Organizing as negotiation.

The making of a pathway in Norwegian psychiatry.

Abstract

The purpose of this article is to provide a thorough examination on the making of a pathway in Norwegian Psychiatry. During the last decades, much research has examined implementations and outcomes of different public health sector reforms and services in Western societies. However, there has been a lack of research on the process and the making of these reforms and/or services, in particular how they emerge as constructs in context policy, profession and practice.

Based on qualitative data and theories on institutional logics, it shows how the two main actor groups are guided by values belonging to a specific logic when understanding the concept of a clinical pathway. The findings show that actors within the political field believe in control and efficiency, in contrast to actors in psychiatry guided by values of discretion and autonomy. This led to a debate of the concept of clinical pathway and psychiatry. The discussion became a polarization between concerns for patients as opposed to efficiency concerns. The making of the pathway was led by the Directorate of health, health professionals operating in the political domain, and with knowledge on both logic’s values. The end result became a logistic pathway were both “logics” got to keep their values, but where the original aims were highly negotiated.

Key words: Clinical Pathway, Psychiatry, standardization, autonomy, discretion, Health profession
Introduction

Most western countries are struggling with the rising cost of health care services. There is a common view that better organizing of these services is the answer to the issues of lack of resources, and increased demands (Rod & Høybye, 2016). This context reinforces an ideology of increased monitoring and transparency, where management is given more power to ensure that hospitals are better controlled and more predictable (Gruening, 2001; Kuhlmann et al., 2013, Magnussen et al., 2007). These elements all bring forward standards and standardization as a solution to the issues above (Timmerman and Berg 2010). Organizing health care services through standardized clinical pathways is found in several areas of Norwegian health care, with the implementation of clinical pathways within cancer treatment as the biggest national introduction of standardized service production (Fineide, 2012). The European Pathway Association (EPA) defines the standardization of care processes into ‘clinical pathways’ as ‘a methodology for the mutual decision making and organization of care for a well-defined group of patients during a well-defined period’ (Vanhaecht et al., 2012). The method defines goals and decision making on which measures to include in the treatment. The measures should reflect evidence, best practice solutions, as well as the involvement of the patient (Biringer et al., 2017).

More than once has politicians been accused of not prioritizing mental health and this expresses itself in long waiting lists, as well as an eminent capacity and resource problem1. Furthermore, over the last decades, Norwegian psychiatry has met much criticism from professionals and patient’s within the field (Åsebø et al. 2016). This has led into a debate regarding the organizing of mental health care. Often polarized, viewpoints circulate around terms of efficiency and/or care, user participation and/or medicalization (Tørrisen 2016, Røssberg et al., 2017). This battle regarding organizing of health care services are often presented in the literature as disputing logics influencing health care practices in different ways. These logics contains a particular set of behaviors, rules and norms, and functions as guiding principles by the actors inhabiting them (Scott et al., 2000, Evetts, 2003, Greenwood et al., 2011, Reay and Hinings, 2009; Thornton et al., 2015). In January 2016 the official assignment on producing several clinical pathways in psychiatry from The Ministry of Health and Care Services were given the directorate of health2. The clinical pathways in somatic medicine were imported from Danish health care, rearing a desiree to copy the pathways in psychiatry from

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1 The Norwegian Directorate of health, official statistics, mental health care
2 The Norwegian Government, New clinical pathways for mental illness and substance abuse, (12.09.2018, )
Denmark. The clinical pathways in Danish psychiatry have an outlook into diagnosis with strict time frames and different standardized manuals to follow.

The analysis provided in this article builds on the main groups of actor’s different views and interpretations of clinical pathway within the field of Psychiatry. The logics and values is vital when analyzing the process that brought about the final product (Doolin, 2002). Elaborating this further leads me to the following research question.

How do the actors in the field of psychiatry interpret and understand the concept of clinical pathways, and in what ways did this affect the making of a pathway in Norwegian psychiatry?

This article starts by elaborating the main actors in the field of psychiatry before discussing the current elements of what constitutes a preferred way of organizing health care services today. Professionalization and its discreitional activities contrast scientific bureaucratic medicine. In enabling an explanation of the different actors understanding of clinical pathways, I present theory on institutional logics to show how different values belonging to a logic influences the actors sense making and interpretation of a CP. In the methodological section I show how a case study in combination with discourse analysis enables me to categorize my textual analysis into two main institutional logics. The analytical part explains how the pathway became a complex negotiation process between the two logics, and where both actors get to keep their core values. Finally, this paper concludes that a cautiousness towards mental health professional values is of vital importance when trying to change established services and/or routines within psychiatry.

This paper’s contribution, is twofold. By looking into the development of a new policy, I offer a supplementary approach for those studying health organization and implementation (Checkland et al., 2019). As Dobson (2015) has highlighted, the unconscious use of linguistics by the enactors of policies becomes a reflection of their social worlds. By elaborating this, I wish to demonstrate that the different values belonging to different actors influence implementation of a policy development. Furthermore, I extend the literature on both clinical pathways by researching other issues than its use in an individual care setting, as well as broadening an understanding of institutional logics’ empirical expressions. Johansson and Waldorf, 2017 point towards the lack of studies on how actors cope with an environment at the intersection of several institutional fields with multiple sets of expectations. Conclusively, they encourage researchers utilizing institutional logics to “know much more about the informal organization, the chaos and the ‘muddling-through’ (Lindblom 1965), in decision-making processes, and the actors’ tiring negotiations and power struggles”. This article aims to answer these callings.
The field of psychiatry

Psychiatry as a field are encompassing many actors, and the field meets ongoing critic from different hold. (see f. ex Horwitz and Wakefield 2007, Roberts 2005, Foucault 1991, 2002, Rose 2007, 2018, Vitz 1995), Norwegian psychiatry is no exception. As the field of psychiatry with its actors does not anticipate shared meaning (ibid), this paper utilizes a more practical definition by DiMaggio and Powell 1983 that suggests that a field is “those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce services or products” (:148). Furthermore, they concede that the struggle to write the rules and control the resources are all a part of the construction of an organizational field (Scott, 2004). Finally, fields become centers of debates in which competing interests negotiate over issue interpretation (Waldorff, 2010).

The psychiatric field examined in this paper is circulated around politicians deciding and executing mental health policy, as well as health professionals and patients operating in the field. Norwegian mental health care strategy is to be found in the document; “Coping with life”. ³ The field is heterogenous, and the different actors all bring about various meanings about how to provide correct care. Moreover, the actors in the field are both organizations as well as individuals who inhibits the prospect of expressing logics, values and perspectives that potentially influences both organizations as well as the field more in general. In particular the way different health professionals express their sense making on how to provide correct care is heterogenous within the field of psychiatry, for example doctors believing in medication is contrasting social workers believing in peer support and care.

Professionalization in health care. Discretion and autonomy as core values.

Professionalization in health care is often referred to as discretion practiced autonomously by an individual practitioner or professional group (Abbott, 1988). The professional actor does not follow their own selfish interest, as their profession is developed to solve problems and or issues to the best of society. Therefore, their ethics is based on the needs of the client (Parson 1975 ), and the professional groups define performance standards as well as ethical codes for its members in accordance with thorough training (Mastekaasa, 2011; Scott, 1998, Sena 2017). The “power” of a profession is among several, to identify and safeguard the content and practices of its work (Abbott, 1988, Sena, 2017). Furthermore, Freidson (2001) concludes that autonomy and discretion are more

³ Coping with life, (2017) The Governments strategy for good mental health (2017- 2022)
important than professional knowledge and expertise, because upholding autonomy is the only way a profession can secure control and protect their standards, autonomy and discretion (Abbott, 1988).

Freidson (2001) also argued that professionalism is an ideal type of organization of work (or what he termed ‘a third logic’), where health professionals acts as mediators presiding over the interests of the state by serving the needs of the public and demands of patients (Gabe et al., 2015). The arguments above all rests on the idea that professional knowledge should be valued in such a manner that health professionals have the freedom to execute their work without further external restrictions (ibid).

Scientific bureaucratic medicine

Scientific bureaucratic medicine is a terminology from Harrison and Ahmad (2000) research into care pathways and its following guidelines. It is called scientific in the sense that it draws on the accumulated evidence of largescale research, and ‘bureaucratic’ in the sense that it translates the output of such research into a particular species of bureaucratic rule, for application in medical care organizations (Harrison et al, 2000: 134). The concept could be understood scientifically in light of evidence-based medicine (EBM), and bureaucratically in light of new public management.

EBM is grounded in best practice solutions, guidelines, protocols, and checklists to standardize procedures believing it to be the best way to reduce unwanted variation in diagnosis and treatment (Masic, et al., 2008, Bondevik and Engebregtsen 2017). In the Norwegian context, EBM was introduced in 1995, and was institutionalized in 2004 through the establishment of the Norwegian Knowledge Centre for the Health Services (Bondevik and Engebregsten 2018).

EBM has found an ally in New Public Management (NPM), a concept motivated by increased efficiency as the desired outcome, and inspiring public reforms across the western world (Gruening, 2001). The focal point is adopting market-based models aiming at a large focus on performance measurements and control measures within public sector, and to be monitored by the political level (ibid). Within health care, NPM has been an international trend during the last three decades (Pettersen, 2003, Brorström et al, 2008, Groot et al, 2008, WHO, 2000) and the implementation of performance based financing in Norwegian somatic hospitals in 1997 and within psychiatry in 2017 is two among several NPM ideas within health care(ibid, Timmerman and Berg 2010, Timmermans and Almeling 2009). However, despite the influence of NPM and EBM in public health care, there are huge differences in the understanding and opinions of the concept, placing the ideas as a conflict between core opposing values such as care and quality treatment versus financial objectives.

\[4\] Directorate of health, Financing
(Dopson et al., 2003, Timmermans and Almeland, 2009). Furthermore, between professional and political work (Linneberg et al. 2009, Townley et al. 2003).

**Institutional Logics**

The foundational work on institutional logics is viewed as “organizing principles” (Friedland et al., 1991). Fundamental to this perspective is the belief that interests, identities, values, and assumptions of individuals and organizations are embedded within prevailing institutional logics. (Thornton and Ocasio, 2008:103). Thornton and Ocasio (1999: 804) defined institutional logics as

*"the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality ".*

Despite the fact that an institutional logic consists of several elements that the actors utilize when making sense of the world, there is an understanding that this sense making consisting of assumptions, beliefs, rules and material practices is based on the values. This makes

...*value central to an institutional logic: a presumed product of its prescribed practices, the foundation stone of its ontology, the source of legitimacy of its rules, a basis of individual identification, a ground for agency, and the foundation upon which its powers are constituted* (Friedland, 2012: 584).

To understand the ways institutional logics influence actors sense making is when they identify with the collective identities of an organization and/or profession (Tajfel et al., 1979; March and Olsen, 1989, Thornton & Ocasio 2008). Within professional fields, professional logics offer the identities that professionals make sense of who they are. Professional role identity is enabled and constrained by the institutional environment and provides interpretation that professionals adopt” (Chreim et al., 2007). The relationship between institutional logics and identity is recursive—each shape the other, institutional logics give identity to those who share them, and those who share identity mutually reinforce their shared logics. Identity provides the link between the field-level meaning, institutional orders, and the sense making of individual human actors (Friedland and Alford, 1991; Glynn, 2008, Meyer and Hammerschmid, 2006, Rao et al., 2003; Thornton and Ocasio, 2008). In and between different situations encountered by actors, they activate a variety of social identities from different institutional logics (James, 1968: 42). Johanssen and Waldorff (2017) have examined ways research within this domain of institutional logics have had a tendency in the empirical expression of the logics to lack a common ground for operationalization (Almandoz, 2014, Voronov et al., 2013). Studying how actors in the field of psychiatry engage in a negotiation can provide empirical insight into how
an operationalization based on Thornton and Ocasios 1999 initial definition expresses itself. To identity the different actors’ logics is to look for similarities in the expression within material practices, assumptions, values and beliefs as it unfolds in the idea of a clinical pathway, and to generalize based on these expression in order to identify the main institutional logics within the field. A detailed outlook is to be found in Table no. II; clinical pathways and institutional logics (page 9.)

Research methods

Data sources

To understand the making of the pathway in its context, and how the different actors make sense of the phenomena a methodological outlook as a case study is fruitful (Yin, 1994), where the goal is to describe a policy development, understood as a negotiation process between different logics. First, The written material in the public realm of clinical pathways in psychiatry is analysed, This process involves examining chronicles, political speeches, documents as well as the hearing responses, and the end product, the pathway. This part of the analysis focuses mainly on identifying the institutional logics.

Secondly, the interview data comes from ten in depth interview with members of the work group designated by the directorate of health. The informants were found via the directorate of health’s web page. The interviewees were strategically selected based on the criterion of optimal variation (Creswell, 2007), so that actors from different professions as well as user groups are included. To control for variations in personal opinions (Eisner, 1991) interviews were carried out with two representatives from equal backgrounds where it was possible.

The interviews were collected between August – October 2018 and took place either over Skype or face to face and lasted between 40 – 60 minutes. The informants were asked about their own ideas of a clinical pathway, what they thought about it at first as well as the result. In addition, I asked them about the process of making the pathways, such as difference of opinions and if there were any power imbalance in the group. Further, they were asked to give a brief account on what they portrayed as the biggest challenges within Mental Health Care and to what extent the Clinical Pathways improved these elements. All the interviews were taped and transcribed. Furthermore, approval for the project were given from Norwegian Centre for Research Data (NSD). The gathering of data followed the ethical guidelines provided by NSD, involving obtaining written, informed consent for my interviews and its purpose. The documents involved were sent out before each interview by e-mail.
An overview over the Data Sources is to be found in table number I., Data sources:

Table no I., Data sources.

|                          | Articles and opinion pieces (Aug.2015 - Nov.2017) | Public Hearing responses to clinical pathway | Political documents and texts | Interviews affiliated with “the work group” |
|--------------------------|---------------------------------------------------|---------------------------------------------|-------------------------------|---------------------------------------------|
| The Government           | 8                                                 |                                              | 5                             |                                             |
| Health professionals     | 33                                                | 15                                          |                               | Psychiatrists: 2, Psychologist: 2, Psychiatric nurse: 2 |
| User groups & Special interest Organizations | 11                                                | 15                                          |                               | 2                                           |
| The Directorate of Health |                                                  |                                              | 3                             | 3                                           |

Data analysis

A discursive approach is a choice when one wants to make a depth going, methodical analysis of a given phenomenon. The term discourse covers the basic idea that language is structured in different patterns when we interact within different social domains (Fairclough 2001, Jørgensen and Philips 2002). Discourse analysis is not just one approach, but also a series of interdisciplinary approaches that can be used to explore many different social domains in many different types of studies (Jørgensen and Philips, 2002:9). When linking a certain discourse with a certain expert community, it is not simply a question of a particular group of experts having a common set of goals and language; it is what the experts want and know how to impose on the audience (Smirnova, 2011: 37-38).

To understand a field’s belief system and practices is a complex process, I follow the examples of Reay et al 2009, Scott et al. 2000 by looking into indicators that identify the field’s institutional logics. The operationalization of the logics consists of elements that enabled a structured coding of the
written material. NVivo (qualitative data analysis software) enabled me to categorize my material in a structured manner. Later, I reread the material and looked for patterns that enabled replication. The findings of this part of the analysis is to be found in table number II., Clinical pathway and institutional logics.

Analysis

This part of the paper seeks to provide a thorough examination of the making of the pathway in Norwegian psychiatry. The analysis start by providing an outlook into the main institutional logics and how they make sense of the idea of a clinical pathway. A complete overview is to be found in Table number II., Clinical pathway and institutional logic.

| Characteristic | Mental Health Professional logic | Political Logic |
|----------------|---------------------------------|----------------|
| Material Practice | EBM & standardization interfering with discretion, making it hard to provide correct patient treatment | Clinical pathway secures correct and best practice execution of services |
| Assumption | Clinical pathways is unsuitable for psychiatry because each patient needs individual care. | CP is the solution towards capacity problems, unwanted variation and inefficient treatment |
| Values | CP collides with discretion and autonomy | CP secures control, efficiency and quality |
| Beliefs | CP is only concerned with efficiency and cost reduction making Patient care and recovery harder. | CP will improve the services. |
| Rules | CP opposes Professional values: Humanity (patients), care (services), knowledge and autonomy | CP requires rules and standards to be monitored and controlled |

It is obvious when looking at the table that the two actors relates to pathways differently, and that their sense making is guided by already established values, assumptions and rules to be found within their professional identity. How the logics interpret CP and the reason for this is explained more thoroughly in the following section.
The political logic; clinical pathway as the solution to the issues in Psychiatry.

Recent years has shown issues of capacity within Mental Health Care, and in accordance with the NPM- and EBM-inspired beliefs within the political logic, increased control and standardized measures could be the solution to some of these issues. The wish to implement CP into psychiatry is saluted as something that could revolutionize psychiatry and the issues it faces when the prime minister Solberg in 2015 first elaborated the idea;

“We will make a radical grip to make Diagnosing and treatment of mentally ill patients faster, better and more predictable. We will introduce Clinical Pathways into Psychiatry”

There is a firm belief in this way of organizing health care services, leading way into more efficient services. Standardization is the preferred strategy aiming at this goal. This is further explained by Minister in health Høie in 2016 when he states;

“"The methodology behind clinical pathways is about standardizing the patient’s services with two main objectives; To reduce unnecessary waiting time, and to secure that everyone gets the best possible treatment"

Furthermore, clinical pathways combine evidence based medicine with new public management making the concept belonging to the idea of scientific bureaucratic medicine. This form of medical logic is based on as well as promotes the values found within the political logics, namely values of efficiency, quality, and control.

Political logics values of efficiency, quality and control.

These values functions as corner stones in several issues regarding governing of public health care, and in the matter of psychiatry where these issues have been frequently discussed there is an almost taken for granted assumption that control and standardization namely through clinical pathways is the solution. This quote from prime minister Solberg (2016) enhances this:

“clinical pathways in psychiatry would lead to less discrimination by implementing standards for the content in the examination of, and treatment strategies for the patient as well as more predictability for the patient with timeframes for the different steps.”

Control, efficiency, and quality is guiding the arguments on how and why clinical pathways is the best way to organize psychiatry. The way to control the services is by outsourcing responsibility that can be monitored and thereby, controlled, by the political logic. This will, hopefully lead to better quality and efficiency which is stated explicitly by The minister of health, Høie (2016)
Clinical pathway will not only provide the patients with more predictability, they will also give practitioners in the different parts of the services more predictability. They will clarify what responsibility the different practitioner has during examination and treatment.

There is a conspicuous absence of a softer language that pinpoints work in this field. Compassion, trust, and care are all important parts when it comes to understanding work within a psychiatric institution often utilized through discretion or autonomy. However, these elements are more difficult to quantify and standardize, leaving them out of the discussion regarding CP from the political level. Conclusively, the different belief, assumptions and material practices found in this institutional logic comes from the core values of efficiency, quality and control as the driver behind the clinical pathway.

Health professional logic and the conflict between standardization and individual care.

The overall assumption found within this logic is that clinical pathways is unsuitable because each patient needs individual care, making standardized practices unsuitable for patients within the psychiatric field. Individuality is closely linked to discretion and what the psychiatrist Aare and psychologist Mehdi (2015) pinpoints in their chronicle The house of cards that collapses in Psychiatry

“It’s about time to fight for the patients right for individuality and professionals calling to be professional

This individuality is further emphasized in the overall debate as something that characterizes patient treatment within the field and there is consensus that individuality, and not equality, is something that characterizes good patient treatment. The way the CP unfolds from the outlook of health professionals is a portrayal as something overall negative and what the doctors Vogt and Pahle (2015) states in their chronicle, “Equality on assembly line

«The government wants to standardize Mental Health Care in Clinical Pathways and sells it in as equal treatment. The basic idea of what it means to help is at risk.” Clinical pathways belong more to Toyota then humane psychiatry...

Prolonged, the rationale behind clinical pathways is the same as NPM, efficiency and cost reduction. This brings forward an assumption of being concerned with either efficiency and cost reduction (political level), or patient and care (Health professional level) leading the debate into a polarization.
The polarization originates from strong professional values believing in discretion and autonomy as the ideal way of practicing work within mental health care.

Values: clinical pathway interferes with discretion and autonomy.

The number one guiding value in a health professional logic is discretion, closely followed by autonomy. An overall understanding of the public debate made visible that withholding these values in the making of the pathway were of vital importance. The consequences of losing their discretion is addressed by psychiatrist Aare and psychologist Mehdi (2015);

“The values that form the basis for patient’s health service is not compatible with clinical pathways. In worst case they are making new rules on how patients and practitioners should organize themselves. Rules that take away their freedom and creativity.”

The fear of losing their freedom in terms of executing treatment and provide care is in accordance when Freidson (2001), elaborates how health professions secure control and determine their standards by protecting autonomy and discretion (ibid).

“What are the core values behind Clinical Pathways? Control! Control over professionals, and a system one experiences as uncontrollable, cost reduction and efficiency, efficiency, efficiency!”

The above quotation from the two doctors Pahle & Vogt in 2015 further enhances the protection of boundaries, done by discrediting the opponent’s values as not being concerned with patients. The polarization of the debate is namely done by agents in the health professional logic, and the arguments are centered around how the change in material practices influences patients poorly. Health professional view standardization as incompatible with individual adaption and flexibility, a major part of their work practice.

The Directorate of Health as a mediator, an understanding of both the logics.

Elaborating this further means assuming that actors in the field are strongly guided by values in their way of viewing their world, and in their organizing of time and space (Thornton & Ocasio 1999). As an overall consequence this creates an arena where the making of the pathway becomes an informal negotiation arena where the logics of professions and politicians meet. The actors acceptance of these logics creates leverage in the informal “negotiation”. When pursuing an understanding of the making of the pathway the issue of identification is of vital importance. In social situations encountered by the actors in the field, they activate a wide variety of social identities from different
institutional logics (James 1968). Actors who work in the Directorate of Health are operating in the field between health professional executing their daily work, and politicians deciding on different health care policies and strategies. Identification is therefore from different institutional logics. Furthermore, this gives them a unique and knowledge on both of the institutional logics. This sense making enables them to know which elements that are negotiable, and those that are not.

“When we first got the assignment from The Department, we thought. Well, if Clinical Pathway is an answer to a question, then what is that question”

The following quote from a health professional working in The directorate of health shows the start of a “muddling through” (Lindblom 1959), the process where negotiation occurs and where the different logics, values, and assumptions clash, affecting the making of, and final result of the Pathway. Shortly after the Directorate of health were given the assignment from the department, conferences with different professionals working within psychiatry were arranged. The agenda and motivation behind the meetings were to provide a space where ideas concerning the implementation of CPs in Psychiatry were to be discussed. Based on psychiatry’s heterogeneous field these conferences often brings about them heavy discussions and the different outlooks disagreements on how to provide the right kind of treatment. However, this did not happen at the conferences where the content of the pathways were to be discussed. This is what one psychologist recruited to the Work Group had to say about the themes that were discussed at the conference:

“People at the conferences were completely agreeing. That was something I found interesting because normally there are big disagreements. There were Users (of Psychiatric Services red.), bureaucrats, and professionals and they all repeated the same message; “we cannot have diagnosis specific treatment as they have in Denmark...

Before it was decided what kind of Clinical Pathway we should make, we found out that we had to bend the order from The Department. The order from the Department said that the pathways would be organized around diagnosis. We bent it by putting several diagnosis into the same pathway.”

The above quotation indicates how strong health professional values like discretion and autonomy are within this professional logic. It is expected that institutional logics affect organizational decision-making by steering the attention of decision-makers (Thornton 2002). This attention was steered towards a common goal where the focus were centered around protecting their values and their professional boundaries. The conference could have been an arena where the different actors used their voice to position their professional outlook as the correct way of providing treatment and making their preferred work practices an overall standard as normally would occur. However, as the

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5 Interview with the Directorate of Health.
informant states above, this did not happen. The protection of values is aligned with Friedland 2012s statement that values are the foundation stone of the ontology, and something that guides an overall sense making (ibid: 584).

An explanation on the phenomena could be that withholding values of discretion and autonomy is more important than positioning their professional logic internally within the field. This made the discussion around clinical pathway a phenomenon that circulated around the themes of clinical pathways and its inappropriateness in psychiatry out ruling normal disagreements often circulating within this field and the different health professionals in the work group as well as representatives from user and relatives perspective all agreed that the work function really well and without big disagreements. This is explained by a psychiatrist in the work group:

“The work group functioned really well. Everyone was heard and there were no big conflicts. Not that we just sat and played along, but there were no big contentious issues. There was not anything to be discussed that the members were really disagreeing on”

And what another health professional in the work group said:

“Everyone was heard, everyone was listened to. Nothing like what is happening in meetings in (psychiatry red.) real life”

This shows the subtle negotiation process unfolding and a possible interpretation of this is that The Directorate of Health had already made sure to out rule disagreements by organizing the pathways into such manner that discretion and autonomy were withheld, and this shows part of the negotiation where the importance of keeping each logic`s values were met by the Directorate.

Considering this matter, a psychiatrist in the work group answered the following when asked about how much the members of the work group were able to influence the making of the pathway:

“We had received a template, that were a bit like the cancer pathways. Like, what titles to fill inn, and we were made clear from our first meeting that this was only logistic, and this was repeated through the process. And I think many were surprised about that. We started out thought that we were there to recommend what diagnostic tools to use, but we were wrong. We were not allowed to recommend anything. “

Despite accommodating health professionals’ values, it was well known from the members of the work group that this was part of a negotiation process, and where not all of their needs would be accommodated by the Directorate of health.
“The Government wanted something in return. I understood that immediately. And then they need something to evaluate, there must be some codes involved. And we must remember the coding, and that is the challenge. I really do not understand how we are going to make it work.”

The coding and the extra work related to this was an overall concern as well as a general discontent from most of the professionals in the work group and the above quote from a psychiatrist indicates when stating “they wanted something in return”, that this was a negotiation between the two logics. Furthermore, it shows that the political logics need for rationalization and control is well known for the professional logic. In addition to this, the need for control of health professionals work is expressed as a burden for the actors involved and the frustration over this is clearly expressed in the above quote. Pursuing this from the different values, the quote also indicates the polarized view on the values behind a clinical pathway. Control from a political logic means efficiency, and better services for patients. Control seen from health professional’s logic means loosing time that could be spent on patient treatment and instead used on administrative tasks. However, the codes involved are not directly interfering with discretion meaning that individuality and flexibility in terms of treatment is not lost.

One of the main issues regarding clinical pathways, from early on and till date is the term, and the issues belonging to the idea of a “clinical pathway”. Clinical pathway is a way of organizing services within somatic medicine, cancer treatment to be one of them. Moreover, the elements of standardized work practices and evidence-based medicine are something that provokes actors in the professional logic, as this collides with the core values of discretion and autonomy. However, from a political logic the name clinical pathway indicates success as this has been proven to reduce waiting time and unwanted variation and is more or less portrayed as a success (Laland 2017). As off this, the name “clinical pathway” legitimates political will and action in the field of health care services. The name, clinical pathway was also misleading, as for the fact that the clinical aspect of the pathway was lost early on in the making of the pathway. Some of the critique from actors in the field of psychiatry could possibly have been avoided by naming the pathways differently and leaving out the negative connotations these actors associate with the name. However, misleading the name was, it was not for sale;

“It was not our call to decide the name of the clinical pathways. It was given. So... there has been quite a lot resistance towards it. We addressed this with the Department. The department is familiar with these issues, and they have been for some time. They kept the name “clinical pathway”, it was not our call to make.”
The quote from a health professional in the Directorate of Health also indicates the possibility that the department knew “how to choose their battles”. The withholding of the name was not something to fight for, as this did not interfere with the issues in the conflict regarding CPs suitability in psychiatry. The name however, caused much unwanted noise as the connotations this brings forward cause the Professions to feel threatened long after their autonomy and discretion were safe.

The final product - From clinical pathway till logistic pathway.

At the time for implementation the number of Pathways had been reduced from 22 till 9. From the idea of having Diagnosis Specific Pathways based on Evidence Based Medicine with standardized practices copied from the Danish model like the model “Clinical Pathway for depression” illustrates, the outcome had moved far away.

**Clinical Pathway for depression**

The final result became a general pathway involving several groups of patients. Within this Pathway all patients belonging to the same service area is generalized, making the pathway into a description of the services. The pathway explains the process from diagnosing, treatment and finalizing treatment. The different steps involve timeframes that needs to be coded, but without stating which
diagnostic tools to be used, nor does the pathway explain preferred treatment strategies for the different diagnosis. The table illustrates the general pathway for treatment in psychiatry for adults.

Each step is registered by codes

Finally, the product changes professional work practice by bringing in a more rigid system of documentation, and a coding of the different steps involving a more bureaucratic system to comply. This documentation is making the time spent by Health Professionals pr. patient in their daily work more transparent, and to be monitored by the political level, but without touching professional discretion and autonomy. The pathway in the matter of the previous discussion therefore ends up being a product negotiated from the values in the institutional logics presented.

Conclusion

This article brings about a thorough examination off the making of a new health reform in Norwegian psychiatry. The idea of a clinical pathway in Norwegian psychiatry from 2015 is one such reform. This article has shed light on some of the issues that occurs in the making of new health reforms. In the Health care field, different actors interpret the ideas of the clinical pathway differently, bringing in their values and assumption belonging to their institutional logics in this understanding. In the alternation of this, a negotiation process occurs where the guiding values decides the elements that are up for negotiation or not. Within the professional logic, the values of autonomy and discretion is not for sale, and this is accepted by the political logic because they get to keep their values, control, and efficiency. The Norwegian Directorate of Health led way in the process. Actors who work here have a Health Professional background, but work within the Political field, entailing the actors with both logics. This knowledge of the values makes the process a rather seamless negotiation as both logics gets to keep the core of their identity.
However, the analysis also shows a downside of having a sense making guided by strong values belonging to a institutional logic. It seems to be an almost taken for granted way of viewing ways a certain health care service should be organized without questioning if this is, in fact, the best solution applicable. The political level has an almost taken for granted assumption that transferring successful ideas from other parts of hospitalization services is easily applicable, but without having a thorough knowledge of the field. They did not adopt a context-sensitive and, focused on understanding the nature of the problems and how they might be solved, which is considered as a condition for appropriate problem solving (see f.ex Schön 2009, Falkenstrøm and Høglund, 2019). Therefore, a thorough understanding of the field and the mission is essential for every decision maker’s competence. In the case of psychiatry, this involves understanding empathy for patients, and health professionals’ work, respect for professional knowledge, responsibility for limited economic resources and social trust (Falkenstrøm and Høglund 2019).

Furthermore, despite the fact that health professionals guided by their values, namely discretion and autonomy, has a thorough knowledge of the field and its weaknesses, its seems that withholding these values is of more importance than actively involving themselves in the debate regarding the negative sides and issues of the organizing of psychiatric services today. According to Argyris (1991), the way a certain problem is defined and solved may be the cause of the problem. Therefore, it is necessary to question the underlying assumptions and principles and look for a broader, more dynamic, and critical understanding of the problem. Hence, this way of learning and looking upon things differently implies a change of the mental model that forms the basis for decision making (ibid: 6). Nevertheless, an outlook into theory on institutional logics show how the change of a mental model means opposing values forming strong identities and in the quest for a new perspective and understanding one could possibly end up losing one`s identity.

Conclusively clinical pathways is understood in a polarized terminology from health professionals where being concerned with efficiency means not caring for patients and the public discussion regarding mental health care became a battle field where their main motivation were to discredit the idea of clinical pathway and its suitability in psychiatry instead of what could possibly have become a more constructive discussion.
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