg vereist respect voor beide betekenissen van tijd.
    Vrij naar Leertouwer, Medisch Contact nr. 36, 2003, 1349; 'temps' en 'durée' zijn beschreven door Henri Bergson.

11. Vrouwen zijn ondervertegenwoordigd in de top door het 'glazen plafond' of de 'plakkende vloer'; mannen zijn ondervertegenwoordigd in het huishouden door de 'glazen muur' of het 'plakkende kantoor'.

Karen Kruijthof, Amsterdam
18 februari 2005