Due to changing policies, shifts in payment models, technological developments, and growing consumer pressures, the way medicine is organized is continually evolving (Light 2010; Timmermans and Oh 2010). The complexity of this evolution requires theories that integrate micro-, meso-, and macro-level factors to understand how change takes place (Scott 2004; Thornton, Ocasio, and Lounsbury 2012). What is missing from many extant theories is an account of workers' microinteractions during times of change (Fine and Hallett 2014), which is especially problematic when considering how large health policies are interpreted, negotiated, and implemented on the ground (Lipsky [1980] 2010; Strauss et al. 1963). In fact, some organizational scholars have called for “inhabiting” the study of institutions through explicitly theorizing, documenting, and analyzing the microlevel worlds of workers (Hallett and Ventresca 2006; Hallett 2010).

In this article, I analyze longitudinal qualitative data to show how a Medicare policy change affected hospice practices. I show that before the policy change—when organizational pressures are low—hospice workers are able to enact the interdisciplinary team, which combines the expertise of physicians, nurses, social workers, chaplains, administrators, and even volunteers. This combination of multiple forms of expertise is a direct challenge to medical hierarchies, which are organized around the dominance of physicians (Light 2010). However, when organizational pressures increase because of the policy change, hospice administrators put in place a new division of labor, and workers react by falling back on taken-for-granted medical logics that prioritize physicians’ authority.
By examining workers’ interactions under varying organizational contexts, I argue that workers draw on institutional logics to make decisions about care, prioritize work, and make meaning. Workers are always embedded in multiple institutions and find ways to reconcile tensions between logics. But during times of strain, workers adjust their configurations of logics to meet their immediate needs. In seeking to meet immediate needs, workers shift practices in both intentional and unintentional ways, reinforcing some logics over others in the process. These findings elucidate some of the challenges of sustaining team practice patterns in healthcare organizations, especially as rationalization makes financial concerns central.

BACKGROUND

Medicine is complex, shaped by many different (and potentially incompatible) institutional logics that stem from the larger social and regulatory environment (Greenwood et al. 2011; Quadagno 2010). Institutional logics are symbolic systems that make some kinds of actions and meanings appear to be logical to actors in the setting (Friedland and Alford 1991; Thornton et al. 2012). Institutional logics include assumptions about the world, values, beliefs, and routinized practices that can be seen in actors’ daily activities, such as how they divide labor (Troyer 2004), make decisions as individuals and in groups (Ocasio 1997), and classify persons and objects in their environment (DiMaggio 1997; Thornton 2004). Most relevant for this study, institutional logics are used by actors to assign authority, jurisdiction, and credit for work.

Institutional logics also play a pivotal role in organizational change. It is through conflicts, tensions, and openings between logics that new strategies of action are made available (Friedland and Alford 1991; Martin et al. 2017; Reay and Hinings 2004). Some studies have shown that when multiple logics exist, they will compete, and one will “win” over the other (Lounsbury 2002, 2007; Lounsberry and Rao 2004). Others contend that logics can and do coexist aside one another (Goodrick and Reay 2011; Marquis and Lounsberry 2007; Reay and Hinings 2009), even as they produce contradictory demands (D’Aunno, Sutton, and Price 1991). Contradictory logics can be held in “productive tension” with one another through actors’ maintenance of professional boundaries (Murray 2010). Given the differing views on the consequences of multiple logics, studies are needed to link the context of logics to their varying levels of compatibility (Greenwood et al. 2011) and the subsequent effects for actors.

Examining organizational change using the institutional logics perspective offers a complement to existing organizational theories. Studies of change in healthcare organizations frequently take a neoinstitutional theoretical perspective, focusing on the ways that healthcare organizations become more homogenous over time (Beckfield, Olafsdottir, and Sosnaud 2013; Scott et al. 2000). Through their attempts to gain legitimacy, organizations come to adopt the practices of others like them (DiMaggio and Powell 1983; Meyer and Rowan 1977; Powell and DiMaggio 1991). Extant neoinstitutional theories have been critiqued for failing to understand the microlevel (Hallett 2010) and focusing too little on change and variability in institutional practices (Greenwood and Hinings 1996). Additionally, studies of macro- and mesolevel change miss workers’ experiences of interpreting, applying, modifying, and implementing policies that do not always fit with the lived reality of the work (Lipsky [1980] 2010). A focus on how actors use logics under varying organizational contexts enriches understandings of the effects of policy change.

Microinteractions within Medical Work

How actors use institutional logics is structured by their previous experiences of professionalization (Dunn and Jones 2010; Lawrence, Suddaby, and Leca 2009). Professional statuses and the resultant divisions of labor become taken for granted; though during times of change, they can be challenged, creating the potential for conflict between workers (Martin et al. 2015). Abbott (1988) suggests that professional groups jockey for jurisdiction and authority over aspects of work, especially during times of transition, where it is not clear which set of abstract knowledge should be applied to the problem at hand. Innovation in work practice often involves redefining professional jurisdictions, requiring participation from professional groups, which reinforces their powerful role in shaping institutional change (Scott 2008).

Although the logics available to actors are structured by the institutions within which they are embedded (Battilana and D’Aunno 2009; Pache and Santos 2013; Wright and Perry 2010), actors do have partial agency that allows them to use logics as they are judged appropriate for the situation (McPherson and Sauder 2013; Voronov, De Clercq, and Hinings 2013). Much of the research on actors’
agency focuses on actors’ intentional actions, such as strategizing and advocating for change (Garud, Hardy, and Maguire 2007; Lockett et al. 2012). However, actors also exercise agency through their everyday work practices, which may be less intentional or strategically defined.

Workers’ actions in the face of change, both intentional and unintentional, are especially needed in the study of medical settings, where rationalization and deprofessionalization have been common for several decades (Haug and Lavin 1983; Light 2010; Ritzer and Walczak 1988). Because of changes in payment models and expectations for the work of medical providers, some have argued that medicine increasingly focuses on formal rationality and commercial interests over patient needs (Ritzer and Walczak 1988). Simultaneously, the power and prestige of medical professionals are challenged, leading some to argue that physicians are experiencing deprofessionalization (Light 2010). There is debate about the extent to which physician dominance is threatened, however. Some have argued that physicians fight against rationalization and find ways to continue to have professional dominance (Navarro 1988). The question of medical dominance is especially relevant in settings where we see increasing medicalization, such as end of life (Castra 2014; Field 1994; Ruggie 2015). The extent to which rationalization and deprofessionalization are present likely varies by context.

In this article, I ask, How does a macrolevel healthcare policy change affect workers’ practices in intentional and unintentional ways? Grounded in medical sociology and organizational theory, my focus is on the small adjustments that are made when time is short and only the basic minimum can be completed. To understand the nature of this change, however, it is critical to place hospice care within the larger institution of medicine.

**Medicine and Hospice Resistance**

Hospice is an end-of-life care option that emphasizes quality over quantity of life and comfort at the end of life (National Hospice and Palliative Care Organization [NHPCO] 2015). In 2014, there were approximately 6,100 hospice programs in the United States, providing support for over 1.6 million people facing the end of their lives (NHPCO 2015). The number of hospice organizations has grown in recent years, and the expected need for these services will increase over the next few decades as the U.S. population ages and more people wish to remain in the home as they near death (Stevenson 2012). However, hospice care has at times had a tense relationship with the larger institution of medicine (Lawton 1998).

Arriving in the United States in the 1970s, early hospices were formed as alternatives to conventional medicine, which was seen as too biomedically focused to meet complex needs at the end of life (Paradis and Cummings 1986). Medicare began paying for hospice in 1982 and has since become the dominant payer for hospice services. Since that time, there has been a trend toward integrating hospice into conventional medicine, especially as hospice has been shown to decrease costs at end of life (Risse and Balboni 2013; Stevenson 2012). Even given increasing integration into conventional medicine, hospice differentiates itself through its use of interdisciplinary teams. Essential to the hospice philosophy is the combination of expertise from medical and nonmedical professionals, including physicians, nurses, social workers, counselors, chaplains, and volunteers (NHPCO 2015).

In this article, I conceptualize hospice as informed by a mix of three institutional logics that exist at the organizational level and are enacted within workers’ interactions and everyday work practices. The first two logics are professional logics from medicine and holistic care, while the third is a managerial logic. Although these three logics are likely present in most healthcare settings, recent reforms and concerns over profitability (Iglehart 2009) make hospice a particularly useful case for understanding change processes, as incompatibilities between logics are more readily observable to both participants and researchers during times of strain.

**Medical logic.** Although hospice was formed as an alternative to conventional medicine, logics stemming from conventional medical practices still enter into hospice work through the prioritization of medical tasks and authority given to medically trained actors. The medical logic emphasizes scientific developments (Bloom 1988; Dunn and Jones 2010) and the importance of diagnosing, explaining, and treating the physical bodies of patients (Rosenberg 2007). This combination of professional knowledge and the application of science gives physicians and nurses the most authority under the medical logic.

**Holistic logic.** The holistic care logic focuses on identifying gaps in conventional medicine and understanding complex individual patient needs (Patterson 1998; Rosenberg 2007). It attempts to
integrate the “lifeworlds” of patients into medical care (Barry et al. 2001; Mishler 1984). Hospice holistic tasks—especially related to seeking acceptance of death, exploring spirituality, tending to the whole family, and treating psychosocial problems (Mount 1993)—are largely under the authority of the social support staff, consisting of social workers, counselors, and chaplains.

Managerial logic. Healthcare organizations, of all sorts, have become more concerned with containing costs and profitability, especially with the growth of corporate control (Mahar 2006). The increased emphasis on costs means that healthcare professionals are pushed to develop managerial skills in addition to their health-related training (Scott 2008; Waring and Currie 2009; Witman et al. 2011). Under this logic, workers are expected to follow bureaucratic procedures (Jackall 1988), often coming at a sacrifice to meaningful emotional experiences with patients (Rodriquez 2011), and focus on more readily controllable aspects of care, such as medication lists (Livne 2014). Under the managerial logic, authority is given to administrators and managers who bureaucratically oversee costs of care and make staffing decisions.

As hospice workers in this study encountered patients and one another, they drew on these three logics to make decisions. Their decision making was not a straightforward application of one logic over another, however. Almost all decisions involved a mix of logics as well as trade-offs between countervailing logics (Light 2010). A classic example of this comes from the study of “dual lines of authority” in medicine (Allcorn 1990). Because of the expansion of management practices in healthcare settings, physicians and other have been subject to two different sets of authority (Rundall, Shortell, and Alexander 2004). One comes from clinical expertise, while the other is derived from managerial needs. Under these dual lines of authority, every decision made is partly about clinical needs and partly about administrative needs. To fully understand healthcare decision making, it is critical to examine how both medical and managerial logics structure interactions. In this article, however, I expand beyond just medical and management logics to also consider how holistic logics enter into workers’ interactions and practices.

Medicare Policy Change
The Medicare policy change that took place during this study was meant to curb costs stemming from long hospice stays. This change came as a result of a Medicare Payment Advisory Commission report that claimed that the Medicare benefit “contains incentives that make very long stays in hospice profitable to the provider, which may have led to inappropriate utilization of the benefit among some hospices” (Centers for Medicare and Medicaid Services 2009:348) and recommended that physicians become more active in direct care. In response to this report, Medicare began requiring a hospice physician to see every patient whose hospice enrollment extended beyond 180 days, causing many hospices to change their practices and procedures to meet the new requirements.

DATA AND METHODS
Ethnographic data collection for this project began in 2009 when I became a hospice volunteer at a midsized, for-profit hospice, here called Rose Hospice (pseudonym), in the southwestern United States. Rose employed approximately 45 staff and provided home-based care to approximately 100 patients at a time. Medicare paid for over 85% of care provided to Rose patients, which was typical for Medicare-certified hospices in the United States (NHPCO 2015). From my first meeting with the volunteer coordinator, I was overt about my status as a researcher. In fact, the volunteer coordinator, here called Robin, became a key informant as the study progressed. Entering as a volunteer permitted a “side-in” approach to access (Chambliss 1996), which helped alleviate some of the feasibility problems of research in medical settings. All research was approved by the University of Arizona’s institutional review board.

As a volunteer and researcher, I attended weekly meetings during two time periods: a secure period from October 2009 to May 2010 and a strained period from January to September 2011 (Figure 1). These meetings were called interdisciplinary group meetings (IDGs), and they included all major team members (i.e., physicians, nurses, social workers, chaplains, counselors, the volunteer coordinator, and administrators). Nurses generally directed these meetings by giving updates on a set of patients, asking for more information from other team members, and passing around paperwork. These meetings lasted between one and four hours. Throughout and between both time periods, I also observed workers’ interactions outside of meetings, especially social workers, nurses, and administrators. While observing staff interactions, I took extensive notes on issues discussed, informal interaction rituals, body language, and assignment of tasks and credit. In total, I spent...
almost two years observing hospice work for 3 to 10 hours per week, producing more than 1,000 pages of field notes and over 12 hours of voice memos that synthesized emerging themes and questions.

Data from observations were supplemented by semistructured interviews with 41 staff members, collected in 2010 through 2012. I recruited interviewees first from the ethnographic site, Rose Hospice. I invited all patient-facing workers and their supervisors to offsite interviews. Of these, the physician medical director, almost all of the nurses (seven out of eight), all of the social support workers (total of nine), all of the supervisors (total of two), and a small sample of certified nursing assistants (6 out of approximately 18) agreed to be interviewed. I then expanded the sample of interviewees by asking each Rose participant to pass along my recruitment information to hospice workers in other organizations within the same city. Twenty-five (61%) of the total sample worked at Rose Hospice. The other 16 respondents (39%) came from six other hospices and included four additional medical staffers, seven additional social support workers, three administrators, and two certified nursing aides. Interviews from non-Rose staff were analyzed separately from Rose staff to determine if differences in themes existed. No major themes differed, so the two sets of interviewees were combined in this article.

My interview sample comprised workers most frequently involved in patient care, including nurses, social workers, counselors, and chaplains. Selecting interviewees this way ensured that I had a diversity of experiences represented while maintaining a focus on those who provided patient care. Staff members left out of this analysis included marketers and offsite managers. Marketers and offsite managers tended to administrative concerns and did not have direct patient access. My focus was on the division of direct care tasks, so the exclusion of marketers and offsite managers did not fundamentally alter my findings.

In the interviews, I asked a range of questions about working in hospice. Most relevant for this article, I asked about times where coworkers were helpful, times that coworkers made the work more difficult, and things that got in the way of work. Although I did not explicitly ask about the division of labor, workers told stories that revealed issues within the process of allocating the work of hospice. Interviews lasted between 38 and 87 minutes, and were all audio recorded and transcribed. I also took notes during the interviews about respondents’ nonverbal communications and facial expressions.

The analysis of both ethnographic and interview data was an iterative process. I identified themes as they emerged, took extensive notes to elaborate ideas, and refined my conceptual and theoretical ideas as I went along (Charmaz 2006). Similar to Burawoy’s (1998) extended case method, this allowed me to

![Figure 1. Timeline of Study.](image-url)
refine my approach as new questions emerged. I also used an abductive logic: I entered into the setting with expectations about how work would be carried out, but as I discovered problems with my expectations, I worked backward to explain these observations and develop new theory (Van Maanen, Sorensen, and Mitchell 2007). In particular, I entered into this study assuming that the interdisciplinary team approach permitted a more democratic work process than conventional medical settings. As the policy change went into effect, I found that this expectation did not accurately reflect the new division of labor. I coded ethnographic field notes and interviews by identifying disagreements between staff, discussions of the division of labor, observations of how tasks were allocated, mentions of changes to hospice, and giving and taking credit for work.

I used ATLAS.ti to manage coding and compare and contrast findings across time periods. As my interpretations were taking shape, I also checked with key informants to ensure that my understandings of the situations reflected their experiences. Data presented here represent common patterns in the setting and stand in for multiple possible interactions.

RESULTS
Throughout this section, I show that the Medicare policy change had both a direct and indirect effect on Rose Hospice. In terms of direct effect, administrators at Rose made several changes to the staffing model and team meetings. These changes made management priorities more central. In terms of indirect effect, news of the policy change created a sense of fear about the future of hospice, which then pushed workers to further adjust their everyday practices in ways that undermined the interdisciplinary team. The first section will describe how the interdisciplinary team worked during the stable period before the Medicare policy change was announced. The next section will focus on the direct changes that centered the managerial logic; the final section will show how workers’ practices undermined the team. I will show that while this Medicare policy change may seem to be minor in scope, the changes in practices fundamentally changed how the team worked together.

Stable Period: Interdisciplinary Team Practice

Hospice was founded on interdisciplinary collaboration between professionals from diverse medical and nonmedical backgrounds. In the ideal hospice situation, whole-person care came from engaging the knowledge and perspectives of multiple professionals but also pushing staff to think beyond their own professional boundaries. This ideal could be observed at any team meeting at Rose Hospice during the stable period of this study. Nurses typically led these meetings and brought up both medical and nonmedical issues as they discussed patient needs. Other team members participated as needed to create a holistic vision of the patient situation:

Josephine [nurse] discussed her latest meeting with a patient, talking about his emotional state and his relationship to his family. After her story ended, others added details about this patient and his family. Ramon [social worker], Michelle [counselor], and Robin [volunteer coordinator] all added information about the patient’s social and emotional well-being. The medical director did not ask any questions. Instead, he looked at his paperwork and took notes. (field notes, IDG)

In this instance, team members enacted interdisciplinarity in that they each brought their disciplinary training to the discussion, but they did not isolate their comments to a single discipline. Crucially, Josephine fully integrated the social and family needs into her discussion of the physical state of the patient. Discussions like this relied on medical logics when the nurse listed diagnoses but quickly transitioned into more holistic logics when the nurse integrated emotional states and complicated family relationships. Social support team members frequently participated to add information and answer questions, but the medical director almost always remained quiet. In this stable period, his role was primarily as a consultant for nurses when they needed advice about additional treatments, pharmaceutical changes, or underlying pathologies.

Physicians on the hospice team took a different role than they did in most other medical settings, where doctors had ultimate authority. Observations of hospice team decision making showed that physicians’ authority was more symbolic than realized in the stable period. One physician explained, “The traditional physician role was show up, shut up, and sign these forms” (interview, Dr. Lewis, physician). In practice, this meant decisions were made by the team and the physician signed off on those decisions, drawing out information to justify a decision made by the group:

The nurse said that because the patient’s only symptom was confusion, she was not sure if he could continue to qualify for hospice, but wanted
him to stay on service. She asked the doctor what he was going to write in the report. The doctor looked up at her, smiled, and then asked additional questions about cognition, self-care, mobility, feeding, and physical symptoms. It appeared that he was trying to answer the questions on the form in a way that would keep the patient on service, as was the preference of the nurse. He passed the form back to her for approval before signing. (field notes, IDG)

This exchange was common and illustrates the ways that commitments to patients were prioritized over administrative requirements. The nurse perceived the patient to be best served by staying enrolled in hospice, so the team worked together to make sure the documentation supported that decision.

The original ideal of hospice included professionals working interdependently without strong formal medical hierarchies that privileged physicians or clinical managers. Medical and holistic logics were complementary in care decisions, and managerial logics remained mostly in the background. While this organization of team decision making was not without problems, it did deliver on whole-person care as it was defined by the hospice philosophy.

**Strained Period: Changing Management Priorities**

Management practices quickly changed after the Medicare policy change was announced. Although this particular policy change was highly publicized, changes to Medicare policies were not new to hospice. One long-time hospice nurse described the history of Medicare changes:

> They tend to be financial-focused changes and regulatory-focus[ed] changes. It’s very seldom that I see a new regulation coming out of Medicare that I can look at and say, “Oh, that’s going to help my patient.” It seldom has anything to do with the actual patient care. And that is very frustrating because these regulations that are either money-driven or regulatory are very time-consuming. And that puts a huge burden on the nurse, and it directly impacts the ability to provide care to the patient from a time management standpoint. (interview, Sally, nurse)

Even though Medicare changes were common, some workers were especially concerned about this policy change because of the level of attention it was getting from the news media. One administrator announced the Medicare change during a staff meeting:

> Nickie [general manager] mentioned that Medicare changes were coming down, but that she didn’t have all the details yet and did not want anyone to worry about it yet. Another administrator mentioned that she saw hospice on the news the night before as being threatened by more audits. She said that the news showed people picketing. Michelle tried to reassure the others by saying that [Medicare] needs to understand how much less expensive hospice is. Others agreed but said that they would just have to go along with the changes and when the patients were all in nursing homes [Medicare] would see just how wrong they were [about costs of hospice vs. nursing homes]. (field notes, all-staff meeting)

This policy change was perceived to be dramatic enough that it prompted the owners to change Rose Hospice’s management structure. While the manager during the stable time was trained as a nurse (Nickie), each of her successors were management trained and had no clinical experience. Each business-focused manager came with a new plan for cutting costs. Often the cost-cutting measures included reducing social-support personnel. Sean, a chaplain, responded to an interview question about feeling overwhelmed by saying,

> I think—yeah, I will say that over the last month or, you know, with the changes that’s happened here…. They’ve clearly been trying to cut corners in terms of staffing, which I understand from a bureaucratic perspective, but in terms of what we’re supposed to cover, it is pretty overwhelming. And, also the tension of the fact that I really feel called to being in personal relationships with people, instead of this [paperwork]. (interview, Sean, chaplain)

The change in management resulted in one chaplain being laid off and Sean going to part-time. The caseload did not decrease, however, so Sean transitioned some of his in-home visits to phone calls. Additionally, because Rose Hospice required that a chaplain be available 24 hours a day, Sean could be called upon at any time to assist.

Another way that management logics became more prominent during this period was a shift in enrollment practices. The focus became on enrolling the “right” kinds of patients, which appeared to
be those with a clear prognosis and who would not be expected to live beyond the first 180 days. This also meant that those already on care were at risk of being removed if there were concerns that they would not continue to meet Medicare guidelines:

The patient has “failure to thrive” listed as their diagnosis. Dr. Lewis said he didn’t like this as a diagnosis and wondered if it could be changed to COPD [chronic obstructive pulmonary disease]. He verbally went through the medication list and asked questions about if each was still necessary. The nurse didn’t respond and it appeared that he was asking himself these questions aloud. He then asked the nurse if she thought the patient was still appropriate and when she said yes, he said “Well, we have to justify that now—how is his blood pressure? Any change in symptoms? Anything to justify this?” After a prolonged conversation, the doctor looked to the administrator and she said that Dr. Lewis should see the patient himself to make sure he was still appropriate. (field notes, IDG)

Because of the change in enrollment practices, the census went down, creating anxiety for some workers. For instance, Michelle (counselor) entered a team meeting, looked at her paperwork, and said, “Whew, 56. That’s an all-time low. Has ‘El Capitan’ [general manager] seen this yet? I’m kind of freaking out” (field notes, IDG). The manager then decided that social-support workers were to replace 10 of their patient-facing hours with marketing activities. Additionally, Robin (volunteer coordinator) had her hours reduced from 40 to 32 per week; 24 of those hours were to be spent coordinating volunteers, while the other 8 hours were assigned to marketing. This was not enough time to complete all essential work, so upon visiting Robin several weeks into this transition, she told me, “This week I was finally able to only work 35 hours…. that means I only volunteered three hours of my time to the company” (field notes, office visit).

Others echoed this frustration by revealing that they strongly disliked the new marketing requirements but put up with them because they valued time with patients. However, new requirements put time with patients directly at odds with managerial logics that prioritized marketing. A chaplain at another hospice in the same city described his company’s approach as similar and noted,

So frankly a whole lot of my time now is going into [paperwork and marketing], and I’m getting to see people about one third to a quarter the number of visits I was able to do before, which is disappointing for me. I’m not happy with that. (interview, Don, chaplain)

Administrators responded to the Medicare policy change by immediately making changes to the management structure, reducing staffing hours for social-support workers, refocusing some staffing hours on marketing, and asserting more control over enrollment decisions. These changes made the managerial logic more present in everyday hospice decisions and could have threatened the authority of all clinical staff. If that had happened, this would be a clear case of rationalization pushing clinical care to the margins. However, the next section will show that physicians’ authority was shored up during this time—not challenged. In fact, managerial and medical logics fused, pushing out the holistic logic.

**Strained Period: Undermining Team Practices**

In addition to creating new managerial concerns, Medicare’s change in policy reemphasized the importance of medical care for hospice patients. The new policy required physicians to spend more time in patient contact, especially when patients were enrolled longer than 180 days. This moved authority from nurse case managers to physicians. One physician explained the difference:

And then there’s a lot more home visits, a lot more direct [contact], from a medical director or physician point of view. It’s involved a lot more patient visits, and that’s mandatory. So in some respects it’s good because then I know who the patient is…. So that, in a way, has helped in some respects. But that has taken a little more time. (interview, Dr. Clark, physician)

Team meetings, which were led by nurses in the stable period, came to be dominated by physicians, who directed the conversation and often spent a great deal of time examining medication lists to identify medications that could be discontinued. For example, during one team meeting, the physician recommended ending an expensive heart medication: “I don’t know what we are trying to save their arteries for” (field notes, IDG). The assumption was that because the patient was already at the end of life, these preventative medications were unnecessary costs.
Because meetings were already long, adding this task meant that team members lost patience for anything that did not immediately seem relevant. During one meeting, Josephine (nurse) tried to re-focus the conversation on the nonmedical needs of her patient, only to be ignored by the physician and chastised by another team member who appeared to be frustrated by the late hour:

The doctor reviewed the paperwork while the nurse discussed the patient’s wishes and recent conversations with his primary care provider [PCP]. The nurse expressed frustration that the PCP didn’t seem like he really cared about the patient’s wishes. The hospice doctor didn’t respond to these comments, but continued to ask questions about weight. The nurse then tried to integrate information about the patient’s early life [history of illicit substance use and work as a dancer] to contextualize the patient’s wishes. The nurse kept coming back to her disappointment with the PCP’s behavior. A counselor finally interrupted to comment that they were “speeding right along.” The nurse apologized and then moved on. (field notes, IDG)

These gentle reminders to limit ostensibly unnecessary information became common during team meetings in the strained period. Even social-support workers, whose jurisdictions prioritized nonmedical information about patients, were frustrated by the length of meetings and cut discussions of nonmedical information short. One social-support worker often lamented the move away from truly interdisciplinary work, but her actions showed an unintentional realignment with medical logics.

These shifts in practice also changed the type of care patients received, especially through defining quality of life primarily in terms of physical symptoms. This was made clear by the following team meeting, where the counselor argued for an expansive definition of quality of life, while an administrator and the medical director were interested only in a medical definition:

The nurse called the patient “another casino gal,” and the group started joking about putting together a hospice bus to the casino. The physician joked that if the patient is well enough to go to the casino, they probably shouldn’t be on hospice. After several minutes of joking, Michelle [counselor] said that going to the casino is a quality of life issue for some of these patients. She said she wanted to “defend their choice” on how to spend their last days. The nurse and the medical director did not respond to Michelle’s comment. Instead, they then started discussing the patient’s medications. (field notes, IDG)

While a truly interdisciplinary discussion of this issue may have resulted in acknowledgement of casino visits as a quality-of-life issue, this interaction shows that Michelle felt the need to chastise her fellow team members for their judgment of patient activities. She made her point, but then the medically trained team members quickly moved on to topics that were clearly within the medical jurisdiction, largely ignoring Michelle’s comment. Michelle expressed resistance to their medical characterization of the situation, but because of the shift in how meetings were conducted, the physician moved the conversation forward without seriously considering Michelle’s point. This shift in team discussions became common in the strained period.

The team dynamic was also undermined because social-support staff began to feel sidelined in care decisions. Sean (chaplain) called the social-support team the “auxiliary to medical care” and explained that this exclusion reflects an understanding that medical care was essential, but holistic care was an “added benefit” of hospice (interview, Sean, chaplain). This often meant social-support workers were pushed to the margins of hospice interactions:

After the meeting ended, the doctor and clinical coordinator cornered Mindy [social worker] to ask about a patient’s condition. Dr. James and the coordinator kept asking the same question over and over again. Mindy first tried to answer the question, but didn’t know enough about the medical procedure to give a satisfying update on the patient’s condition. They asked again. Mindy then said that they should check with Cheryl, the nurse. The coordinator said she would, but then asked another question about the procedure. After at least three minutes of this, Mindy finally put her hands up and said, “I don’t know. Don’t ask me, I’m not a nurse!” They both then chuckled and the coordinator said, “Well, you should know.” (field notes, IDG)

By focusing entirely on the medical aspects of care—even as they interacted with someone who admitted she was not familiar with the medical procedure—the doctor and clinical coordinator pushed the social-support worker to the point of making the prioritization of medical care explicit in their interaction.
Mindy was visibly upset by this interaction, and although her work with the patient might also be relevant to the discussion of his recovery, her expertise was not part of the discussion.

One result of social-support workers’ marginalization was a lack of communication when major patient changes took place, such as the removal of patients from hospice services:

The nurse mentioned that this patient had gone off care. Several people around the table were visibly surprised and the conversation came to a stop. Keith [chaplain] looked shocked, sat straight up in his chair and said, “What, who? Who is off care?” The nurse repeated the name of the patient, and Keith commented that he did not know this person was coming off care. The nurse said that the patient was a “cranky old woman, but she wasn’t a dying cranky old woman” and therefore she had to come off care. Several team members seemed upset that the woman came off care and they were not told. (field notes, IDG)

Incomplete membership meant not only that social-support workers were not included in decision making but also that they were not even informed when decisions were made by others. Because of fears stemming from the Medicare changes, patients being removed from care came up more frequently, which further exacerbated the divide between the medical and social support staff, reinforcing that medical logics were the basic minimum, even in hospice care.

The Medicare policy change intended to give physicians a stronger role in hospice care. Given this, it may not be surprising that the medical logic became more prominent after the change. However, the ostensibly unintended effect of the Medicare change was that administrators became more concerned about costs and properly justifying each patient enrollment. These concerns prompted more active guidance from administrators, who then relied heavily on medical logics to justify decisions that complied with Medicare and kept costs low. In this section, I have shown that the result was that medical and managerial logics fused together to push out the social-support team members, effectively undermining the hospice interdisciplinary team.

DISCUSSION

As the institution of medicine continues to change in response to macrolevel policies (Light 2010; Timmermans and Oh 2010), studies of workers’ experiences of change are needed to fully elaborate the linkages between microinteraction, mesolevel organizing, and macrolevel institutional features and policies (Hallett and Ventresca 2006). The stable period of Rose Hospice included a balance of medical and holistic logics, with managerial logics remaining in the background. After the policy change, administrators made changes at the management level. Simultaneously, the new Medicare policy required physicians to take a more active role in preventing long stays. Rose responded to this requirement through expanding the role of physicians in several ways, including more face-to-face visits with patients, physician leadership during team meetings, and reduced attention to nonmedical concerns. This change fused the medical logic with the managerial logic and defined the medical care as the basic minimum of hospice. Because of this fusion, the holistic logic was increasingly excluded. Social-support workers, who had authority under holistic logics, experienced incomplete team membership, and exclusion from decision making and information networks.

It is clear from the data presented that the changes created a great deal of frustration, especially for those whose time with patients was replaced with marketing and administrative duties. Given this frustration, new questions emerge, such as why did the hospice workers not resist these changes? As shown in several interactions, some hospice workers did resist the move toward medical dominance in end-of-life care. Those especially active in their resistance were the social-support workers, who also continued to use a strong discourse about the need for interdisciplinary support. This discourse, however, was hollowed out in practices observed during team meetings and office interactions. During these interactions, resistance in the form of advocating for the holistic logic actually exacerbated the underlying problem: lack of time with patients. When workers pushed for a holistic vision, it extended the meeting time, so even social-support workers began ignoring and subtly discouraging information that was deemed not relevant for medical care. In this way, their small concession during decision-making meetings may have ultimately led to their continued marginalization.

Additionally, these findings raise questions about how these changes affected workers’ willingness to continue their work in hospice. Is it possible that some of these workers continued to find times with patients and family members meaningful, even with these new pressures? While my observations
were focused on workers’ interactions with one another, interviews provide evidence that workers from multiple backgrounds continued to define time with patients as central to their motivation to stay. However, there is also evidence that that time was increasingly cut short or transferred to phone instead of face-to-face contact. For some workers, this change was unsustainable and they changed hospice organizations in hopes of better working conditions. Others ultimately retired or left hospice care altogether. While this study does not include systematic data on turnover, I witnessed turnover frequently and was often able to discuss it with the person leaving or their coworkers. Most often, organizational issues that got in the way of meaningful interactions with patients were to blame.

This progression of events enriches medical sociology and organizational theory in three ways. First, hospice workers’ experiences illustrate that we must view actors as embedded within multiple layers of institutional logics. Workers balance potentially conflicting logics by creating configurations or constellations of logics to make sense of the work (Besharov and Smith 2014; Goodrick and Reay 2011; Martin et al. 2017; Pache and Santos 2013; Voronov et al. 2013). My findings complement this literature by showing that during some policy changes, workers prioritize logics in a hierarchical fashion. They are not simply choosing between logics but ordering according to which were best suited to their current needs (Lipsky [1980] 2010). For many hospice workers, their current need was to continue providing high-quality care to patients, but because of the strain, they ordered the logics in their environment in a way that mirrored conventional medical settings. While one interpretation of these data could be that workers simply complied with managerial demands, my analysis shows a deeper set of practice reorientations. As the organization shifted, workers subtly changed their team-related behaviors, even as they remained committed to the interdisciplinary team.

Second, and related, it is important to note that actors’ responses to the policy change were not all intentional, strategic actions. In many ways, changes to hospice organizing were a product of small, subtle shifts in work practices. Reminders to keep the meeting moving at the expense of integrating nonmedical information, the constant focus on medical indicators of health and decline, and the hours spent on marketing instead of with patients are all seemingly small shifts that aggregated to a major change in the practice of hospice. Most of these workers affirmed their commitment to the team, but their practices did not match their discourse. Many of these small shifts could be explained by workers’ previous professional training (Abbott 1988; Dunn and Jones 2010). Workers fell back on their medical training, which emphasized siloes, bodies, and acute-care practices (Bloom 1988; Rosenberg 2007). The institution of medicine and larger systems of occupational prestige made it seem “natural” that physicians take control (Zhou 2005). Even though most workers had selected into hospice because they found holistic approaches to care to be meaningful, they always had these medical logics available for use during times of strain.

Because of their explicit medical professionalization, physicians and nurses had the easiest time slipping back into medical logics, but even social workers, chaplains, and therapists eventually came to act in ways consistent with their own exclusion. This finding makes it clear that theory about actors’ agency in times of institutional change must account for both intentional and unintentional action. Unintended actions are those small adjustments in practices that are best captured through ethnographic observations. As the context changed, workers were forced to reconsider their work practices and sense of self (Kaplan 2007). Through this process, their actions came to align with medical logics, even as their discourse still emphasized the interdisciplinary team.

Third, these findings illustrate how the larger trend toward rationalization of medicine continues to affect end-of-life care. These changes in team practices do appear to be part of a longer trajectory of the rationalization of hospice care. In fact, scholars have been worried about this since the beginning of studies of hospice (Field 1994; James and Field 1992). What is missing in many of these accounts, however, is a detailed documentation of the mechanisms at the level of worker practices. This article shows that there were several processes—at the administrative, team meeting, and individual practice levels—that ultimately allowed the medical and managerial logics to fuse, giving authority to physicians and pushing out holistic logics. Importantly, though, this is a story not of pure professional dominance of medicine but of the ways that three logics (medical, holistic, managerial) contradicted, countervailed, and cooperated to make some kinds of action seem more reasonable than others (Light 2010).

A methodological contribution of this study is the use of both ethnographic and interview methods during this time of policy change. Combined, these
methods illustrate contradictions between what workers said and what they did. The most central contradiction in this analysis was between the continued rhetoric about interdisciplinary teams, while workers from all positions acted in ways that were contrary to interdisciplinarity. Even the social-support workers, who were most dissatisfied and had the most to lose by the increasing emphasis on medical logics, changed their approach to meetings to reduce time in the office. Reduced time in the office meant more time with patients, which is what workers said was most rewarding about hospice. My data do not allow me to draw conclusions as to whether or how interactions with patients changed after this policy was implemented, but they do allow me to conclude that patient time was more limited and that many workers were frustrated by this.

While my in-depth, longitudinal qualitative approach helps to further the theoretical contribution of this study, it also has some limitations. The study is geographically limited, and while it is likely that hospices all across the country faced pressures because of this Medicare policy change, some organizations may have had different sets of resources or constraints and therefore responded differently than the ones I studied. I directly observed changes at Rose Hospice and supplemented with interviews with workers from six additional hospices in the area. These supplemental interviews confirmed that the Medicare policy change affected the division of labor at all of the organizations in this study. More research is needed on these shifts in practices, especially as the environment is continually changing, and we do not know if these patterns have been exacerbated or reversed. Finally, Rose and the other hospices studied here were all independent, for-profit hospice organizations. One of the big trends in end-of-life care today is for major health systems to buy out independent hospices, potentially furthering the integration of hospice and conventional medicine. Studies of these integrated hospices are needed.

Despite these limitations, the theoretical contributions of this study are likely applicable to other settings. In particular, medical institutions are constantly shifting in response to policy changes, and scholarship is advanced by examining workers’ responses to those policies (Mechanic and McAlpine 2010; Wright and Perry 2010), especially when knowledge from medical sociology, organizational theory, and policy approaches are combined (Currie et al. 2012). New policy pressures will likely affect work practices through observable shifts in leadership and the division of labor, but they will also appear in the subtle adjustments workers make to meet the demands of the job and continue to find meaning in the work they do. Hospice is often held up as a model of successful interdisciplinary care, but this analysis shows that even with a strong history of interdisciplinarity, macro policy changes can undermine hospice approaches meant to challenge the medical hierarchy.

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Cain


 AUTHOR BIOGRAPHY

 Cindy L. Cain is an assistant professor in the Department of Sociology at the University of Alabama at Birmingham. Her research interests include medical institutions, care work, support for older adults, and end of life. She has published articles on care work in the Journal of Contemporary Ethnography; Gender, Work and Organization; Human Relations: Health Sociology Review; and the Journal of Interprofessional Care.