BRIEF COMMUNICATION

Implementing person-centered care in a general medical clinic: cultural barriers and driving forces

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Introduction

Public healthcare organisations in Sweden have been described as strongly hierarchical and coherent organisations [1]. To bring about control, generalized care models have been developed to handle hospital clinics and primary care sites [2]. This paper examines the preparedness to change in hospital settings. The purpose of the present study was to reveal barriers to the introduction of person-centred care (PCC). Organisational culture and resistance to change on hospital ward and clinical level and was based on the 2 concepts of "organisational culture" and "resistance to change". These 2 concepts were measured by questionnaires based on theories of organisational culture and resistance to change.

The concept of organisational culture is based on the Competing Values Framework [3-5]. The model is developed on the idea that organisational culture consists of opposite values [6]. They are: a) Human Relations (HR); b) Open Systems (OS); c) Rational Goal (RG) and d) Internal Processes (IP). HR is characterised by flexibility, cohesion, trust and belongingness. OS indicates extrovert outgoing organisational characteristics. It is assessed by benchmarking, experiment and the ability to run projects independently. RG favours planning, goal setting and economy in order to improve effectiveness and efficiency. It is characterised by competitive behaviour with an emphasis on winning. An IP organisation seeks stability and continuity by maintaining control, routines, rules and hierarchies [7].

Oreg [8] has identified the following 4 sources of resistance to change: a) routine seeking (RS); b) emotional reaction to imposed change (ER); c) short-term focus (SF) and d) cognitive rigidity (CR). These dimensions are based on 7 studies and represent a 4-facet structure of resistance to change [8]. RS corresponds to a reluctance to withdraw from old habits. Organisational members prefer to act within a well-defined and familiar framework. In the ER dimension, change is a stressor. Individuals with a high ER score suffer from a lack of resilience and are reluctant to participate in change processes. The SF focus identifies an individual's ability to adjust to new situations. A high score can indicate a resistance to change, because it involves more work in the short-term. CR corresponds to dogmatism. Dogmatic individuals resist change because of rigidity and a closed mindset.

Method

Surveys, based on The Organisational Values Questionnaire (OVQ) developed by Reino [9] and Resistance to Change Scale (RTC) developed by Oreg [8], were sent out to 4 hospital wards in a medical clinic in Sweden. A total of 117 nurses (69%), 105 (89%) women and 12 (11%) men, agreed to participate by answering the questionnaire. The response rate was 69%. The homogeneity of the items of the subscales was analysed through a calculation of Cronbach's alpha. The results varied between 0.67 and 0.84 which, according to Brace *et al.* [10], is considered to be satisfactory. The surveys were numbered and variables were defined in the computer program "Statistical Package for the Social Sciences 17.0" (SPSS). Statistical significance was established at $p < 0.05$ and all tests were 2-tailed. The analysis stems primarily from descriptive data and regressions (bivariate and multiple). Means and standard deviations were used for descriptive purposes.

Results

The medical clinic had been subject to a research project implementing PCC for patients with chronic heart failure. During this study they were in an introduction

Figure 1 Mean values for the OVQ scale, divided in subscales and wards
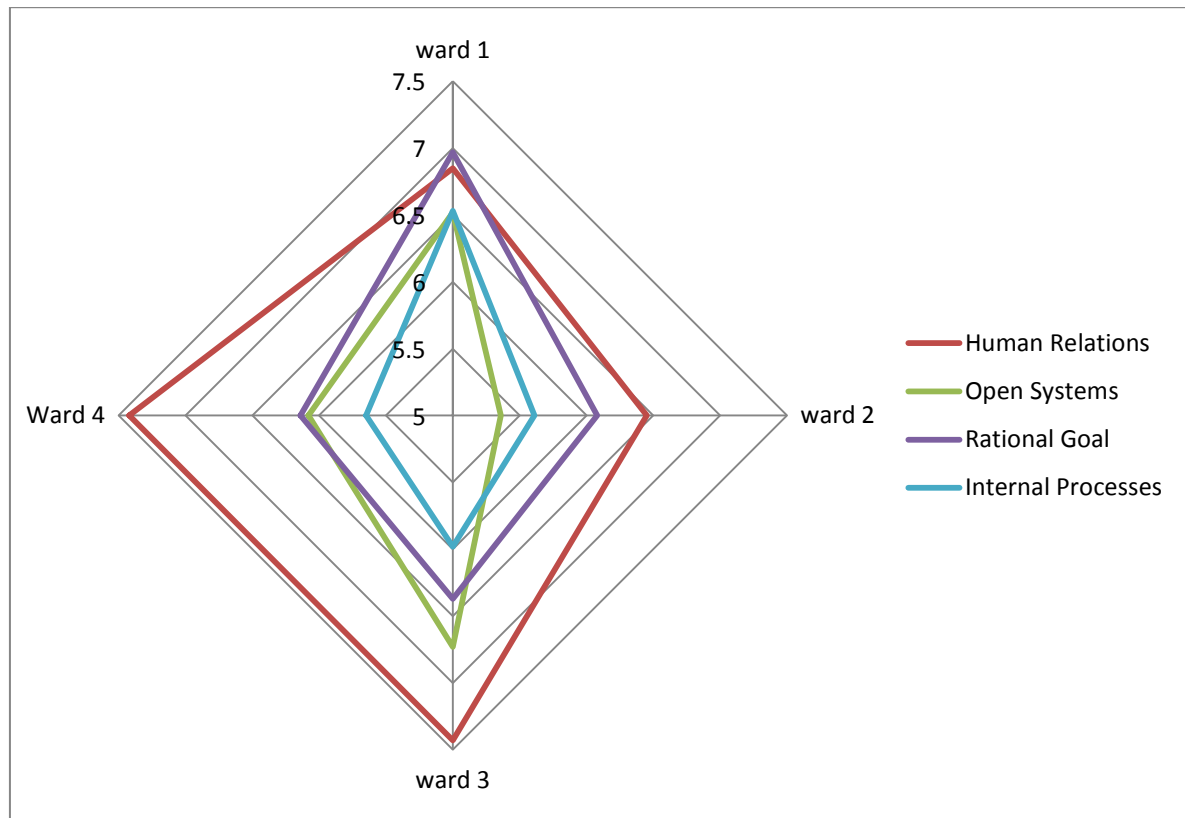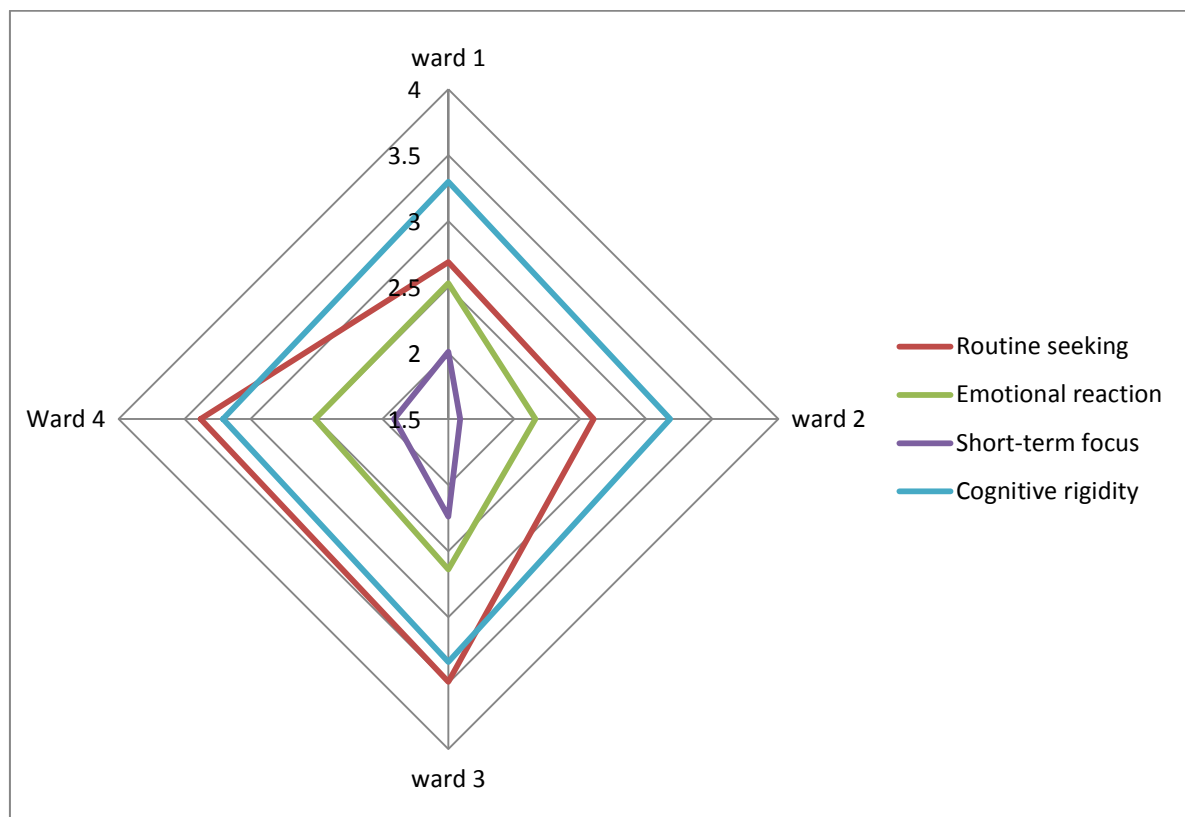

Figure 2 Mean values for the RTC scale, divided in subscales and wards

phase introducing new working methods. The staff progressed from standardised care based on diagnose specific flowcharts and a sequential distribution of work, to care based with individually shaped care plans and daily team decisions.

Organisational culture

The dimension of Human Relations (HR) dominated the hospital wards (M=7.11, SD=1.12) and was closely followed by Rational Goal (RG) (M=6.3, SD=0.98), Open Systems (OS) (M=6.2, SD=1.17) and Internal Processes (M=5.9, SD=0.82). This reveals that cultures of flexibility, cohesion, trust and belongingness were dominant among the health workers. There was, however, a slight difference between the wards. Two of them (Ward 3 and Ward 4) were strongly dominated by HR and 1 of the wards (Ward 1) was slightly dominated by RG, that is, planning, goalsetting, focus on economy and efficiency (Figure 1).

Resistance to change

The nurses' mean resistance to change, recorded *via* the 6-point RTC scale, was as low as 2.72 (SD=1.14). The nurses strongly disagreed with Short-term Focus (SF) (M=1.99, SD=0.98). This result reveals that the group of nurses was ready to endure a period of learning and change to adjust to the new situation implementing PCC. The Emotional Reaction (ER), that is, stress during a change process as an effect of lack of resilience, was slightly higher (M=2.49, SD=1.4) than the SF. This subscale is based on the presumption that less resilient individuals are reluctant to make changes. These 2 subscales were closely followed by RS and CR (Figure 2).

Bivariate and multiple regressions

The effect of HR, OS, RG and IP cultures on change resistance behaviours was tested in a number of bivariate and multiple regressions. Either OS, RG or IP were, however, significantly correlated to RTC and HR was not significantly correlated to the RTC dimensions of "Short-term Focus" (SF) and "Cognitive Rigidity" (CR). The only significant correlation was between the OVQ dimension of HR and the RTC dimensions of "Routine Seeking" (RS) and "Emotional Reaction" (ER).

In a multiple regression it was seen that statistically significant HR factors together explained 21% (R2=0.21) of the decreased routine seeking behaviour. It meant that 79% was still accounted for. The results indicate that a culture of flexibility, cohesion and trust negatively covariate with the overall need for a stable and well-defined framework. A human-relations type of culture improves the ability to cope with change.

Discussion

In this study, culture was measured in the staff of 4 hospital wards within 1 clinic in a Swedish hospital. The study reveals that a culture of HR decreases change-resistant routine behaviours. The results also showed that flat hierarchal structures and social competence contributed to a decreasing tendency to resist change to the PCC care model. This supports the idea that change is induced by cooperative and supportive cultures. HR stands out in contrast to the other 3 types of organisational culture, OS, RG and IP, as the only one that reached a level of significance. HR culture consists of a high tolerance to mistakes and flat hierarchical structures. The opposite,that is, a low tolerance and steep hierarchies, can induce a collective fear which restrains change processes and hinders the dissemination of innovations in healthcare [11].

Conclusion

An instrument that pinpoints the conditions of a particular healthcare setting can improve the results of a change project. Furthermore, managers who are aware of the organisational culture in their wards can use instruments such as those employed in the present study to investigate and plan change processes.

References

[1] Axelsson, R. (2000). The organisational pendulum: Healthcare management in Sweden 1865-1998. *Scandinavian Journal of Public Health* 28, 47-53.
[2] Gustafsson, R.Å. (1989). Origins of Authority: The Organisation of Medical Care in Sweden. *International Journal of Health Services* 19 (1) 121-133.
[3] Quinn, R.E. & Rohrbaugh, J. (1981). A Competing Values Approach to Organisational Effectiveness. *Public Productivity Review* 5 (2) 122-140.
[4] Quinn, R.E. & Rohrbaugh, J. (1983). A Spatial Mode of Effectiveness Criteria: Towards a Competing Values Approach to Organisational Analysis. *Management Science* 29 (3) 363-377.
[5] Scott, T., Mannion, R. & Davies, H. (2003). The quantitative measurement of organizational culture in health care: A review of the available instruments. *Health Services Research* 38 (3) 923-945.
[6] Quinn, R.E. (1988). Beyond Rational Management. Mastering the Paradixes and Competing Demands of High Performance. San Francisco: Josey-Bass.
[7] Cameron, K.S. & Quinn, R.E. (1999). Diagnosing and Changing Organisational Culture, Based on the Competing Values Framework.Massachusetts: Addison-Westley.
[8] Oreg, S. (2003). Resistance to Change: Developing an Individual Differences Measure. *Journal of Applied Psychology* 88 (4) 680-693.
[9] Reino, A., Kask, T. & Vadi, M. (2007). Organizational Culture and Environment: Dynamics in Dynamics, the Case of Ordi. *Trames* 11 (2) 124-138.
[10] Brace, N., Kemp, R. & Snelgar, R. (2006). SPSS for Psychologists. New York: Palgrave MacMillan.
[11] Berwick, D.M. (2003). Disseminating Innovations in Health Care. *Journal of the American Medical Association* 289 (15) 1969-1975.