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Occupational Control on Drift—National and Local Intervention in Clinical Work at Emergency Departments

Abstract: In Swedish emergency departments, various initiatives have been introduced in order to reduce long waiting times for patients: lean methods, targets for waiting times related to revenues, interprofessional teams, and different forms of triage systems. This study focuses on the physicians' views on dilemmas related to these interventions. The study is based on the interviews with 14 physicians in four emergency departments. The interviews have been analysed thematically and presented in the form of brief narratives. The study follows changes from clinical practice to national policy level. The changes appear to be ineffective or counterproductive—waiting times are rather getting longer, but the measures have a number of other effects. Decisions are taken at a central level and are carried out by means of rules, incentives, and projects and end in the medical profession being displaced from the central position they have held in the working processes of health care.

Keywords: Discretion, emergency care, New Public Management, physicians, teamwork, work environment

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According to the Swedish Work Environment Authority (2012), there is a chronic overcrowding at the emergency departments (ED) in Sweden, creating problems for the working environment in 54 out of 60 emergency hospitals. The hospitals in big cities face the most troublesome situation resulting in long waiting times (NBHW, 2014). When media sounded the alarm in 2010, politicians promised changes to reduce waiting times and increase patient safety. Among other things, new targets have been set and new working methods brought in to increase flow and patient safety. But the changes did not produce the expected results. Waiting times have become longer and increasingly often a "stand-by" situation has been declared; that is, an extraordinary situation in which the hospital resources are reallocated from planned care to the ED.

This is the background to the present study, which focuses on the attempts to alleviate the crisis-like situation. The swift and decisive measures, of which some are designed at the national level and others at the local level, have had a considerable impact on the EDs. The effects, we argue, are an interesting example of how seemingly non-controversial "improvements" may undermine occupational control of clinical work, while at the same time not solving the espoused problem. We see interventions to rationalize EDs as a part of larger and more persistent pattern, where professions are increasingly under the pressure of new forms of management, which

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is particularly the case for physicians (Aasland, 2015; Numerato, Salvatore, & Fattore, 2012). The EDs are in many ways a crossroad for the interests, conflicts, and unavoidable problems that follow suit with that development.

The purpose of this study is to analyse how a set of decisive measures intended to improve patient flow at EDs affect the traditional form of occupational control of clinical work. The study highlights how physicians in EDs perceive and cope with this development. The development at three EDs are compared and put in a wider context by linking the local contexts studied to the interventions designed at the national level. The concluding sections of the paper discuss the results in the perspective of the conceptual apparatus introduced in the theoretical section, constitutive and contingent elements of professionalism (Freidson, 2001) and the socio-cultural and task-related sphere of professions.

Conceptualizing professional control

Professions display a considerable variation and heterogeneity over time and different contexts in terms of their manifest traits, such as working conditions, terms of employment, status, and regulation of practice. The variegated manifestations of professions can be understood in a systematic way suggested by Freidson (2001), which firstly denotes a number of *constitutive* elements of professions. The constitutive trait of professions are: work is intimately connected to a recognized body of knowledge based on theories and concepts, the professional labour of division and labour market are occupationally governed, and university education is partly under occupational control. The mentioned elements are not unexpectedly those that we associate with the medical, law, or accounting profession. But the invariable traits of professions are always situated in the midst of societal and historical particularities and idiosyncrasies, the *contingent* variables. Government organization and policy, dominant ideologies, and the substantial content of bodies of knowledge are typical examples of conditions that can and do vary considerably among contexts and over time. Freidson (2001) suggests and exemplifies in his seminal book that the distinction between constituting elements and contingent variables can be used as an analytical model. How and to what extent do changes in the contingencies of professions affect the conditions for reproducing the constitutive traits of a profession? For instance, do new dominant ideologies in the western societies impose obstacles to the traditional occupational control of labour of division, labour markets, and education for professions? In research on professions in working life, the most pertinent question is of course occupational control of division of labour and the work process at large—themes explored in numerous publications in the last decades. The development of occupational control of labour markets and education, on the other hand, has received considerable less attention as these elements of professionalism have seen modest or little changes in most countries.

In the wake of New Public Management (NPM), numerous studies have been devoted to the effects of new forms of management and governance (Brock & Saks, 2016, Clarke & Newman, 1997; Numerato, 2011; Pollitt & Dan, 2013). With respect to the medical profession, the vast majority of measures in the last decades associated with NPM have been aimed at one of the constitutive elements of medical professionalism—occupational control of the labour process (Numerato et al., 2012). Admittedly, a complex and vexed issue, there is no consensus in this extensive branch of studies of professions in working life. However, if the previous distinction between constitutive and contingent elements of professions is recalled, the complexity is somewhat narrowed down. Hardly any recent research on professions employed in the public sectors of the industrialized world denies that the contingent elements of many professions have changed in recent years. Governments apply new methods to govern public services, guided by new policies, often intended to have an effect on professional groups. Albeit difficult to establish, dominant ideologies

have probably also seen some change in the recent decades. In that respect, many researchers agree in that there have been considerable changes in the context of public sector professions (Kurunmäki, 1999; Levay & Waks, 2009; Pollitt & Dan, 2013), but there are different conclusions whether the manifest reforms also have changed more profound aspects of professions, such as their status, identity, and professional practice (Evetts, 2009; Kastberg & Siverbo, 2016; Kurunmäki, 2004).

The conclusion that occupational control of division of labour in professional work is challenged find support in some extant research (e.g., Evetts, 2009; Jespersen & Wrede, 2009), while others hold that the medical profession often succeed in mitigating or short-circuiting the attempts to impose new forms of control on their work (e.g., Hanning & Spangberg, 2000; Levay & Waks, 2009; Waring & Currie, 2009). The most comprehensive recent account of extant research by Numerato et al. (2012) point out that the effects of managementization pertain to two different spheres of professional work—the socio-cultural and the task-related spheres, and the effects are conceptualized as five different forms of responding to challenges to professional control: submission to managerial hierarchy, co-optation of management, negotiated managerialism, strategic adaptation, and resistance. Again, it should be noted that according to Freidson's (2001) definition of professionalism, the socio-cultural sphere is by definition a part of the contingent elements, while occupational control of the task-related sphere is at the core of professional practice and a constituting element of professionalism. The research on effects on the task-related sphere summarized by Numerato el al. (2012) cover a wide variety of measures even though most examples are related to guidelines and medical protocols intentionally designed to govern medical practice.

Most research on how the medical profession is governed tends to focus on the measures that are unequivocally designed to alter the position and influence of physicians in the health care system. Changes with respect to new legislation and rules, the fee system, accreditation or the influence of a national medical association are typically such empirical cases. But public sector reforms often unfold in a vortex of many different forms of interventions (Bejerot & Hasselbladh, 2013). Singular forms of interventions seldom have an effect on their own. But local interventions in management, audit or regulating professional practice often find its support (financially, ideologically or by guiding attention) in interventions by law, rules and ordnances or political initiatives on the national level. Sometimes there are considerable time lags between the different forms of interventions that make up public sector reforms such as new legislation and local instances of management practices. We have studied a number of changes in the Swedish healthcare system where a national initiative have become closely linked to various local redesigns of EDs. Our empirical case offers a window into the complex level crossing between new priorities and incentives set at the national level, intended to redirect the priorities of clinical work at EDs. In this case, contingent elements at the national level of healthcare system—policy and regulation—become directly linked to the task-related sphere. The ways these measures are designed and launched at the local level directly impinge on one of the constituting elements of professionalism—occupational control of the division of labour—that largely corresponds to the task-related sphere.

Method and material

In 2014, 14 physicians working full-time in EDs were interviewed (five women and nine men). Four interviews were conducted in each of three hospitals: two very large EDs (100,000 patients/year) in a big city and one mid-sized ED (50,000 patients/year) in a mid-sized city. Two interviews were also conducted in a small ED (20,000 patients/year) in a small city closely connected to the mid-sized hospital but somewhat out of the centre of things. Nine of the individuals were specialists and consultants, and five were resident physicians. Among the latter, four were being

trained within the new specialism of emergency care, that is physicians that reside in the ED and are not brought in as "guest physicians" from other clinics. The choice of informants was made through so-called "snowball sampling" (Biernacki & Waldorf, 1981). This method entails a risk of a distorted selection. However, this process did not start from a *single* network but had different inputs.

The interviews lasted between 45 and 90 minutes and were recorded and transcribed, and anonymity was secured at this point. All informants received written information in advance on the focus of the research project, anonymity, and their freedom to end the interview at any time. The interviews were held by two of the authors of this article. The regional ethics committee approved the study. As the aim was to understand physicians' work from their own perspective, flexibility was important during the interviews. Thus, questions were asked based on a semi-structured guide that included questions on how clinical work was organized, what changes had occurred, if their work had been affected by these changes, what work dilemmas they perceived and how they dealt with them. The interviewer asked follow-up questions until the informant's account was well understood. The interviews were aimed to capture informants' stories, and it was often noticeable that informants had a work story that they wanted to pass on. In line with analytical interviews (Kreiner & Mouritsen, 2006), the informants were encouraged to analyse and discuss these stories during the interviews. It is these sections of the interviews that are used in the presentation.

The analysis began with reading and rereading the transcribed material. First, a coding was carried out, inspired by thematic inductive analysis (Braun & Clarke, 2006). The main categories were interventions by governance and management, and challenges or dilemmas at work (i.e., lack of discretion, resource deficiencies, frames of control, staff situations, cooperation with nurses, support and collegial arenas, patients' needs). Second, the context around the interventions and their impact was analysed by organizing the interviewees and their stories per organization, comparing similarities and differences between the EDs. This step of the analysis resulted in new knowledge and questions to ask in relation to the material. Third, the interventions mentioned by the informants were tracked to documents on the national level, where national priorities and even particular approaches to organize patient flows were described, and then back to the interviews in order to better understand the informants' stories. The process of analysis was characterized by "zigzagging back and forth between theoretical ideas, data collection and analysis" (Layder, 1988, p. 77).

We have chosen to present the interviews in a way that aims to capture the complex interplay of levels. Longer quotations are presented from one interview per organization in order to capture how the informants describe the contexts and the flow of events and how they interpret and deal with these. The chosen interview per organization is seen as being representative of the specific ED; that is, the themes and meanings presented are found also in the other interviews in the specific ED. The quotations capture complex reasoning and the different ways measures are designed and launched in the EDs. The quotations have been lightly edited for the sake of readability. Clarifications inserted within the quotations are written in the brackets.

The documents about measures to shorten waiting times were found in the archives of the Swedish Association of Local Authorities and Regions (SALAR) and the National Board of Health and Welfare (NBHW). Search was also carried in two Swedish journals that are arenas for information and discussions among physicians working in hospital environments: *Läkartidningen* and *Sjukhusläkaren*. The search was limited in time from 2010, when the change process started, to 2014 when the interviews were made. Although the results section is introduced with a description of the national level, the research process was largely in reverse, in that the work began with the interviews with physicians who indicated what external measures were influencing clinical practice—statements that were subsequently corroborated by analyses of documents from the national level.

National interventions in the governance of emergency departments

In the interviews, two areas of national interventions stand out as reshaping the previously existing occupational control of clinical work: the introduction of waiting time targets, and new methods to improve throughput and the flow of patients though the healthcare system. These measures are described as a background to the interviews that follow.

The four-hour target

During the 2010 campaign for the Swedish parliamentary elections, the Minister for Health and Social Affairs announced that he wished to introduce legislation on a maximum waiting time in EDs. There was a political consensus on this goal, but after the election neither legislation nor waiting time guarantees followed for EDs.[1] Instead, waiting-time targets became related to revenues from the government to county councils and EDs. The targets define the maximum time patients should have to wait to *one* hour before meeting a physician and *four* hours before they are ready to return home or be transferred to a ward (hereinafter abbreviated as the four-hour target). On the request of the Government of Sweden (2012), the NBHW specified indicators and a new quality register for waiting times, measuring performance in detail, automatically and continuously (compare Bejerot & Hasselbladh, 2010). Out of 21 county councils, 18 established these targets; between 70 and 100 per cent of all patients were to be completely processed within four hours, a target that few county councils succeeded in achieving (NBHW, 2013). [2]

New methods in clinical work

In order to render ED working methods more effective, SALAR (2013) initiated a national programme in 2012, financed by the government to stimulate county councils to find solutions to reduce waiting times, increase patient safety, and improve staff satisfaction. In 27 projects, *lean methods* were introduced with the ambition of rendering processes more effective and speeding up flows. Central elements in these projects were: changing how cooperation between physicians and nurses is organized through the implementation of *team triage* in which specialist physicians work together with nurses sorting patients by priority on ED intake (traditionally intake was staffed by nurses, except ambulance patients that bypassed the intake), staffing the entire ED flow with *interdisciplinary teams* (physician, nurse, assistant nurse), *checklists* of treatment directions, *fast tracks* for different groups of patients (e.g., hip fractures), and *minor injuries units* for patients who are not seriously ill (SALAR, 2013). These are also the central points of advice in a regional report on best practices of organizing EDs by McKinsey & Company (SLL, 2013). SALAR (2013, p.

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1 However, national legislation was introduced in planned specialist care and primary care. The pressure to reduce waiting times in those parts of health care directed more patients to emergency care, as older patients and those with long-term illnesses were less likely to have planned follow-up appointments that they needed. This is considered as one explanation for why waiting times at EDs has been difficult to reduce (NBHW, 2012, p. 80 ff.).

2 Apart from a few minor units specializing in planned care and one hospital, the regional councils run Swedish hospitals. The regions employ the staffs, including physicians. The hospitals are often, but not always, governed through some kind of purchaser-provider arrangement within the region. The regions, or county councils, are organized in a national union (SALAR) of paramount importance in policy-making and relations to the national government. The latter is responsible for legislation and audit in health care sector. With respect to our present case, this is a typical situation where national initiatives must be handled at the local level, regardless if the measures are mandatory or recommendations.

7) reported brilliant results based on these projects, but this success seems to have been local or short-lived, as countrywide waiting times were not reduced.

All in all, expert groups and research do not support the effectiveness of targets in reducing waiting times, although altered working methods with team triage may contribute to a positive development in EDs (SBU, 2010, p. 25),[3] and lean methods may simplify clinical work processes (Mazzocato et al., 2014). However, research gives stronger support for structural changes such as initiating units for minor injuries and fast tracking for certain patient categories (SBU, 2010). The point here is that although the measures undertaken in Sweden do not seem to have unequivocal support, they are being widely introduced nevertheless.

Submission to change

The initiatives from the national level often display an amalgamation of different types of measures based on politics, management, evaluation and rationalization of professional practice (Bejerot & Hasselbladh, 2013). The interventions aimed at EDs display a pattern similar to other parts of Swedish healthcare: politicians legitimize and finance, the National Board of Health and Welfare (NBHW) investigates and measures, and the national union of county councils (SALAR) design programmes for change. This may explain why comprehensive changes of governance in Swedish healthcare are often regarded as diffuse—many actors in different positions point in the same direction (Bejerot & Hasselbladh, 2010; Hasselbladh & Bejerot, 2016). Additionally, the county councils have some independence, so non-mandatory changes may not be introduced everywhere or simultaneously.

Even though the interventions designed at the national level was likely to have some effect on the occupational control of clinical work, the medical profession at large does not seem to have been involved in formulating the new priorities nor engaged in evaluating or commenting upon their possible, or known, effects (cf. previous studies displaying the same pattern: Bejerot & Hasselbladh, 2006; 2010; Hasselbladh & Bejerot, 2007). The two main journals aimed to physicians in Sweden (Läkartidningen and Sjukhusläkaren) briefly mentions the four-hour target in 2011 and a couple of published studies on team triage are referred to, while the organization of the entire work process in interdisciplinary teams is not described at all. No texts were found on new methods such as targets, team triage, interdisciplinary teams, lean methods or central registers for follow-up. This may partly be explained by the historical fact that EDs have traditionally been staffed by physicians from hospital wards who work there intermittently and correspondingly no physicians regarded emergency care as their domain before emergency medicine was established as a specialism in 2015.

The totality of interventions designed at the national level made up an unusual configuration by both specifying distinctive targets—what to do—and particular methods—how to do it. In terms of our model, there were decisive changes in some of the contingencies of professionalism—mainly regulation and managerial doctrines—that were likely to directly affect one of the constituting traits of professionalism—occupational control of the labour of division of professional work.

[3] A Swedish study showed a reduction in waiting times when physicians work in team triage on intake (Burström et al., 2012). In this study, however, Sweden's only privately owned ED is compared with two publicly run EDs. Many factors differentiate these hospitals, and the conclusion that it is the position of physicians in the triage that is the decisive factor is questionable.

Interviews with physicians

In all the studied EDs, physicians describe a heavy workload, difficult personnel situation, and lack of hospital beds and examination rooms. The themes recur in almost every interview with the exception of the two informants from the small ED, which seems less stricken by staff turnover and conflicts. However, when reading the fourteen interviews organized by workplace, some other differences also become visible. Although almost all the interviews relate to the four-hour target and the effects it has on the possibilities to exercise discretion in clinical practice, the extent of organizational changes to meet this goal differs. That is, some EDs are forerunners in programmes introducing new working methods. Differences in the work conditions of ED physicians are thus associated with how pliant local management or managers on the county council level have been to the interventions formulated on the national level.

The following section is based on the narratives of three physicians, one from each of the two large- and the one mid-sized EDs. Here, the physicians describe what they regard as problematic conditions and dilemmas in their work, related to governance and organization. The three cases are ordered after the extent of organizational changes. In the first example there have been least changes, and in the third, mid-seized hospital, most.

"There's no other reason than angling for votes"

This ED in a large city hospital has in recent years introduced a project on lean methods focused on improving flows; a flow-team with a doctor and nurse allot the patients on the ward. Lean methods were introduced by the clinic manager who learned this at a previous workplace, a private hospital, and the physicians of the ED seem to have had some influence on the design. For example, the clocks that showed each team's ranking, were removed after their complaints. No other organizational change was reported on this ED. The following interview was conducted with an experienced male specialist and consultant (IP 3). The physician is critical of many of the introduced governance measures and explains what he sees as causes of increased waiting times.

> The short waiting times we used to have been based to a great extent on these chest pains.… That patient doesn't exist anymore but has been replaced by a multimorbid 90–95-year-old without focus. Tired but nothing to get hold of. Has not been to the toilet for two weeks. Doesn't eat without help.… It would still work [in the ED] if we had somewhere to put all those people waiting for a bed [on the ward], then the flow would not in itself be a problem. But we have nothing. It is full, physically full in emergency.

The informant draws attention to a new and particularly care-demanding category of patients, the very elderly and multimorbid. These patients do not receive care from Geriatrics, as its compensation system now favours less sick patients. Also, the four-hour rule is assessed as being completely arbitrary, implying a resource shift from very sick patients on the wards to healthier patients in the ED, the other increasing patient group in the emergency.

> It's nothing we have decided, this waiting time; [the minister] decided it, promised it. There is no evidence at all that precisely four hours is good. You might say, why should you need to wait more than three hours, or why not five? So what we have done is taking physicians from the ward and brought them down to emergency to talk to the healthier patients. That's the sum total of the four-hour rule.

> Completely without evidence.… There's no other reason than angling for votes.

The physician expresses himself cynically about the politics and measures to cut waiting times. Measurement is regarded as an irritation, as it does not measure what he considers to be important. Below, several measurements and rewards are described as steering the work in the wrong direction.

> Personally, I have always been horrified at the fact that we have such an incredible number of metrics, how long the patient takes up a bed, what drugs they take, but no one has ever asked whether we made a good diagnosis or treatment. This is never measured.… [We can] never say that this patient came in with a supposed heart failure but didn't have that, but rather chronic obstructive lung disease. Good, five points! That has never happened. But that patient went home, after an adequate medical treatment, but there was no medication review! Our budget will be cut next year! That's the type of focus there has been.

This informant expresses bitterness on medical quality not being considered. A focus on the four-hour target and remuneration put the emphasis on monitoring waiting times. In this ED, however, management has not attempted to introduce new working methods such as teamwork and team triage. Although the physicians largely commit themselves entirely to patient work, not even the parameters of their most immediate tasks are considered to be possible to influence. The interview shows how the physician's thoughts are permeated by an irritation towards the national systems that form the framework for the ED. The physician does not express annoyance with how lean is implemented, or discontent with the management. The problems are considered as being of political origin.

"The whole system around it is like treacle"

The next ED is placed in a large city hospital where structural changes have been implemented. The queue to the ED has been cut from two sides, on the one hand a minor injuries unit for patients that are considered relatively healthy, and on the other hand—an "observation department" at the ED where ill patients who have not received a place in a ward within four hours are placed. Several doctors mention that these structural changes are made for economic reasons only. This is an ED whose leadership also have introduced SALAR's change initiative concerning new working methods such as lean methods and team triage. The physician quoted is a male resident who is soon to become a specialist in emergency medicine (IP 7). Replying to a question on what new measures have influenced his work, he mentions the four-hour target as well as the attempts to streamline patient flows by introducing team triage and interdisciplinary teams. The physician describes how these measures have failed in practice.

> This four-hour target has led to certain organizational changes. Among other things, we have created an observation department.… So those patients we can't deal with in the emergency department within four hours, they are admitted there. And it's an admission only in an administrative sense, but it's something that reduces the waiting times in the statistics.… And they've also introduced another system in which the physician assesses the patient as early as possible [team triage], and there are good reasons for doing this, but that's all. In that, there is no spare capacity in the system, they take a physician from one place and move them to another in the chain of care, so they are short in another place.… Formally we should be working in a [interdisciplinary] team. In practice, it doesn't work like that, but it's a more or less organized chaos I'd say, how we work.

This informant has no illusions about the changes; they only improve statistics, move physicians between positions, and so forth. He regards teamwork and team triage as good in themselves, but impossible to use properly because there are not enough nurses. The informant also describes inefficiency, what he calls working in "treacle."

> I can quite quickly get a feeling for what it is I want to do … but the whole system around it is like treacle. You have to do dictation, and then there's a long note to make sure you've included absolutely everything, and then you have to make phone calls here and there, and papers have to be sent here and there, and you have to talk to so and so.… While you're doing that, some relative arrive wanting to know what has happened, and then a new nurse arrives who has to know what has happened, and the patient may be getting worse during this.… There is no bed anywhere [in the hospital] and then I have to go back.

In this hospital, the ED physicians do not have "key rights," that is, they cannot demand beds on other wards for their sick patients, and there are constant negotiations with the wards to produce beds. Some slowness also depends on difficult personnel situations with high staff turnover.

> The emergency department is in a Catch-22, I would say. It is a very tough working environment … and then people will not stay there very long.… So there is never a critical mass of experienced staff that knows the workplace and the work.

This physician describes a lack of professional influence in his work and keeps quiet to avoid being regarded as negative. Management encourages dialogue but primarily wants proposals for improvements.

> Maybe, at least I feel that many of the problems that exist are so well known and they are maybe not always worth bringing up. And then there is also something else, you don't want to be regarded as somebody who, you know, brings up problems and so on.… And we are encouraged to come up with suggestions for improvements and the like.… I think a lot of people, you know, they've just given up and are resigned in the face of these things [lack of influence]. And then we have our patients to look after and our profession, we want to develop, we want to become good physicians and we support each other in this.

In the description of the lack of influence on the part of the medical team, the informant addresses how the physicians are resigned to their lack of influence and no longer suggest improvements. Instead, it is the professional project of becoming a competent physician that keeps them going and striving to improve. He points to politics, rationalization, and pushing responsibility downwards—with the ED at the bottom.

> In one and the same breath they [the politicians] reduce the number of beds in [the hospital] by so many hundred. And then, the concomitant of this is: "I am convinced that the quality of care can be maintained and that this will not affect the quality of care." And they can say that, but then they're only moving the responsibility down the hierarchy, because the people down there, with fewer resources, have to maintain some kind of quality of care.… And at the bottom of the hierarchy is emergency care.

This interview contains nothing to indicate that the structural interventions or the improvement project with lean methods, team triage, and teamwork have contributed to solving the problems the informant faces in his work. Rather a lack of resources, political promises and management's improvement projects appear to be sources of irritation. Resistance occurs in the form of distancing oneself from the involvement that management craves (that physicians should come up with suggestions for improvement). The physicians are, according to the informant, resigned on issues concerning the clinic, and instead concentrate entirely on their work with patients; this is where they are needed, and this focus makes them in some sense less vulnerable, they are doing their jobs. Although there is a clear criticism of the local management in this interview, the focus of criticism in the overall context.

"Then I am just an island, an island that goes around"

A third hospital in a mid-sized city stands at the forefront of introducing the specialism of emergency medicine and interdisciplinary teams. This means that the physicians work solely at the ED, and implies a change of roles and forms of collaboration of doctors and nurses. The focus on lean methods, teamwork, and economics is particularly prominent in this ED. The circumstances thus deviate somewhat from the other hospitals in the study. A female resident in emergency medicine describes lean methods and the four-hour target and its impact on clinical work (IP 12).

> And lean is very much implemented in our working methods, in that together we [physician and nurse] have to look at the patient as quickly as possible and prepare this joint plan. Then we can also quickly process the patient and this way finalize the case because it is also important that we have a medical evaluation within an hour and the patient should be processed by the emergency department within four hours. These are the targets that provide the funding for the department.… On the other hand, it feels as if, because lean is so very important and the times are very important, as that's what provides financial compensation for the emergency department.… It's as if the content has less importance.

Thus, the targets of short waiting times and lean methods seem to threaten the physician's discretion in executing the daily clinical work. Apart from the focus on treatment times, a standardization of clinical work has been introduced. Team triage implies that the patients are categorized by colour coding that describes their degree of acuteness in order to facilitate communication with the care staff.

> So, [the system of categorization] has really made things easier for us, because we have a better joint team understanding of the acuteness and investigation needs of the case. Then, in practice we can only press a button when we get this "abdominal pain, yellow," and then a piece of paper comes out with what the patient should have.…There is some resistance among physicians against this type of PM because they think that it is within our competence to be able to assess what should be done with a patient.

Here, standardization is embedded in the team triage system in the form of decision support for inexperienced staff—at the same time as management wants to place experienced specialists in triage. The physicians protest among themselves but accept the development. Below, the informant describes the loneliness that follows from interdisciplinary teamwork.

> So, we're working in these teams, and between the teams there is not much contact. So, you can work a full shift in this corner and have no idea who has worked here.… You know your team, of course, but I think that you also have a need of community with your own profession and, when you don't meet the other physicians so much, you can feel a little lonely.

Because of irregular working hours, there is no time for the physicians' traditional morning meetings, and monthly meetings are often held when they are working with patients. Senior consultants are not present in EDs as role models and give no support to resident physicians being trained in the new emergency specialism. There is no community, and the physician becomes "an island."

> You see, in other clinics the consultants are very important, but here, well, they are rather invisible; they are out on the daily rounds, but they should be helping to look into the future a little and being seen and showing the youngsters the ropes.… When we as a group can't have some form of community, it is very difficult to pursue any kind of development work, and so workmates are important of course, they are very important, but if we never meet, then I'm just an island, a line on a timetable, an island that goes around. But I want to feel I'm part of a community.

Although work methods in the interdisciplinary team with a nurse and an assistant nurse are regarded as positive, this organization leaves physicians feeling isolated from their colleagues. Nor is there uncomplicated cooperation within the team.

> In that, I have the highest medical competence, I also have the ultimate responsibility, and, in this way, I also see myself as team leader. But this has never been expressed, and when we write our report—we always have a written reflection after each shift— then it is often the case that the nurse sits as a team leader. I have not taken up this matter. I consider I have the responsibility, that's the case, and then I think I also have the right to take the decisions.… [Interviewer: But do the nurses see themselves as team leaders?] I think they do, I think perhaps they do. It's a really interesting question. It is in a way something that you don't dare to raise. I have not dared to lift that rock, quite simply.

During this period, the framework for the new specialism emergency medicine is being drawn up and teamwork is being introduced, but in a diffuse and sometimes confounding way. An individual physician does not dare raise the question of which professional group should lead the team, nor is there any support from consultants or arenas for collegiality. The loneliness of the work that this doctor describes, is also mentioned by physicians at the previous ED that had carried out major changes, but at this ED, the question is even more prominent.

Discussion

The government, NBHW and SALAR were the driving actors behind the interventions concerning waiting times and new working methods at EDs. Between 2010 and 2015, these interventions have *not* led to shorter waiting times. The solutions seem to have increased the problems they were intended to solve. Nor does this study find any indication that EDs have achieved a stronger position in hospitals through the introduction of targets (cf. Timmons, Coffey, & Vezyridis, 2014), or that they were able negotiate or adapt the new targets (cf. Kitchener, 2002). The interviewed physicians work intensively with patients and have no opportunities to influence the

larger framework of change, the organization of clinical work, nor priorities or working methods. From this perspective, the ED physicians appear to have been outmanoeuvred, such that their previous ability to exercise occupational control of clinical work has been diminished. Aside from insisting on trying to maintain good-quality medical work, the only resistance is silence and withdrawal from development projects and similar arenas. In principle, resistance is a possible scenario—but this study shows no trace of it on behalf of the medical profession.

There is no escape from the four-hour target, which is closely connected to revenues, but the results show that there are differences between EDs, which indicate that the management at the ED or hospital level has some discretion and can choose how proactively they want to engage with the methods proposed from the national level. Also, several interviews revealed that the cooperation between physicians and nurses had become more complicated. Limitations of this study lie in this complexity and the limited number of interviews. Future research in this area should include interviews with politicians, managers, and nurses.

Extant research on the medical profession tend to regard external interventions to impose control on clinical work, indirectly through the socio-cultural sphere or directly through regulating the task-related sphere, as destined to become watered out and adapted to priorities and concerns of the medical professions. The result of this study differs, therefore, from previous research that tends to emphasize the possibility to resist changes imposed from outside the profession (cf. Hanning & Spangberg, 2000; Kastberg & Siverbo, 2016; Levay & Waks, 2009; Waring & Currie, 2009). There are no signs of manifest resistance from physicians in our study, but ample evidence of cognitive and emotional reluctance (Piderit, 2000) to the measures imposed from above. The categorization of responses to challenges of professional control by Numerato et al. (2012) does not really cover our results. The identified reactions, which are not merely individual idiosyncrasies, attest to resignation, withdrawal, and sadness. It is akin to "cynical distance," as coined by Fleming & Spicer (2003), when employees distance themselves from various forms of cultural control in organizations by silence, denial, and cynicism. The changes we have studied are even more difficult to contradict than programmes of cultural control, sanctioned by top management. The changes are seen as meaningless, well-intended but disastrously designed or opportunistic attempts at quick fixes, any such meaning can be harboured among the physicians *as long as they do what they are told to do*. This might explain the apparent contrast between the actions, which largely follow the intentions of the reform, and the gloomy attitude to the reform expressed in the interviews. The reform as such impinges forcefully on professional control over the process of medical work but also nurtures attitudes that might reshape the sociocultural dimension of professionalism; such as professional knowledge development, identity and sense of belonging (Numerato et al, 2012). If the attacks on professional control from local management, and the government, are perceived as strong enough, working in solitude becomes as a final protective strategy.

Conclusions

The distinction between constitutive and contingent elements of professionalism suggested by Freidson (2001), and the more fine-grained distinctions suggested by Numerato el al (2012), invites to an inquiry on how professionalism is reshaped by the elements that might vary greatly between contexts and over time. It seems apparent that different aspects of professionalism can change, sometimes fairly independent from each other. Our case study illustrates how one aspect of professionalism—occupational control of the division of labour—can be decisively affected by contingent elements (regulation, organization, and ideology), while not affecting other constitutive aspects of professionalism at all. Notwithstanding that the Swedish medical profession in many ways have maintained their occupational control over

the constitutional elements of professionalism *outside* clinical work, our study illustrates how occupational control of the division of labour can be seriously undermined as a consequence of seemingly small interventions from the national level; such as changes in funding, national objectives, and recommended methods in clinical work, mediated through politicians in county councils and local managers. Physicians can still, with restrictions, make decisions about individual patients, but more as subordinate experts, and as trend suggests, in a team led by a nurse. This is a poignant example of how the autonomy and discretion of a professional group can be eroded under the pretext of high and pressing aims ("the patients must receive care quickly"), without neither involvement nor resistance from the profession. These changes pertain almost solely to what Numerato et al (2012) define as the task-related dimension of professionalism. But if such changes are considerable and reproduced over time, it seems likely that they also would affect the socio-cultural dimension of professionalism. Hard-wired changes of the type we have studied can also be seen as a way of ingraining certain values and principles, in a less negotiable manner than by way of exercising cultural control. Values, beliefs, and identities are difficult to separate from the practices where they are enacted and made real, a theme worthy of further investigation.

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