”As long as we all just do what we are supposed to be doing ”

Institutional logics and the boundaries of professions and positions in end-of-life care

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Background in a nutshell

Component	Description
Objective	To analyse how healthcare professionals produce and negotiate boundaries between professions and positions
Data	22 semi-structured theme interviews with health care professionals working in or managing end-of-life care in a university hospital district in Finland
Method	Qualitative content analysis
Theory and concepts	Boundary work & institutional logics

Context

Finnish healthcare system & end-of-life care

- Finnish healthcare system is mostly publicly funded and operated
- End-of-life care has been properly established as its own (medicalized) field only in this century
  - Most deaths still not included
- Differs to some extent from other specialities
  - No aim to cure the patient
  - Ethical and even existential questions present in compelling ways
  - Often hospital-at-home

Part of my PhD

- This study is a part of my PhD monograph about institutional work in healthcare – the monograph is in progress
- This presentation is based on a draft of a chapter in the monograph

Why + What

How did this catch my eye?

- The topic emerged from the interviews
  - Most informants in managing positions spontaneously brought up the issue of moving from clinical work to manager work
  - After starting the analysis it became evident that there are several other types of interesting boundary work in the data
    - There is a lot of research on the tension between professions – but here the hard boundary seemed to settle somewhere else

The research questions

- What kinds of boundary work do professionals do to produce, negotiate, maintain, and disrupt relations between professions and positions?
- What does this specific data tell about how institutional logics explain these phenomena?

Analysis

4 types of boundary work

	Naturalizing boundary work	Neutralizing boundary work	Emphasizing boundary work	Justifying boundary work
Central boundary line	Physician profession >< nurse profession	Physician profession >< nurse profession	Person doing patient work >< supervisor or manager	Person doing patient work >< supervisor or manager
Typical speaker	Physician, sometimes nurse	Nurse	Physician or nurse	Manager or supervisor
Institutional logics	Somewhat congruent professional logic	Somewhat congruent professional logic	Professional logic >< managerial logic	Professional logic >< managerial logic
Typical manifestations of boundary work in interviewees' speech	Emphasizing how well things go, as long as everyone simply recognizes their own role and respects others' roles.	Acknowledging a few difficulties but explaining them away and downplaying their significance. Difficulties often existed “before,” but no longer at the moment of speaking.	Suspicion, sense of alienation, emphasizing differences.	Emphasizing or justifying one's own role and task.
Degree of spontaneity	Comes up here and there spontaneously in speech, strengthens when asked.	Comes up here and there spontaneously in speech, strengthens when asked.	Often fully spontaneous, sometimes emerges when asked.	Often fully spontaneous, sometimes emerges when asked.
Motives	For physicians: maintaining their own authority and the status quo. For nursing professionals: possibly emphasizing their own authority. Perhaps everyone wants to convey unanimity and harmony to the interviewer?	Adapting to the status quo, explaining away the limits of one's own agency — a way to advance one's own agenda by adapting to the prevailing logic.	Emphasizing the cohesion of one's own professional community, the value of patient work, and the primacy of professional logic.	Justifying one's own professional orientation, constructing one's own supervisor/manager identity, legitimizing managerial logic.

But in the team, everyone has to understand that you represent your own profession and bring that profession's expertise into it, and value the other profession's expertise and role, and give the other profession room. -- we keep those traditional, profession-specific roles, which the legislation itself already sets limits on for us, on what each of us is allowed to do.

(Chief Physician)

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Well, sure, that kind of thing probably comes up sometimes, probably right when it's busy and the lists are full of patients and there'd be pressure to squeeze in even more patients. And the doctor would of course want everyone to get admitted, and then I'm kind of like, no, it doesn't fit now. So yeah, we do sometimes get these situations where we have to negotiate a bit, because honestly it's not fair to anyone if we're running around here full tilt with no breaks, not even bathroom breaks, and the patients are waiting… But yeah, sometimes we do have to negotiate a bit [with the doctors]. It's nothing like an outright thing where we'd get shot down or anything.

(Nurse)

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Yeah, well, let's just say the management could probably help with that too, if they said, hey, this is a good new… [Management's] positive attitude and that sort of thing could probably help things along.

That's the whole idea, that access to that [care home] gets blocked before you're weak, before your condition is bad enough, so to speak, because of the municipality's decision-makers.

Well, collaboration brings me joy, when I notice that the nurses in my own clinic trust me. And, um, if there's some dispute, like this morning they came straight at me like, look here now [interviewee's own first name], and then I somehow managed to calm the situation down, like okay, let's sort this out, and I can write you up a guideline. -- so that there's an open line of communication, so you get to actually enjoy it.

(Ward Physician)

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It's more like, how should I put it, a hobby, in that I don't want to lose my professional skills completely. - - That was definitely the most fun month of the year, of course.

(Chief Medical Officer)

That's probably also part of what creates that tension for some people, that there's been a certain expectation that you'll go on to have this kind of top-level career, but then you end up having to move into management instead.

(Director of the Health Care District)

But it's like, you get those kinds of thoughts, like, gosh, we could actually develop this thing, if we just got this and that sorted out, and how do I start taking it forward there. - - The regular rank-and-file nurses, they don't really think about it that much, they just do the job and go home.

(Nursing Managers)

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The hard boundary: between positions

- There is an established structure in how the relations between professions are organized and negotiated – as opposed to the relations between clinicians and managers
  - Professions – doctors and nurses – recognize each others jurisdiction or mandate and understand the logic
  - Managerial logic is alien and unrecognized
- Established relations & mutual recognition ➔ blurring boundaries
- Unfamiliarity & inability to comprehend ➔ emphasizing boundaries

- The dominance of medical logic is essential in all relations

Kiitos!

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