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**Professional Work in Health Care Organizations: The Structural Influences of Patients in French, Canadian and American Hospitals**

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# Professional Work in Health Care Organizations:

# The Structural Influences of Patients in French, Canadian and American Hospitals

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**Abstract:**
Although there are several studies of the impact of employment of health professionals in large bureaucratic organizations, there has been significantly less research focused on the structural influence of patients on this relationship. In this paper we present comparative qualitative data gathered on the work experiences of health care professionals in Canadian, U.S. and French hospitals. We elaborate specifically on a typology of structural influence of clients on health care professionals work in hospitals in terms of open and closed units.

**Keywords:** health professions, health care organizations, patients, hospitals, physicians, nurses, comparative perspectives

**JEL Classification:** I18

**Résumé:**
Bien que de nombreuses études se soient intéressées à l'impact de l'emploi des professionnels de la santé dans les grands organismes bureaucratiques, il existe sensiblement moins de recherche portant sur l'influence structurelle des patients dans cette relation. Dans cette étude, nous présentons des données qualitatives comparatives sur l’expérience des professionnelles de la santé dans les hôpitaux canadiens, américains et français. Nous passons plus spécifiquement en revue une typologie de l’influence structurelle des clients sur le travail des professionnels de la santé dans les hôpitaux en termes des unités ouvertes et fermées.

## Introduction

Although there are several studies of the impact of employment of health professionals in large bureaucratic organizations, there has been significantly less research focused on how clients – or patients in this case – influence this relationship. In a previous paper we developed a conceptual model that attempts to better capture the dynamic relationship between professions and organizations where clients are more explicitly recognized (Bourgeault, Hirschkorn & Sainsaulieu, 2005). Briefly, this model acknowledges the importance of understanding as much the internal working of organizations as the interrelations between professions, and the ways in which clients can influence both organizations and professions either directly or indirectly (i.e., on professions through organizations or on organizations through professions). The key aspect of this model that we expand upon in this paper is how the influence of clients is structured into particular divisions of an organization, and how this differentially affects professional work within that organization. We do so by examining the specific case of the structural influence of patients on the work of health care professionals within hospitals. We undertake this examination through a comparative analysis of qualitative data gathered on the work experiences of health care professionals in Canadian, U.S. and French hospitals. With these data we elaborate specifically on a typology of structural influence of clients in terms of open and closed units.

## The Relationship between Organizations and Health Professionals

### *Organizational Pressure on Health Care Professionals*

When one examines the sociological literature on the relations between professions and organizations, the vast majority of it posits a tension between a bureaucratic orientation and a professional orientation (Etzioni 1969, Evetts 2004, Roberts & Donahue 2000, Wilensky 1964,

etc.). Indeed, employment of professionals in bureaucratic organizations has typically been considered to result in varying degrees of deprofessionalization or the diminishment of professional autonomy (Derber 1982, Murphy 1990, Oppenheimer 1973). In the case of health professions, this has been studied for physicians (Hoff 2003, McKinlay 1982) and even more extensively for nurses (Armstrong & Armstrong, 2002, Campbell 1992). For example, research conducted of the reforms to rationalize the organization of nursing work has found that they ultimately have a negative impact on nursing by increasing its fragmentation and quantification (Armstrong & Armstrong, 2002). The impact of rationalisation on nursing work has also been found in French hospitals with similar effects: increasing bureaucratization and intensification of work resulting in equally increasing frustration with the inability to provide care (Sainsaulieu, 2003). This perspective was the primary focus of research that one of us (Bourgeault) conducted with colleagues (Armstrong et al. 2000, 2003, Bourgeault et al. 2002, 2004) of the experiences of health care professionals with the increasing management of care in Canada and Managed Care in the U.S.

While this research has important implications for the enhancement of appropriate policy development to address the problems noted by these health care professionals, it suffers from some important limitations. The focus on the negative effects of organizational imperatives on professions concealing a more complex relationship that exists between professions and organizations, how professions can resist organizational imperatives, and further how clients influence this relationship. For example, in exchange for some limits on their autonomy, professionals who work in organizations are guaranteed access to a clientele, resources or otherwise have some form of job security (albeit increasingly limited in recent years with extensive hospital cutbacks and layoffs, etc.) (Fielding & Portwood 1980, Waters 1989, Zucher

1991). Further, many health professions – technicians, aides, etc. - evolved directly out of the hospital sector (Larson 1977, Barley & Tolbert 1991) to meet the changing needs of clients and the increasing technological approaches to care so their very existence is tied to an organizational setting or field. Others have also argued that the work of professionals within organizations does not necessarily lead to dysfunctional relationships of conflict (Scott 1982). Barr & Steinberg (1980), for example, argue that "through physician participation in organizational mechanisms, the potential clash between bureaucratic requirements and the professional norm of autonomy may be reduced" (p. 355-6). Indeed, organizations often evolve to accommodate the needs of the professionals that work within them as well as to external environmental pressures, including those from clients and the public at large (Montgomery 1997).

*Breaking Down the Relations between Professions and Organizations*

Beyond whether there exists an inherently antagonistic or synergistic relationship between professions and organizations, there is a growing literature highlighting the importance of organizational culture on professions (Bate 2000, Foner 1993, Mills 2002, Sobo & Sadler 2002, Thompson et al 1996, Weil 1988, Wooten & Crane 2003, 2004).[1] Montgomery (1997) argues, for example, that "…while the vast majority of professionals today are integrated into organizations in order to do their work, independent professional identities and cultures continue to exist apart from organizational identities and cultures." (p. 177). French organizational theory is notable for its focus on the social world - *le monde social* (Francfort et al., 1995) - that exists within bureaucratic institutions of which the hospital has been analyzed as a key example.

[1] Strauss (Strauss et al. 1963), and others (Bucher & Stelling 1969, Stelling & Bucher 1972) from the Interactionist school of thought also attempted to 'unpack' organizations by proposing a negotiated order to it, but this tended not to focus on a cultural perspective.

Sonnenstuhl and Trice (1991) present a *grid-group analysis* as a way of breaking down the relations between professions and organizations and linking organizational and professional realms. Grid refers to the structural dimension indicating the degree to which management exerts control over the work of professional members. Thus, a high score on the grid indicates strong managerial control, low autonomy for workers. The "group" dimension indicates the level of interaction amongst professional members, and the strength of their norms. Using these dimensions, professions tend to be considered a weak grid, strong group community. The strong grid-strong group accommodative community includes professions who work in large corporations and government agencies where the professions have not derived their own administrative structure, e.g. corporate physicians. Sonnenstuhl and Trice (1991) argue that this form of analysis reflects "the outcome of negotiations between occupational members and managers because it describes the structure and culture of the occupational community within the organization which emerges from these interactions" (p. 297).

Consistent with Sonnenstuhl and Trice's (1991) group dimension, is Brown and Duguid's (2001) concept of a *community of practice* which acknowledges how members "are often simultaneously members of that organization and members of a larger, dispersed occupational group" (p. 203). This, they argue, influences professionals' perceptions of their work. Other work uncovers the hybridization of nurse and physician managers who come to work both in the interests of the organization as well as their profession (Duran Arenas et al 1992, Hunter 1992) though this has been criticised in some contexts, particularly in the case of Managed Care in the U.S. (Leicht & Fennell 1997, 2001).

*Summary & Objectives*

In sum, there has been a great deal of literature addressing the organizational pressures on professionals, particularly within the health sector, and how we can better understand these responses by breaking down our units of analysis within professions and organizations. Neither of these bodies of literature adequately addresses the role of clients – particularly at the meso or structural level. The objectives of this paper, therefore, are to:

1. analyze the structural influences that clients play in this relationship; and
2. examine how these influences compare across professional groups – nursing and medicine - and health care organizations in different countries – Canada, the U.S. and France.

**Methods**

The data on which this paper is based is derived from two independent studies – one conducted by Sainsaulieu of health workers in French hospitals – the other conducted by Bourgeault and colleagues of physicians, nurses and managers working under Managed Care in Canadian and American hospitals. The analysis we present here is of a secondary nature – that is, beyond the initial purpose of the original research.

*Data on French Hospitals*

Sainsaulieu (2003, 2004) conducted in-depth, semi-structured interviews between 2001 and 2004 with over 400 health workers across all grades and service domains – from dietary, geriatrics, pediatrics, technical services and administration - in public and private hospitals across France. Interviews were conducted with physicians, nurses, auxiliaries nurses, non professionnals workers, technical and medico-technical workers. All sessions were taped, mostly

transcribed (when possible) and the content was coded thematically. These studies were first under contract with Assistance publique des hôpitaux de Paris, the Ministry of Work and Health (DHOS), the Federation de l'hospitalisation privée on one hand and the National Scientific Research Center (CNRS) on the other hand. The specific purpose of this research was to analyse how the concept of 'Social Words' was pertinent in the case of French hospitals, with a particular focus on the influence of the environment, division of labour, professional identities and organisational cultures.

*Data on Canadian and American Hospitals*

Bourgeault conducted research with colleagues (Armstrong et al. 2000, 2003, Bourgeault et al. 2002, 2004) of the experiences of health care professionals with the increasing management of care in Canada and Managed Care in the U.S. Our specific aim was to challenge the claims of managed care against the everyday experiences of front line nurses and physicians working in two Canadian provinces (Ontario and British Columbia) and two American states (New York and California). Focus groups and individual interviews were conducted with a purposive sample to ensure a range of experiences by specialty and location of practice - intensive care, public health, general medical/surgical wards, emergency rooms, and out-patient surgery. In total, focus groups and interviews were conducted with 81 nurses and 52 physicians. All sessions were taped, transcribed and the content coded thematically.

*The Secondary Data Analysis*

The secondary analysis of the data from these two studies began initially with a discussion of the similarities of our findings with respect to the pressures that organizations impose upon health care professionals and their responses to these pressures. Sainsaulieu, however, had begun to

move beyond this more typical approach to begin to explicate the implicit and explicit role of patients within the 'social world' of French hospitals. He noted how patients were implicit in the interviews with hospital managers – when they highlighted that the pressure of hospital work was as a result of patient demand – and in the interviews with professionals. More explicitly, Sainsaulieu began to conceptualize the impact of patients upon collective cohesion and groups dynamics within the different units of the hospitals he was studying.

Similar themes were evident in the Canadian and American hospital data but they had not been explicitly coded in this manner. Following these discussions, we jointly developed a comparative coding scheme that we used to tease out of our existing data those issues which pertained to the role or influence of clients. All of the interviews for which we had transcripts for comparative analysis, specifically physicians and nurses, were coded according to this new scheme.

We begin with a brief description of Sainsaulieu's conceptualization of open and closed units following which we more fully explicate their comparative characteristics. It is important to note at the outset that we use 'open' and 'closed' communities are ideal types: that is, open and closed communities can be found in different degrees in the units we studied.

**Open and Closed Units**

Briefly, where clients have a large influence on professional work their unit is more *open* but where patients have a small influence - and where technical cooperation is more intensive, the unit is said to be *closed* (see Table 1). This influence is exercised in two key forms: 1) quantitatively and 2) qualitative in terms of interaction. Specifically, there can be more or less influence of patients on the workload of health care professionals within the hospital unit.

Patients can also influence the work of health care professionals depending on how active or passive they are in their interactions.[2]

**Table 1. Comparative Characteristics of Open and Closed Units**

| | **Open Units** | **Closed Units** |
|---|---|---|
| Primary Interactions | Patients | Colleagues |
| Patient's Role | Active | Passive |
| Relationship with Patient's | Strong | Weak |
| Relationship with Colleagues | Weak | Strong |
| Professional Identity | Individualistic | Collective |
| Longevity within the Unit | Short = high turnover | Long = low turnover |

*Open Units*

The *open* units that Sainsaulieu identified in his research on French hospitals were those where there was a strong influence of patients and a strong relationship, though not necessarily of a positive nature as there were numerous cases of aggressive or abusive patients mentioned. Such relations were typical where professionals have a direct, one-to-one relationship with the patient, such as in the emergency room or in maternity care. Although the members of open units feel a unity of purpose, it is for shorter periods of time, and with greater intensity of emotions. Although there is coordination and cooperation amongst professions, in these units, patients are the primary focus of their relationships. As a nurse in an open unit in one hospital mentioned:

[2] This is along the lines of the variability in activity and passivity that Szasz & Hollendar (1956) described.

> *We are heavily involved in relationships. I also make education more centred on relationship more than on technical matters.* [3]

These units are thus considered to be more open to outside influences in part because of their greater interaction with external actors (i.e., patients). This in turn influences their identification with the patients perhaps more so than their colleagues and their unit. But the strength of patient influence in these units – quantitatively and qualitatively – may reduce the potential for collegiality within the unit. In emergency rooms, for example, the sheer quantitative pressure of patients, the number of problems – both social and medical – that they present, and their aggressiveness can make it difficult to foster a sense of collective interest. Because such strong relations with patients are emotionally exhausting, Sainsaulieu found that units with a more open orientation tended to be less stable and health care professionals that work on these units experience higher rates of burnout and turn over. Thus, what little community culture that exists in these open units tends to constantly be in a state of flux.

The primary examples of open units we witnessed in the Canadian and U.S. data were those related to the emergency rooms as well as outpatient clinics. Although the health care professionals within these open units had to interact with other professionals both within and with other units, particularly when they needed to admit their patients, their primary interactions were with the steady stream of patients that presented themselves for care. As one New York nurse stated, "*Our first interaction is with the patient and everything else comes out of that interaction*". In the following example, a nurse in an outpatient clinic in a large urban hospital in California, negotiates directly with the patient to ensure that they get access to the care, circumventing the administrative denial of care in hospital by whispering to patient to check himself in through the ER:

[3] All of the quotes from health care professionals in France have been translated into English.

> *[You say,] 'Yes, your procedure has been denied and I know you're in absolute agony now. But you could always leave the hospital and go to the emergency room'. Or if you need to be seen 'I know you are hurting in your stomach but say you have chest pains and you'll get seen rapidly'.*

In these open units, health care professionals often act as a conduit or intermediary between the organization with all of its bureaucratic rules and their patient, indeed even as their advocate. This seemed particularly salient in the respondents from the U.S., primarily because of their frustrations with managed care as the following case of a doctor who works with homeless clients in New York City:

> *We go to this agency who then calls us back and says this form isn't acceptable Your patient has to call us personally … Then I have to yell and scream at them saying 'no friggen way' These people don't even have phones … And they go, 'okay, send us this form then we'll send you back another form, then our patient just signs that, then fax that back to us, then we'll call you' …We just try to insulate our patients from this as much as possible.*

But as was the case for open units in Sainsaulieu's study, interactions with other colleagues are still important albeit still focused on the patients' interests, as this quote from a doctor in New York reveals:

> *Nurses are wonderful people who can say 'doctor, you look exhausted.' And so the doctor doesn't have to drop their macho pose and say 'I'm exhausted." The nurses can say that …we can make alliances on those kind of issues which are really about the patient … 'oh yea, remember why you're complaining – it's the patient.'*

*Closed Units*

In contrast to these open units, Sainsaulieu describes *closed* units as those where health care professionals work on or around the patient but not necessarily with him or her. That is, the

patient could be unconscious or in a high risk situation more clearly under the control of the professionals in a more passive manner (e.g., in an operating room or intensive care unit). Professionals in these units face stressful situations but more of a technical than an emotional nature. These professionals tend to interact more with each other so that internal relations within the unit are considered to be more important or perhaps more salient than their relationship to the patient.

> *You take the first colleague coming and you get it off your chest. One should talk to each other. And have good times together.* - intensive care nurse, French hospital.

Such a collegial context creates strong feelings of community:

> *It's community, oh yes, it is the least one can say. It is very comfortable, you feel at home, making your own business, then you go. We are in charge of the room, we are entrusted, we do everything, including temperature. Everything is done for the patient, we can do anything, he is totally under our control.* - operating theatre nurse, French hospital.

Also in contrast to open units Sainsaulieu found that this kind of community oriented unit is more stable in that the professional members are usually employed there for long periods of time. Indeed, it was found to be the case that internal cohesion in these units is paramount and where conflict arose, members of the unit often forced through various covert measures the non-cooperative or non-collegial member to leave their position. There were also cases where the union representatives, upon consultation by a nurse who wanted her case to be judged, came to the same conclusion as the unit members in question – that she leave and find a new situation, because the community consensus should not be broken. Such informal regulations are not particularly rare in health professions, which have their own rules, official or unofficial which do not necessarily reflect, and in some cases contradict, organizational imperatives (i.e., in the case

of illegal rules). Thus it could be argued that the stability of the unit is perhaps more important or is more likely to be made more prominent when the patient has less influence.

In the data from Canadian and American hospitals, we also found a similar closed community to that which Sainsaulieu describes. A coronary care unit associated with a large teaching hospital in one of our Canadian sites is illustrative in this regard. Interview data with physicians and nurses associated with this unit revealed a cohesive interprofessional unit where the patient had minimal involvement other than being the recipient of care that ranged from coronary catheterization to coronary bypass surgery. Part of the cohesiveness of the group was related to interpersonal dynamics – not the least of which was related to the chief surgeon's position. From the residents to the nurse administrators and ambulance drivers, he held all members of the unit in high regard and appreciated each person's role. For example, he described

> *"In theory you can phone up the admitting department and say, 'I have Mrs. X who has this and I would like her admitted. And they say we'll put her on a wait list. …Then, there's the negotiation on a day-to-day basis of how to get the patients in. So we have a … fantastic lab [tech] here … whose job is to suck up to the ambulance drivers so they can have coffee and donuts when they get here and they'll hang around and get these people back and forth. …There's negotiations all the time with those folk cause that makes the place run"*

What this quote also reveals is that similar to Sainsaulieu's finding of closed units' resistance towards administrative rules, this community also attempted to bypass organizational procedures for admitting through these interpersonal negotiations. Increasingly, however, organizations have responded in kind by creating protocols where it is not another group of professionals that one must negotiate with to achieve the unit's goals but rather an administrator who's affinity is towards the bureaucratic and maintenance of its rules (see Bourgeault et al., 2004).

**Discussion**

This secondary comparative analysis of the experiences of health care professionals within Canadian, American and French hospitals reveals 1) the importance of teasing apart organizational experiences and responses to organizational pressure and 2) that doing so by conceptualizing the structural influence of clients is a useful heuristic device.

Our data help to expand upon Sonnenstuhl and Trice's (1991) grid-group analysis and Brown and Duguid's (2001) concept of a community of practice by adding another dimension pertaining to the client or patient. For instance, to imbue patients with agency and recognize their importance conceptually is something very much in need in the literatures on professions and organizations. Fine (1984) began to alert us to the extent of socialization that occurs within in organizations, including how one's "organizational role" (p. 248) comes to be defined, but even his focus in terms of patients was on how "transient clients" were socialized by doctors and nurses in hospitals. But it is not just the micro relations with clients that we need to focus on but also how the interactions with clients in general influences the structure of interprofessional units working within organizations (i.e., open versus closed). Much more research with this kind of focus needs to be undertaken to more accurately reflect underlying social processes within hospitals.

Further, our analysis is illustrative of the robust nature of the concepts of open and closed units across different hospital, health care system and cultural contexts. For example, although professions in France are typically thought to be more drawn to an organizational orientation than are professions in either the U.S. or Canada, and further despite the differences across public and private hospital settings (at least in the case of France and the U.S.), strikingly similar findings are revealed.

The secondary nature of our comparative analysis is an important limitation to raise. For example, because we did not have an organizational frame to our sampling strategy for the Canadian and American study, we were limited in the extent to which we were able to get multiple perspectives of particular units. We also did not ask specific questions in the interviews pertaining to the structural influences of patients on their relations within their organization. These themes needed to be teased out of the more discussions that ensued following our questions about their experiences with managed care and how patients were navigated through this system of care. Nevertheless, in addition to the interesting thematic consistencies highlighted above, some key hypotheses are raised from this preliminary work which could be tested in a protocol that is explicitly designed to compare across these ideal typical units or which could more generally guide future research in this area.

First, as some of the quotes reveal, there may be a difference between professional groups with respect to their community orientation. For example, Sainsaulieu found that nurses tended to be more involved in unit collectivity than physicians. This is particularly the case for ongoing institutional evaluations of quality of care (Sainsaulieu 2005). Similarly, some of the comments of the physicians in the U.S. and Canadian study highlighted the integral role that nurses and other support staff played in the cultural or collective focus. This concurs with other research. For example, as Chua and Clegg (1989) have noted, "as nurses moved from one sub-environment to another, they could be socialized into a different set of criteria. As the locale and the identities change, it may not be too traumatic for the nurse to speak a different language, articulate a different vocabulary and occupational sub-culture and thus play a different role. Inchoateness, ambiguity and conflict between locales may well be the norm" (p. 124) (see also Wooten & Crane 2003). This may be one of the reasons behind the relatively smaller influence

of collective culture in open units that are subject to high turnover. Perhaps the local cultures are influences by broader cultural issues. For example the differences between nurses and physicians can mask overarching gender difference. Indeed, several studies of organizational culture have noted the importance of gender, particularly to the informal work culture (Annandale 1996, Cancian 2000, Kleinman 1996, Weil 1988).

Second, another important issue for follow up is the difference in the pace of work in each of these unit types (implicitly the quantitative influence of patients) and how much control health care professionals have over this pace. Work pace – insofar as professional to patient ratios are concerned – is much more tightly controlled in the case of the more closed intensive care units (indeed through hospital or state regulation) than it is in the more open emergency rooms.

Third, the theme which emerged with respect to how alliances are made either with colleagues in the case of closed units or with patients in the case of open units to subvert or circumvent organizational policies and practices is also key for future research. These are yet another set of ways to better conceptualize or tease apart professional responses to organizational pressure. On the other side, it would be important to examine or deconstruct the ideological uses of 'the patient' in managerial discourse. 'The patient', for example, can be a substitute for economic issues, such as 'the market' or 'demand' with the aim of reducing costs and rationalizing health care.

In sum, we hope that this preliminary comparative analysis will encourage those in this field to more explicitly consider the implicit and explicit influence of patients moving them from the background to the foreground of analysis of relations between health care professions and organizations.

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