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Les valeurs des chefs de service de médecine à l'hôpital. Exploration à travers les admissions non programmées selon la méthode de la Grounded Theory

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Résumé en français

Introduction

La saturation des structures des urgences (SU) est un challenge organisationnel pour le système de santé et le parcours de soins des admissions non programmées (ANP). La saturation des SU est à l'origine d'une morbimortalité importante (Sun et al., 2013). La principale cause de la saturation est l'attente de lits en SU. Cette attente est multifactorielle et à l'origine d'une perception négative des patients et des équipes soignantes (Garson et al., 2008; Huang, Pines, & Van Der Linden, 2017). Elle est liée à l'état de saturation de l'établissement dans son ensemble mais certains auteurs constatent une saturation des SU dans des hôpitaux sans saturation des lits d'hospitalisation (Robin et al, 2012). Le American College of Emergency Physician recommande la mise en place de protocoles de saturation adaptés à chaque hôpital. Ces protocoles sont le témoin d'une nécessaire dynamique managériale pour résoudre le problème de la saturation des SU. Pour améliorer les parcours des ANP, les équipes doivent se connaitre et en particulier les managers de la SU doivent comprendre la perception des ANP au sein des unités d'hospitalisation (UH).

L'hôpital et les UH sont des organisations publiques. Pour les explorer, la théorie de Bozeman (2002) propose d'explorer l'interaction entre les contraintes de l'environnement (économique, politique) et les valeurs (Davis &West, 2009). Pour Rokeach et Selznick, les valeurs constituent les objectifs d'une organisation (Rokeach, 1973 ; Selznick, 1953). Comprendre les valeurs permet de comprendre les choix et le fonctionnement d'une organisation (Kernaghan, 2003; Rokeach, 1973).

Les chefs de service (CDS) jouent un rôle stratégique central dans les organisations de par leur lien hiérarchique. Ils influencent les décisions stratégiques et le comportement de leurs équipes (Arieli et al, 2020).

L'objectif de notre étude est d'explorer les représentations des ANP par les CDS dans l'hôpital. Nous espérons ainsi comprendre les contraintes des ANP sur les UH.

Cadre théorique

Pour explorer les valeurs des CDS, nous avons utilisé la théorie des valeurs publiques de Jørgensen et Bozeman (Jørgensen & Bozeman, 2007) et la théorie des valeurs de Schwartz (Schwartz, 2012).

Il faut différencier la notion de « valeur » et « valeurs » (Nabatchi, 2018). Selon Porter la « valeur » correspond à la différence entre le bénéfice et le dommage produit par un service en prenant en compte la quantité de ressources utilisées (Porter, 2010). Nous nous intéresserons aux « valeurs » au sens de Dewey (1939) et Bozeman (2007). Les valeurs sont des jugements personnels complexes basés autant sur ses connaissances que sur ses émotions. Dans les organisations publiques, les valeurs publiques sont des standards qui guident les comportements et les actions. La théorie des valeurs de Jørgensen and Bozeman (2007) identifie 72 valeurs classées en 7 groupes principaux. Les valeurs peuvent être organisées en valeur mère et en valeurs associées. Décrire ces valeurs permet de définir une organisation.

Les valeurs sont en interaction avec leur environnement (Selznick, 2011). L'environnement est à l'origine d'un stress organisationnel pouvant mener à des modifications des valeurs (Kraatz et al., 2020, Jørgensen & Vrangbæk, 2011). Le pluralisme des valeurs est central dans les organisations publiques et ce pluralisme, conjugué aux pressions de l'environnement peut mener à des conflits et à devoir faire des choix entre celles-ci (Molina & Spicer, 2004). Certains auteurs, comme Moynihan (2009) proposent de décrire les organisations à travers l'équilibre complexe et les conflits entre les valeurs.

Schwartz (2012) propose 10 valeurs de base organisées en cercle (figure 1). Cette représentation en cercle permet de visualiser des valeurs de proximité et des valeurs qui s'opposent. Deux grands conflits sont décrits par Schwartz : openness to change avec conservation et self-enhancement avec self-transcendence. Ce modèle a été validé dans de nombreuses situations et pays.

Méthode

Pour explorer notre sujet, nous avons choisi de réaliser une étude qualitative selon la méthode de la « Grounded Theory » à partir d'entretiens semi-directifs. En effet la recherche qualitative est particulièrement adaptée pour explorer les sentiments profonds en situation réelle (Charmaz & Belgrave, 2015; Strauss & Corbin, 1997). Cette méthode est également

adaptée pour explorer des sujets peu connus et proposer une nouvelle perspective d'une problématique (Locke, 2001). Les ANP sont un sujet essentiellement abordé à travers la saturation des SU mais leur représentation au sein des UH est peu étudiée.

Dans un Centre Hospitalo-Universitaire (CHU), nous avons sélectionné les UH de médecine qui admettaient plus de 50% d'ANP. Leurs CDS ont été sollicités par mail et tous ont accepté. Les entretiens ont été menés en face à face en créant une atmosphère de confiance et de confidence. Le chercheur qui a mené les entretiens est un médecin urgentiste, en poste depuis peu dans l'établissement mais avec une expérience managériale. L'objectif affiché lors des entretiens était de réaliser une étude pour mieux comprendre l'organisation des HU accueillant des ANP et de proposer à terme des pistes d'amélioration. Dans une approche constructiviste de « Grounded Theory », nous avons assumé que les CDS et le chercheur expriment une vision subjective (Charmaz & Belgrave, 2015). Les entretiens ont produit, une fois retranscrits dans leur totalité, 300 pages et 93000 mots de matière à analyser.

L'analyse a été menée par les auteurs selon la méthode proposée par Charmaz & Belgrave (2015). Durant la retranscription, les auteurs ont noté les thèmes à utiliser pour coder les entretiens. Les auteurs ont échangé régulièrement leurs points de vue sur l'interprétation des données à partir des données de la littérature. Une fois le cadre théorique défini, les entretiens ont été recodés selon les principes de la théorie des valeurs.

Résultats

Les valeurs des chefs de service

La valeur mère selon Jørgensen & Bozeman est l'attachement à la mission de service public. Les CDS sont attachés à l'intérêt public et ressentent une responsabilité vis-à-vis de la population « C'est inscrit dans une tradition qu'on essaye de rendre vivante et qui est que le malade est prioritaire » (E9-101). Les co-valeurs au sens de Bozeman et Jorgensen sont l'universalisme, l'excellence universitaire, la reconnaissance par ses pairs et l'intérêt intellectuel. L'universalisme implique que l'hôpital public est fait pour accueillir tous les malades, y compris si le malade ne relève pas uniquement de la discipline de spécialité « c'est mon rôle de service public oui » (E5-32). L'excellence universitaire de recherche et d'expertise est au service de la population : « chacun a des cohortes de patients ultra-spécialisées » (E12-168). La reconnaissance par ses pairs ou par la société peut se faire par le

biais de la production scientifique « L'expertise de très haut niveau permet qu'il y ait des services universitaires » (E5-15) ou le dynamisme de projets pour la collectivité « j'ai besoin d'une reconnaissance aussi. J'essaye de faire en sorte qu'on fasse des travaux scientifiques, pour montrer à la communauté que nous sommes actifs, qu'on essaye de construire un projet pour l'établissement, qu'on est des leaders, qu'on essaye de proposer des prises en charge. J'essaye pour notre spécialité de montrer l'apport que nous avons pour la prise en charge […]. » (E11-108). L'intérêt intellectuel est une valeur importante, surtout dans un CHU où les patients sont sélectionnés et présentent des pathologies complexes ou rares « ça met un peu de piment dans l'activité. Moi les [pathologies], je ne dis pas que c'est toujours la même chose, mais c'est toujours le même principe et d'avoir de temps en temps une autre pathologie ça ne me dérange pas. Il y a aussi des maladies rares, ça demande beaucoup de temps. On ne fait pas le diagnostic juste en regardant le patient, il y a un travail de bibliographie » (E13-293).

Un environnement à l'origine de contraintes dont font partie les admissions non programmées

L'environnement de l'hôpital public est source de multiples contraintes comme les restrictions budgétaires et la pénurie de ressources médicales et soignantes. Les ANP, par leurs caractéristiques propres, sont une contrainte supplémentaire.

L'ensemble des CDS observent une constante diminution des ressources à l'origine de difficultés de fonctionnement importantes « Nous en sommes là, à cause de la politique menée depuis 4-5 ans de maitrise de la masse salariale et donc de fermeture de lits. Clairement la situation s'est dégradée. » (E7-108). A cela s'ajoute une pénurie de ressources humaines au niveau médical et infirmier. La démographie médicale n'a jamais été aussi basse en France « on n'a plus de médecins. Moi, je suis passé de 9 séniors à 6 séniors et dans un mois je serai à 5. Et je suis passé de 8 internes à 2 internes. » (E1-195). Dans cet environnement de pénurie de ressources, la concurrence est rude avec le privé et l'activité non programmée souffre d'un manque d'attractivité « on a un problème d'attractivité qui est clair mais ça c'est tous les services de médecine interne en particulier ceux des HUS en tout cas. La polyvalence l'aval des urgences effectivement ce n'est pas attractif. » (E6-121).

Les malades hospitalisés de manière non programmée via les urgences représentent une charge de travail de plus en plus lourde « Il y a des malades de plus en plus lourds […] il y a des semaines où il y a des patients très lourds […] avec beaucoup de soins de nursing, des malades avec des troubles du comportement. » (E9-85). Les malades présentent des

comorbidités rendant leur prise en charge difficile « il y a plein de services qui détestent ça. Ils détestent ça c'est mal vécu, parce que c'est vécu par ces services comme une surcharge de travail. Ils préfèrent les patients programmés. Imaginez les services de médecine ils font une [activité hyper-spécialisée]. C'est quand même plus simple de faire un patient programmé pour un bilan plutôt que de se trouver avec un patient […] un peu limite […] un peu poly-pathologique » (E8-72). Dans un CHU où toutes les spécialités sont représentées, ces malades peinent à trouver leur place « Il me semble que les frontières sont souvent floues de quel domaine relève un malade. S'il y a quelqu'un avec plusieurs pathologies, certains services ne veulent pas prendre les malades des Urgences » (E9-45) ou « on n'est pas les mieux placés pour traiter les poly-pathologies. Je pense que c'est vite problématique. […] C'est vite un travail compliqué et je pense qu'on est trop spécialisé, surtout par exemple, dans notre discipline » (E10-167). Cette ANP est alors vécue comme une contrainte par certains services « Quand on n'a pas d'appétence pour les urgences, pour la prise en charge de l'urgence, on n'a pas envie qu'on désorganise sa journée » (E3-67).

Toutes ces contraintes de l'environnement participent à la tension sur les valeurs des CDS.

Le conflit entre les valeurs selon Schwartz

Le schéma en figure 2 résume le conflit entre les valeurs selon le modèle de Schwartz.

Le self enhancement s'exprime pour les CDS à travers l'hyperspécialisation qui est source de reconnaissance et de satisfaction « Nous sommes dans un CHU, je suis centre expert […], centre de référence […], nous avons été labellisés pour une compétence là-dedans, si c'est maintenant pour faire de la médecine générale, je ne comprends pas très bien. Je suis labellisée, je suis payée, je suis censée avoir une activité de recherche et d'enseignement etc.... dans des domaines particuliers, je ne dis pas que je ne peux pas participer à l'effort commun, mais je ne suis pas là pour faire de la médecine générale ou de la médecine interne. Ce n'est pas pour ça que je suis là » (E13-245). A l'opposé du cercle de Schwartz, la self transcendance est l'expression de l'universalisme comme valeur de dépassement de soi. Prendre des malades des urgences est présenté comme « […] une valeur positive. On l'a écrit et répété souvent. […] Ce n'est pas sans tension, mais c'est une politique délibérée. » (E9-77). Sous les contraintes de l'environnement, la réaction des CDS est de s'orienter vers une direction ou vers l'autre en fonction de l'échelle des valeurs qui l'anime.

Le openess to change représente l'incertitude du malade complexe. Cette activité est complexe et chronophage mais la satisfaction qui en est retirée est importante. « Le terme poly-pathologique je n'aime pas l'employer. La représentation majoritaire, c'est que ce n'est pas nécessairement quelqu'un d'intéressant sur le point de vue médical alors que plus il y a de maladies plus ça représente un défi d'équilibre notamment. Ça aussi c'est une manière de valoriser le travail et aussi de valoriser le diagnostic, car là il y a un gros effort de diagnostic à faire et toute la réflexion thérapeutique et les arbitrages qu'il faut faire. Ces malades dont des collègues ne veulent pas forcément s'occuper, vont susciter une curiosité et un intérêt. C'est juste une histoire d'avec quel type de lunettes on l'observe. » (E9-113). A l'opposé, les conservative values se concentrent autour des admissions programmées de malades et de pathologies connues par les équipes « c'est bien plus facile de gérer ses malades de sa propre discipline. Déjà pour programmer, les malades arrivent dans le service en général c'est des gens valides, ils ont des traitements, des bilans et ils ressortent. Ça fait moins de boulot pour l'infirmière, ça fait moins de boulot pour les soignants, ça n'a pas du tout la même charge de travail. » (E1-52). Sous l'effet de l'environnement et en particulier de la complexité des situations, certains CDS vont avoir peur de cette polyvalence « je peux comprendre aussi que certains médecins ne sont plus assez à l'aise, puisqu'ils sont hyper spécialisés. Il y a aussi cette peur-là. C'est de ne pas savoir gérer. » (E3-171). Les contraintes peuvent également être très fortes, menant à des crises au sein des services. Ainsi si la charge de travail est trop importante, « les gens s'en vont, les plus jeunes. Là on a eu le feu cet été […] parce que les plus jeunes praticiens estiment qu'ils n'ont pas à travailler du matin 8h au soir 18h, qu'ils n'ont pas a avoir une surcharge de travail, qu'ils doivent avoir des journées de récupération... et donc gérer des malades instables venant des urgences, c'est très compliqué pour ces gens » (E1-56).

Discussion

Notre étude explore la perception des ANP par les CDS selon la méthode de la « Grounded Theory », ce qui nous permet de contribuer aux travaux sur la théorie des valeurs publiques. Dans le sujet de notre étude, les ANP au sein des UH sont à l'origine d'un conflit entre les valeurs. Cette conclusion nous permet de proposer des pistes managériales et pourra faire l'objet d'études complémentaires.

La valeur mère au sens de Bozeman et Jorgensen (2007) est la mission de service public et les co-valeurs sont l'universalisme, l'excellence universitaire, la reconnaissance par ses pairs et l'intérêt intellectuel. Elles font partie des 72 valeurs citées par les auteurs et se complètent. En effet, toutes ces co-valeurs permettent à l'organisation publique de fonctionner et de servir la mission de l'organisation publique et la valeur mère (Stoker, 2006).

L'identification des valeurs dans les organisations publiques est complexe (Fukumoto & Bozeman, 2018). Une des méthodes pour y parvenir est de les identifier à travers les contraintes de l'environnement (Davis & West, 2009 ; Nabatchi, 2012). Dans notre étude, la contrainte de l'environnement est représentée par les restrictions budgétaires, la pénurie de ressources médicales et de soignants et la contrainte des ANP. Grâce à cette contrainte, nous avons pu identifier les valeurs des CDS d'un hôpital public et les conflits entre elles, illustré par le modèle de Schwartz (2012).

Nous avons quelques limites à notre étude. Nous avons exploré les représentations et les valeurs des CDS et nous ne pouvons être certains qu'elles soient partagées par l'ensemble de l'équipe. D'autres études complémentaires permettront de valider notre théorie.

Implications managériales

Pour améliorer le parcours des ANP, nous proposons de mettre en œuvre des stratégies managériales comme : diminuer la contrainte et valoriser les ANP, donner une visibilité universitaire aux UH qui admettent des ANP, communiquer entre SU et UH pour développer des valeurs communes autour des ANP.

Mots clés : saturation des urgences, Grounded Theory, valeurs publiques, hôpital.

Abstract

Background: Overcrowding of emergency department is challenging to perform unscheduled admission (UA) pathway. Managerial approach requires to understand representation of UA from head of department (HOD) because they influence strategic decisions from hospital.

Purpose: The study aims at identifying how the values of HOD and conflict between them in public service influence their attitude toward UA.

Methodology: We employed a qualitative, semi structured interview methodology with Grounded Theory. We interviewed HOD of medical HU from a University Hospital Centre to explore their point of view from UA.

Findings: According to Bozeman and Jørgensen the prime value was commitment to the public mission. Co-values was universalism, academic excellence, peer recognition and intellectual interest. They serve the mission of the public organization. As budgetary restrictions and lack of medical or nursing resources, UA, by their very characteristics, are environmental constraints generating values conflict. According to Schwartz model, conflicts exist between hyper-speciality and universalism and between scheduled activity and uncertainty of the complex patient.

Practice implications: HOD and HU are attached to public mission and conflict between values is underlined by UA. To improve the pathway of UA, we propose to implement managerial strategies such as: reducing constraints and enhancing the value of UA, giving academic visibility to HU admitting UA, communication between ED and HU in order to develop shared values around UA.

Keywords: overcrowding, Grounded Theory, public values, hospital

Introduction

Overcrowding of emergency department (ED) is a major organizational problem for health care services and unscheduled admissions (UA) care pathway. It causes significant morbidity and mortality. Many studies find association between overcrowding and mortality (Sun et al., 2013). A retrospective cohort study of all ED patients in Ontario during 4 years find an adjusted odds ratio for death of 1.79 (1.24 to 2.59) for patients with length of stay upper then 6 hours (Guttmann, Schull, Vermeulen, & Stukel, 2011). Overcrowding is also associated with increased risk of medical error, delayed urgent care and less pain quality of care (Ackroyd-Stolarz, Read Guernsey, Mackinnon, & Kovacs, 2011; Morley, Unwin, Peterson, Stankovich, & Kinsman, 2018). Overcrowding conducts to managerial challenges as it can lead to conflicts between hospital units (HU) (Barrett, Ford, & Ward-Smith, 2012). One of the causes of overcrowding in the EDs is time of wait in emergency box, known as boarding (Rabin et al., 2012). This boarding is multifactorial, leading to negative perceptions from patients and staff (Garson et al., 2008). It depends of course on the state of overcrowding of the hospital as a whole (Forster, Stiell, Wells, Lee, & van Walraven, 2003). It also depends on the organization of the ED and its relations with the HU (Elder, Johnston, & Crilly, 2015; van der Linden, van Ufford, Project Group Medical Specialists, & van der Linden, 2019). The typology and complexity of UA is also a factor found in the literature, with older and comorbid patients being at greater risk of prolonged stay in the ED (Aboagye-Sarfo et al., 2015). Contrary to popular belief, the problem of overcrowding in ED and boarding are not solely related to a lack of hospital beds in HU. In fact, there are boarding situations in some hospitals without tension in available hospital beds (Rabin et al., 2012). The American College of Emergency Physician recommend full-capacity protocol to prevent overcrowding and his effects (Handel et al., 2010). These full-capacity-protocols are above all the result of a managerial dynamic within each hospital (Patel, Combs, & Vinson, 2014; Willard, Carlton, Moffat, & Barth, 2017). The entire hospital is tackling the problem of overcrowding thanks to leadership provided by the ED management (Huber, Rodriguez, & Shortell, 2019). To improve patient pathways from UA, managers need to first understand each other, ED and HU. In particular, ED staff need to understand perception of UA in the hospital organization, especially for HU.

At first sight, hospital and HU are public organizations. For Bozeman, defining a public organisation is quite complex because public roots are not only defined in terms of economic basis or in term of degree of political authority constraints and endowments affecting the

organisation (Bozeman, 2002). Exploring public organizations requires to explore other dimension as public values. A key issue to analyse publicness dimension of organisation is to understand the blend of bear of environment constraints (i.e. political and economic) and values to serve common ends (Bozeman, 2002; Davis & West, 2009). Exact definition of values is debated but authors propose that values constitute the objective of the institutions (Kraatz, Flores, & Chandler, 2020; Rokeach, 1973; Selznick, 1953). Values in organizations contribute to guide actions and choices (Dewey, 1939). To understand decision making in organizations and choice made, many authors propose to understand values (Kernaghan, 2003; Rokeach, 1973).

Heads of Department (HOD) played a central strategic role in organizations (Walsh, Harrington, & Hines, 2020). Through their hierarchical authority, they influence organizational values (Arieli, Sagiv, & Roccas, 2020) and shape organizational culture and climate (Schein, 2010). Their position in organizations and their leadership influence the strategic decisions and behaviour of their subordinates (Arieli et al., 2020). Therefore, it is important to understand opinion of HOD in particular, as they decide the place and representation of UA in the hospital.

The purpose of this study is to explore representations from HOD about UA in an hospital organization. We ought to understand constraint from UA on HU. To explore UA in UH, through HOD opinion, we conduct qualitative, semistructured interviews with HOD in a university hospital centre (UHC).

Theoretical Framework

To explore HOD values, we used public values theory from Jørgensen and Bozeman (2007) and values theory from Schwartz (2012).

Values theory in public organization

Studying values to explain human behaviour, Dewey shows that values emerge as the results of a direct appreciation of the immediate qualities of a situation, an event or object and start out as an individual desire which differ from social norms (Dewey, 1939). It is important to

define and clarify terms. « Value » and « values » must be distinguished as “public value” and “public values”. The notion of value or public value in a healthcare system refers to creating value for patient or “as a difference between the benefit and the harm done by a service, taking account the amount of resources invested (Porter, 2010). This “value” concept is often used interchangeably with “values” and “public values” (Nabatchi, 2018). Although, these terms represent distinct concept and « value » is not adapted for our topic. The concept of “values theory” can explore actions and behaviour. Indeed, “values are complex personal judgements based on knowledge as well as an emotional reaction” (Bozeman, 2007, 13). In public administration and healthcare system, values or public values correspond to standard and qualities that lead to behaviour and actions (Wal & Huberts, 2008). Values correspond to standards, principles or ideals held by individuals and organizations (Bozeman, 2002, 2007). For Bozeman, public values are the one that provide “normative consensus about (a) the rights, benefits, and prerogatives to which citizens should (and should not) be entitled; (b) the obligations of citizens to society, the state, and one another; and (c) the principles on which governments and policies should be based” (Bozeman, 2007, 13).

To describe these values in the public administration, the most widely used model is the model of Beck Jørgensen and Bozeman who identified 72 values (Jørgensen & Bozeman, 2007). These numerous values are classified into 7 major groups according to the type of impact they cause. The contribution of the public to society underline that public administration contribute to the common good of society. The transformation of interests to decision suggest that public opinions impact public values. The relationship between the public administration and politicians and between public administration and its environment means that public values closely interact with funder, decision-maker and that public administration is listening entire society. The values associated with intraorganizational aspects and the behaviour of public-sector employees are related to robustness of organisation which is able to agility and attitude of service from employees. The relationship between public administration and the citizens consist to protect citizens with legality and human rights. Values can be organized in prime values and associate values: neighbour values, co-values and nodal values. Neighbour values are in proximity each other and detailed the core value. Co-values appears to be related to prime value and have an effect on it or could be a precondition. The nodal value occupies a central place in the value network to define complexity of public value. To define an organization, the authors then observe the proximity of the values between them: prime value and associated values.

Environment and conflict between values

Values in organizational landscape and interaction with environment was first studied by Selznick in his 50's major work about leadership in administration (Selznick, 1953). His theory was that environment and especially mass society influenced organizational values. Values interplay with other forces and some conditions can facilitate persistence or decline of them (Kraatz et al., 2020).

Some authors claim a "trans-situational" influence of values but they studied individual values and not organizational values (Morgan, Mullen, & Skitka, 2010). Rokeach propose that values are the ''enduring beliefs that influence the choices we make among available means or ends.'' (Rokeach, 1973, 5). In fact, environment is changing and a possible outcome of this change is value dynamics and a various organizational response (Jørgensen & Vrangbæk, 2011). In practical, some authors studied in the field, change in organizational values during external or internal constraint as economical restriction, change in organizational culture, professional standards, regulatory requirements, organizational changes, and so on (Gellermann, Frankel, & Ladenson, 1990; Omurgonulsen & Oktem, 2009; Rokeach, 1973). They observe conflict between values and changing in organizational values.

Public values pluralism is central in public service (Galston, 2002). Several values and orientations exist simultaneously in organizations. This can produce conflicts and "create dilemmas—situations without clear winners or easy answers—whose resolution is the major work of individual bureaucrats, administrative agencies, public administration scholars, and, for that matter, the public sector as a whole" (Buchanan & Millstone, 1979, 280) Environment and policies could lead to controversies and choices among values (Molina & Spicer, 2004). For example, environmental policies might set off conflicts among values such as preservation and economic growth. According to Selznick , in the event of a changing environment, the values are subject to an additional stress (Selznick, 1994). Faced with this unstable environment, individuals and organizations react according to the principles of their values. Schilke observes that environmental pressures can change the historical and constitutive values of the service, profoundly transforming its identity (Schilke, 2018). Values are not fixed in an organization, but are subject to environmental constraints and can provoke different reactions depending on the circumstances. Values can then come into conflict with each other. Moynihan proposes to describe the values of a public organization through the complex balance and conflicts between them (Moynihan, 2009).

Schwartz values model

Based on the work of Rokeach (1973), Schwartz proposes a theory of the value structure of individuals (S. Schwartz, 2012). A value is defined as desirable, trans-situational goals, varying in importance, that serve as guiding principles in the life of a person or other social entity. In this theory, the author identifies 10 basic values (Figure 1). Thus, each individual would give different importance to these values. Some values are related or closely related while others are in opposition, as shown in the circular structure. For example, tradition and conformity are opposed to stimulation while being very close to the safety value. These 10 values and their division have been validated in many situations and in many countries (Perrea et al., 2014; S. Schwartz & Butenko, 2014). Compared to Bozeman's theory, values are not hierarchical. Individual's values are defined through the relationships between them. In addition to identifying fundamental values, it is important to describe the relationships between them: compatibility or conflict. Values may oppose but cohabit with each other. When the environment or context become more difficult, individuals or organizations then led to make trade-offs between values. Conflict between values in public service characterises the organization (Kernaghan, 2003). The pattern of conflict between values therefore determines their structure. Schwartz describes two conflicts: openness to change with conservation on the one hand and self-enhancement with self-transcendence on the other hand. The value openness to change corresponds to openness to new experiences: autonomy of action, of thought, excitement of novelty. Conversely, the conservative value prefers the status quo in tradition and conformity, preferring stability and security for oneself and others. This conflict can be illustrated in political groups: individuals who preferred conservative values are more likely to trust organizations (Devos, Spini, & Schwartz, 2002). The self-enhancement value corresponds to control and power: ambition and recognition according to social standards. In contrast, the value of self-transcendence self-cares for others with benevolence and tolerance, with concern for universalism. This conflict can be illustrated in a group. Self-enhancement and self-transcendence values could be associated with perceived group status and identification (Roccas, 2003).

Methods

Sample

To explore our research topic, we used a qualitative interview technique with a Grounded Theory approach (Charmaz & Belgrave, 2015; Corbin & Strauss, 2014). We conducted semi-structured interviews with HOD of medical HU in a UHC in Eastern of France. To understand head representation of UA, we choose qualitative research. Indeed, qualitative research is particularly relevant to understand and explore real life and opinions of HOD involved in UA (Bell, Bryman, & Harley, 2018). Interviewer was a new corner emergency physician with a management experience in other hospital. Its mission within the UHC, at the request of the head of the unit, was to improve the care pathway of unscheduled patients. He presented the study as a research approach but also as a way to better understand the organization and difficulties of the HU admitting UA. Interviewer and participants assumed subjective meanings, explicit values and beliefs, and suggestive or tentative conclusions as a constructivist approach from Grounded Theory (Charmaz & Belgrave, 2015).

We selected main medical HU by calculating the ratio of UA to total admissions. HU who admitted more than half were selected. We contacted via e-mail the 14 HOD with these criteria, who all accepted to participate. Only two women were interviewed, which is representative of social inequalities, particularly in the field of medical responsibilities. All HOD were physicians and hospital practitioner between 10 and 30 years, suggesting a wide range of hospital social settings, relationships and organization experiences. All medical HU from the UHC were concerned. Thanks to this diverse sample of participants, we improved our chances of capturing the most fruitful data. We selected head of medical HU because surgery HU react differently to UA. Indeed, a patient with a surgery indication or complication need to be admitted in a surgery HU. UA in surgery suggests other questions and reactions from the HU staff and HOD.

We conducted interviews, face to face in the office of each participants. We previously informed them from the aim of our research in this world “understanding UA impact on staff and HU organization”. The interviews were structured and conducted to encourage personal relevance and confidence. Our goal was to focus on real life and inner thoughts from HOD about UA.

The interviews were semistructured. Questions were developed before data collection and we altered these questions or ask a new one depending on interview direction. All interviews

started by the statement “What’s your opinion about UA in our UHC?”. Interviewer create a confident climat and favorize social interaction to capture multiple realities and profond meaning from participants (Charmaz & Belgrave, 2015). Interviews prompts included various aspects to explore many fields. “How are these UA in the HU experienced? by the doctors? By the nurses?”, “In your opinion, what are the brakes on UA?” and “what’s your opinion about ED?”. The length of interviews ranged from 45 to 90 minutes. We taped records and transcribed all of the interviews, which results in about 93 000 words and 300 pages of interview text. We conducted each interview until we felt that no new data emerged in participant responses in accordance with theoretical saturation.

Data analysis

As Grounded Theory requires, authors adopted a deeply reflexive stance called methodological self-consciousness, which leads to scrutinize the data, actions, and nascent analyses (Charmaz & Belgrave, 2015). During interview and transcription process, authors noted themes and series of code that could be used in other interviews and future coding of the study (Corbin & Strauss, 2014). Authors spoke regularly to exchange views about data interpretation, codes and themes and especially literature and theoretical concepts. We used “blended Grounded Theory” approach for interpretation of transcripts interviews (Locke, 2000). Grounded Theory seems to be the most suitable method to explore our topic. For main authors, this method is aimed to develop a new theory which appear during data collection and analysis rather than exploring existing theories. Grounded Theory appears to be the most suitable to theorize an underexplored subject. The research meant to “bring a new perspective and new theorizing to an established theoretical area” (Locke, 2000). UA is a common subject of research in medicine literature but mainly about overcrowding of ED. The HOD perception of UA is not well known. In a management perspective, it represents a possible new area of research, in particular from the perspective of values theory.

To code the transcripts, we used Strauss and Corbin’s guidelines for Grounded Theory research (Corbin & Strauss, 2014). Authors summarized each transcript in shorter phrase. Authors read the transcripts and noted open codes related to the perception of UA and values in healthcare system and public organization. Then we braked down the data, compared between them and groups data in specific codes to be identified for further analysis. During this process, we developed new codes, combined or dropped some with literature concept and

theoretical framework construction. Quickly during interview phase, authors were convinced that values theory in healthcare was central in the evaluation of deep meaning of UA. Authors read transcripts after reading main literature concept and categorize summarize transcripts in codes: public service mission, academic visibility i.e. to describe effect of UA on HU, we observed a conflict between two main directions: promote or limit UA, sometimes in the same HU. To explore this conflict, authors proceed in the same way with encoding transcripts.

Findings

Head of department values

A prime value and 4 co-values emerged from the conducted interviews. The prime value is commitment to the public mission service. HOD are attached to the public interest and feel a responsibility towards the population "It is part of a tradition that we are trying to keep alive and which is that the patient comes first" (E9-101). The mission is to assume their role of care for the population and society "We are regularly called for [advice] and we try to manage, because we feel we are doing our job" (E11-21). The management of UA is a tool that serves this value: "I think that everyone from the HOD to the general director of UHC is aware that we are there to take care of patients in the ED, so there is no discussion" (E6-89).

Co-values in the sense of Jørgensen and Bozeman (2007) are universalism, academic excellence, peer recognition and intellectual interest. Universalism implies that the public hospital is made to welcome all patients, even if the patient does not only belong to the discipline of speciality "it is my role of public HU yes" (E5-32), "I do not do triage" (E13-71). The management of patients with social problems is a component of this. These patients are very dependent, making it difficult for them to return home and therefore to leave hospital. "If you do not take care of social problems, you don't take anyone else in. And anyway, these people don't have to stay in the ED either [...] the state of mind is to say the patient is in [the hospital] so [...] his place is clearly not to stay in the ED so someone has to take him" (E6-101). Academic excellence in research and expertise is working for the benefit of population and need effectiveness: "everyone has cohorts of ultra-specialized patients" (E12-168) and "we are the only HU [...] where we have daily requests for many patients with [...] proven pathologies [...] where we really have something more to offer" (E11-68). Recognition by peers or stakeholder is an important co-value for HOD. It can be done through scientific production "The very high level of scientific expertise allows for acedemic HU" (E5-15) or

the dynamism of projects for the community "I need recognition too. I try to help people to do scientific work, to show the community that we are active, that we are trying to build a project for the organization, that we are leaders, that we are trying to offer support. I try, in our specialty, to show the contribution we can make to empowerment.... " (E11-108). Thus, the UHC is presented as a reference which benefit to the population "we must consider the UHC in a region, like the aircraft carrier. It is the center of reference, it is where the most advanced care is provided [...]. For me, it is for the good of everyone, not to be elitist." (E14-181). Intellectual interest is an important value, especially in a UHC where patients are selected and present complex or rare pathologies "it spices up the activity. I'm not saying that it's always the same thing, but it's always the same principle, and having another pathology from time to time doesn't bother me. There are also rare diseases, which require a lot of time. You don't make the diagnosis just by looking at the patient, there is a work of bibliography" (E13-293). This interest can also be technical and can be enhanced "intellectually or by the interventional medical act carried out" (E10-147).

HOD values affect the organization (E.H. Schein 2010). They are also subject to environmental constraints (Schilke 2018).

A constraining environment of which unscheduled admission is a part

The public hospital environment is a source of multiple constraints such as budgetary restrictions and lack of medical and nursing resources. UA, by their very characteristics, are an additional constraint.

All the HOD observed a constant decrease in budget allowed, which is causing major operating difficulties. "We are at this point because of the policy implemented over the last 4-5 years to control the payroll and therefore to close beds. Clearly, the situation has deteriorated." (E7-108). Thus, bed closures, such as in geriatrics or internal medicine, cause significant tension in beds for UA "there has been a reduction in the number of beds in certain HU, particularly in internal medicine [...], from about 80 beds to something like 40 beds, there has also been a closure in geriatrics, about 40 beds [...]. All of this means that these beds are no longer accessible downstream from the ED. We've been working [...] on the need for beds, and we've come up with a figure of between 40 and 60 beds of downstream ED that are missing" (E1-9).

In addition, there is a lack of human resources. Physician number had never been so low in France "we have no more doctors. I have gone from 9 to 6 physicians and in one month, I will be at 5. And I went from 8 students to 2 students." (E1-195). As a result, the HOD observe that the physician staff is very busy with a heavy workload: "It has to work well [...] and in fact, I find that this is not the case at present, because there are not enough of us. Every time we're called, it's an overload of work" (E11-144). In this environment of scarcity of resources, competition is tough with the private sector and UA suffers from a lack of attractiveness "we have a problem of attractiveness which is clear, but that's all internal medicine HU, particularly those of our UHC in any case. Multi-skilling downstream of the ED is not attractive" (E6-121). The profession of nurse in the hospital would no longer interest the younger generations: "the beds were opened, then some were closed, because of the staff. There are major concerns about recruiting paramedical staff, because it no longer interests the careers." (E1-19). The arduousness of the work is highlighted, particularly for HU that performed UA: "It's difficult for nurses because it's hard, physically hard. The ratio is the same as in other HU" (E7-104).

UA via the ED represent an increasingly heavy workload. "There are patients who are increasingly heavy [...] there are weeks when there are very heavy patients [...] with a lot of nursing care, patients with behavioral problems." (E9-85). They present complicated social problems "it's a few patients with a really urgent medical problem and a lot of patients with social problems via the ED" (E5-19). These patients with social problems often block beds, preventing HU from carrying out the scheduled activity "Yes, it's a bad experience. These are patients that we keep where we do nothing. On the one hand we have patients with programmed care and on the other hand we have those patients who stay for a very long time and embolize a bed" (E4-37). Patients have co-morbidities that make it difficult for them to be managed "there are a lot of HU that hate that. They hate it, it's a bad experience, because it's experienced by these HU as an overload of work. They prefer programmed patients. Imagine the medical HU they do a [hyper-specialized activity]. It's simpler to have a patient scheduled for a check-up rather than being with a patient who is [...] a little borderline [...] a little poly-pathological" (E8-72) and requires complex medical management. "The patients who have been treated have already come. They have a file, we know the history...the relationship is already there. The patient in the ED is not known, there is the family, we don't know the file, everything has to be done again, often these are patients whose pathology is not simple. We have to think more" (E2-59). In a UHC where all the specialties are represented, these patients

have difficulty to find their place "In addition to the problem when it is patients with poly-pathologies, we try to see with other HU but the other HU don't take them" (E4-53) and "It seems to me that the frontiers are often blurred as to which area a patient falls under. If there is someone with multiple pathologies, some HU do not want to take patients from the ED" (E9-45) or "we are not in the best position to treat multiple pathologies. I think this is quickly becoming a problem [...] It's quickly a complicated job and I think we're too specialized, especially in our discipline" (E10-167).

The ED patient is an unexpected patient who comes to upset a well-organized organization. "The UA in our HU is about 2-3 patients a day [...]. And of course, it completely disrupts our activity. Because our main activity now is essentially scheduled activity" (E4-13). This UA is then experienced as a constraint by some HU: "When you don't have an appetite for emergencies, for taking care of the emergency, you don't want to disorganize your day" (E3-67). And this multi-skilling necessary for the care of these patients is not valued "today, multi-skilling works is the opposite of excellence. Being multi-skilling is anything but a quality in the age of ultra-speciality, in the age of the five-legged sheep. It's a pity. But that's the way it is" (E9-136). For all these reasons, UA is seen as a constraint that causes difficulties "those who are most in difficulty are those who do the most unscheduled care. Because unscheduled care is the most burdensome." (E2-15).

All these environmental constraints contribute to the stress on HOD values.

The conflict between values according to Schwartz

The diagram in figure 2 summarizes the conflict between the values according to Schwartz's model. We have observed that there are two types of conflict: between self enhancement and self-transcendence and between openess to change and conservative values.

Self enhancement is expressed for the HOD through hyper-speciality, which is a source of recognition and satisfaction: "We are in a UHC, I am an expert centre [...], a reference centre [...], we have been labelled for a competence in this area, if it is now to do general medicine, I don't quite understand. I'm labelled, I'm paid, I'm supposed to be involved in research and teaching and so on in specific areas. I'm not saying that I can't participate in the joint effort, but I'm not here to do general medicine or internal medicine. That's not why I'm here" (E13-245). Academic visibility through research is also a value of affirmation of self-singularity:

"whoever wants to become an academic will have to choose a niche to be recognized in his discipline. For example, in our team we have a young person who is excellent but who will have to find a research lab, a research... theme, but it will have to be extremely specific. All his work, all his publications, all his readings, all the patients he is referred to, will be this little niche" (E11-140). At the opposite on Schwartz's circle, self-transcendence is the expression of universalism as a value of challenging oneself "About ten years ago [...] there were noises, which were very painful for the staff, that we were taking care patients that nobody wants. Because the policy in our HU has always been: one request, one place, one admission without consideration of anything else. We've tried to turn that into a quality rather than a defect. And since then we haven't heard that kind of noise, which is a good thing" (E9-57). Admitting patients from the ED is presented as "a positive value. It has been written and repeated many times. [...] It is not without tension, but it is a deliberate policy." (E9-77). Under the constraints of the environment, the reaction of HOD is to move in one direction or the other depending on the scale of values that motivate himself. Thus, a HOD, which promotes the care of complex patients in a global manner, is expressed as follows: "I think you lose competence when you're over-specialized". [...] We need specialized HU with a 360-degree view" (E11-128). On the other hand, other HU are moving towards hyper-specialization, allowing self enhancement through special care: "Once again, we are a UHC, we provide specialized care. The physicians remain here to provide this care. If tomorrow we impose on them unscheduled patients... " (E14-65).

The openness to change represents the uncertainty of the complex patient. This activity is complex and time-consuming, but the satisfaction is important "I don't like to use the term poly-pathological. The majority representation is that it is not necessarily someone who is medically interesting, whereas the more illnesses there are, the more it is a challenge to balance, in particular. This is also a way of valuing the work and also of valuing the diagnosis, because there is a great deal of diagnostic work to be done and all the therapeutic thinking and trade-offs that need to be made. These patients, whom colleagues do not necessarily want to take care of, will arouse curiosity and interest. It's just a matter of what kind of glasses you look at him with" (E9-113). This multi-skilling is then presented as an advantage, a skill to be promoted "I know that the students and especially the physicians (...) are very happy to have done an assistantship [in my HU] because they are much more comfortable in their practice, they have learned a little bit to manage in situations that are a little bit hot" (E6-129). On the other hand, conservative values focus on the scheduled

admissions of patients and pathologies known by the staff "it is much easier to manage a patient from his own discipline. Already for the purpose of scheduling, the patients arriving in the HU in general are able-bodied people, they have treatments, check-ups and they come out. It's less work for the nurse, it's less work for the staff, it doesn't have the same workload at all" (E1-52). Scheduled activity then occupies all the staff, to the detriment of UA: "I imagine that they put all their energy into organizing scheduled care and, as a result, there is no longer any workforce to look after the other patients" (E9-180). Under the effect of the environment and in particular of the complexity of situations, some HOD will be afraid of this multi-skilling "I can also understand that some doctors are no longer comfortable enough, since they are hyper-specialized. There's that fear too. It's not knowing how to manage" (E3-171). Constraints can also be very strong, leading to crises within HU. Thus, if the workload is too great, "people leave, the younger ones. We had a major crisis this summer [...] because the younger physicians feel that they don't have to work from 8 a.m. to 6 p.m., that they don't have to be overworked, that they have to have recuperation days.... and therefore, managing unstable patients coming from the ED is very complicated for these people" (E1-56). This is at the origin of a real problem of attractiveness for the HU that admit patients from the ED "we have a clear problem of attractiveness [...]. Multi-skilling downstream of the ED is not attractive. "» (E6-125).

According to Schwartz, the environment and in particular the constraints of UA are at the root of this conflict of values. Universalism and uncertainty are values in conflict with hyper-speciality and tradition.

Discussion

Our study explore perception from HOD about UA with Grounded Theory which permit to contribute to public values theory. In managerial studies, investigate public values permit to understand organization of public services as their principles, norms and practices. In this study, we found that values from HOD presents conflict between them surrounding by UA in UH, in the healthcare system of a UHC. Our findings suggest also managerial solutions and allow us to better understand relations between HU and ED through UA.

HOD values correspond to the values of public organizations (Jørgensen & Bozeman, 2007). The findings outlined in this study indicate that HOD had a great interest for public service mission. The prime value, commitment to the public service mission, correspond to "public service mission" in the first group of public values which concern public interest. We have chosen to describe co-values among the associated values. Co-values better represent the relationships between values. Indeed, there is a hierarchical and a relationship between the prime value and co-values. These co-values also make it possible to specify the meaning of the prime value. These co-values are universalism, academic excellence, peer recognition and intellectual interest. Universalism correspond to the first group of public values too. It corresponds to altruism and human dignity and permit to precise the prime value in this way. Academic excellence corresponds to effectiveness and productivity in the fifth constellation, intraorganizational aspect of public administration. Peer recognition represents competitiveness and/or cooperativeness by stakeholders in fourth constellation, relation with environment. Intellectual interest corresponds to enthusiasm and innovation in fifth constellation. All these co-values are attached to and specify the "public service mission" prime value. Altruism is common and usual. Academic excellence permits to offer advanced care for public interest. Peer recognition and intellectual interest permit also to be attractive and keep physicians and nurses in HU. Without them, none HU could work to serve their public mission. Our findings are conforming with Stoker's proposition (Stoker, 2006). The five elements of a public organizations are "a performance culture," "a commitment to accountability," the guarantee of universal access," "responsible employment practices," and "a contribution to community wellbeing".

The identification of values in public organizations is difficult and several approaches have been proposed (Fukumoto & Bozeman, 2018). They can be distilled from official documents and records (Baehler, Liu, & Rosenbloom, 2014), official statement from organizations (Wæraas, 2014), surveys of managers (Witesman & Walters, 2014), through participation of public (Nabatchi, 2012) and through conflicts or deliberation (Davis & West, 2009). Nabatchi and Davis identified the values of organizations through conflicts created by the presence of the public in services and the constraints of new public management (Davis & West, 2009; Nabatchi, 2012). In this study we identified the values of HOD in the context of the constraint of budgetary restrictions and resource scarcity but also the constraint of UA. We found that UA are an environmental constraint because they are a challenge for organizations due to their complexity and the overload of work they represent. This constraint allows us to identify

the values and conflicts between them. As other authors, we are convinced that pluralism of values is healthy and that conflicts between values are necessary for the formation and expression of the values specific to each public organization (Bozeman, 2007).

We propose an application of the Schwartz model and the conflict between the two main poles of values (S. Schwartz, 2012). Conflict between self-enhancement and self-transcendence represents the conflict between hyper-speciality and universalism. Conflict between openness to change and conservative values is illustrated by the conflict between uncertainty from complex patient and scheduled activity. This model is applied in a hospital around the AU and will serve as a managerial tool to improve patient pathways. Our theory can be validated using Schwartz's validated questionnaire to confirm our model with a different method.

Limitations

Our study had limitations. We explored the HOD with interviews. Because of their leadership position, they influence the strategical choices of the HU and the hospital in general. We cannot be certain that these values are shared by the entire staff: physicians and nurses. Future studies could valid this theory with complementary methods as focus group or exploratory survey.

Practice implications

The findings of this study indicate that conflict between two dimensions of Schwartz's circular model is underlined by UA. HOD choose ways that permit to serve public service mission to which they are attached. We propose managerial axes to improve the UA pathway: decrease the UA constraint, value unscheduled activity, give an academic visibility to HU who admit UA and communicate with UH to build a common culture with shared values. Hospital can decrease the constraint of UA with providing specific staff and more nurse and physicians. This activity isn't comparable to scheduled admission because represent a heavy workload. Recognizing this constraint can create a symbolic value to UA. Value could be heard to the sense of Porter and UA need a special and financial recognition from organization by allowing more resources to HU who admit UA (Porter, 2010). To give an academic visibility to UA, staff needs to promote scientific studies and publication.

Physicians and manager who managed UA should be implicated in hospital organization by suggesting and promote project and patient pathway with leadership (Kernaghan, 2003). Communication is a cornerstone of this new organization and was begin with this study. Staff from ED and HU need to understand each other's to share common values. Regular meeting from physicians and nurses from ED and HU about patient's pathway, presence from ED physician to morning report for medical record transmissions and meeting with review of medical records could be implemented.

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Figures

Figure 1: Schwartz Value circular model (issued from *Theoretical model of relations among ten motivational types of value* in An Overview of the Schwartz Theory of Basic Values, Schwartz S, 2012, 9).

Figure 2: Conflict between values according to Schwartz's model.