LUND UNIVERSITY
School of Economics and Management

Department of business administration

FEKH19

Examensarbete Strategic Management

VT19

THE PHYSICIAN'S WORD MATTERS MOST

Conflicts of interests between patient and superior, as explained by agency theory

Authors:

Hannah Feldtblad

Adam Karlsson

Matilda Karlsson

Supervisor:

Olof Hallonsten

SAMMANFATTNING

Examensarbetets titel: Läkarens ord väger tyngst

Seminariedatum: 4 juni 2019

Ämne/kurs: FEKH19, Examensarbete kandidatnivå i Strategic Management, 15 högskolepoäng

Författare: Hannah Feldtblad, Adam Karlsson, Matilda Karlsson

Handledare: Olof Hallonsten

Fem nyckelord: Agentteori · Principal-agent-förhållande · Svensk sjukvård · Läkaretik · Profession

Syfte: Syftet är att beskriva hur läkare påverkas av och hanterar intressekonflikter mellan patient och överordnade, avseende personlig etik och kostnadseffektiviseringsåtgärder. Mer specifikt, hur överordnade eventuellt påverkar given vård genom att försöka kontrollera läkarens prestation i syfte att spara pengar, medan patienter vill ha den bästa vården som finns tillgänglig.

Metod: Vi valde en kvalitativ-deduktiv metod till vår fallstudie av den svenska sjukvården. Nio svenska läkare valdes målinriktat ut och intervjuades för att utvinna den empiriska datan. Datan transkriberades, kodades och analyserades tematiskt i sex steg i enlighet med Braun & Clarke (2006).

Teoretiska perspektiv: Det teoretiska ramverket för vår studie koncentrerades kring agentproblemet (Eisenhardt, 1989a) och grundades i dual principal-agent modellen (Langer, 2006), som tidigare har använts i försök att fånga konceptet av en läkares dubbla principaler.

Empiri: Från den empiriska datan, information om svenska läkares erfarenheter, kunde vi urskilja distinkta teman: (1) prioriteringsutmaningar, (2) inkonsekvent medicinskt agerande som ett resultat av ökad press och okunnighet, (3) gap mellan beslutsfattande och förståelse samt (4) organisatorisk inblandning i läkarens kapacitet att prestera.

Resultat: Vi upptäckte att professionen skyddar läkaren från aktiva konflikter i agentrelationerna, och att läkaren alltid kommer ge företräde till sina patienters behov som resulterar i marginell konflikt mellan patient och överordnad. Dessutom, för att direktiv och organisatoriska förändringar ska ha effekt på läkare måste förändringarna vara i patientens bästa intresse och i linje med professionens värderingar.

ABSTRACT

Title: The physician's word matters most

Seminar date: 4th of June 2019

Course: FEKH19, Degree Project in Strategic Management, Undergraduate level, Business Administration, 15 ECTS

Authors: Hannah Feldtblad, Adam Karlsson, Matilda Karlsson

Advisor/s: Olof Hallonsten

Key words: Agency Theory · Principal-Agent Relationship · Swedish Healthcare · Medical Ethics · Profession

Purpose: The purpose of this thesis is to describe how physicians are affected by and deal with conflicting interests between patients and superiors, regarding personal ethics and cost-effectiveness measures. More specifically, how superiors might affect given care by attempting to control the physician's performance in the pursuit of saving money, while patients want the best treatment available.

Methodology: We chose a qualitative-deductive approach to our case study of Swedish healthcare by targeting and subsequently interviewing nine Swedish physicians for procuring empirical data. The data was transcribed, coded and thematically analysed, following Braun & Clarke's (2006) six steps.

Theoretical perspectives: The theoretical framework for our study concentrated on the agency problem (Eisenhardt, 1989a) and was based on the dual principal-agent model (Langer, 2006) that has previously been used in attempts to capture the concept of physicians' dual-principality.

Empirical foundation: From the empirical data, information about the Swedish physicians' experiences, we found four significant themes: (1) challenge in prioritising, (2) inconsistent medical acting as a result of increased pressure and ignorance, (3) gap in decision-making and understanding, and (4) organisational interference with physicians' ability to perform.

Conclusions: We found that the profession protects the physician from direct conflicts in the agency relationships, and that the physician will give precedence to their patients' needs, resulting in little conflict between the patient and superior. Also, in order for directives and organisational changes to have an effect on physicians, the changes have to be in the best interest of the patient and in line with the professional values.

TABLE OF CONTENTS

INTRODUCTION

Considerable amounts of attention have long been directed at the evolution of healthcare, concerning primarily quality of care and cost (Ström, 2018; Björnberg & Hjertqvist, 2018; Diamant, 2019). Sweden is a welfare state, and as such, it finances a majority of its healthcare system through taxation (Swedish Institute, 2018). In this way, Sweden differs from other western countries, such as the USA which historically has used a fee-for-service revenue model where patients instead pay for treatment themselves or through insurance (Pearl, 2017). The Swedish parliament has formulated a list of priorities in Swedish healthcare, in the descending order of human dignity, need and solidarity, and cost-effectiveness (1177 Vårdguiden Västra Götalandsregionen, 2018). Criticism has been levelled at the managerial level of the healthcare system, addressing an alleged preference for cost-effective thinking instead of a focus on ethical perspectives in medicine (Höglund & Falkenström, 2018).

In previous research, agency theory has been used to explain challenges in the medical profession, asserting that physicians must act on behalf of both the patient and society (Angell, 1993; Shortell et al., 1998). Several notions have subsequently been made, illustrating conflicts between increased cost-effectiveness measures and physicians' personal ethics (Angell, 1993; Langer, 2006; Langer et al., 2009; Shortell et al., 1998, Höglund & Falkenström, 2018). In this thesis, we show how physicians are affected by and deal with conflicting interests between their patients and superiors[1], in terms of personal ethics and cost-effectiveness measures, using agency theory's dual principal-agent model. In our analysis, we examine increased pressure to improve cost-effectiveness, cost-awareness as an accepted value in the profession, information asymmetries, moral hazard, false incentives and

[1] The superior as a principal is the healthcare organisation and includes the employer and society

moral distress, based on Swedish physicians' experiences. Our conclusions show what motivates physicians in healthcare organisations that lack financial incentives and what is necessary for attempts to control them.

Physicians are experiencing increasing pressure from society to improve cost-effectiveness, while before the dominant factor was the needs of the patient (Angell, 1993; Langer et al., 2009; Shortell et al., 1998). In Sweden, performance-based governance, the so-called new public management (NPM), has been prevalent in the healthcare system since the 1980s (Hasselbladh et al., 2008). Critique has been vocalised by healthcare-staff who claim that the performance-based management impedes the profession of medical care in such a way that the patient is left out of the deliberations on higher levels (Björgell, 2017). Due to increased administrative chores, detached economic goals and therefore misplaced allocation of resources, attention is given to tasks not directly related to patient care, resulting in ineffective efforts of improving care and cost saving (Agerberg, 2014a; Agerberg, 2014b; Björgell, 2017). As of recent years, the Swedish government is working on "the trust reform[2]" to replace the current NPM-model, trust-based governance in welfare which strives for a balance in need for control and confidence in the employees' business-related knowledge and experience (Regeringskansliet, 2018).

Previous research is insufficient in explaining the dual obligations of physicians in Sweden, mainly due to three reasons. First, healthcare systems differ widely between countries, meaning results and conclusions cannot be generalised across borders (Frank, 2013). Second, little research has been conducted in the Swedish context, which has resulted in a lack of a theoretical and empirical basis to build upon[3]. Previous research in Sweden has been concerned with high-level politicians, civil servants and CEOs from caregiver

[2] We are using the term the trust reform which is a translation of the Swedish word 'tillitsreformen'
[3] Based on our search efforts for articles on the subject.

organisation instead of practising physicians (Högberg & Falkenström, 2018). Third, the previous research has primarily focused on observable phenomena and micro-economic deduction, with little factual insight in the medical profession to build the assumptions upon (Angell, 1993; Langer, 2006; Langer et al., 2009; Shortell, 1998). Thus, we intend to find out how physicians in Sweden experience agency problems, regarding cost-effectiveness measures and personal ethics.

Scope and delimitation

The study concerns interviews with working physicians who have patient responsibilities in Sweden. We look at the agency problem caused directly by the conflict between personal ethics and cost-effectiveness measures. We characterise ethics as personal, due to personal ethics being what governs the physician's actions. Medical ethics are included in part in the physician's ethical code, but how much, differs between individuals. With cost-effectiveness measures, we refer to any kind of change with the intent of reducing costs.

Background to the Swedish healthcare system

Legislation. Swedish law regulates how the healthcare system is to be organised and managed, comprising all care-providers, regions and municipalities (SFS 2017:30, 1:1). The purpose of the Swedish healthcare system is to provide good health and care, on equal terms, for the whole population, with respect for human equality and individual dignity (SFS 2017:30, 3:1). Swedish healthcare includes investigation and treatment of sickness and injuries, efforts to prevent medical treatment, patient transportation and care of the deceased (SFS 2017:30, 2:1), and priority is to be given to the one in the greatest need of medical care (SFS 2017:30, 3:1). To meet the requirements for good care, health- and medical care

activities should be conducted in a way that it is of good quality, satisfying the patient's need for security and originated in respect for the patient' self-determination while being easily accessible (SFS 2017:30, 5:1).

The law also stipulates that cost-effectiveness must be promoted in publicly funded healthcare services (SFS 2017:30, 4:1). A region must counteract a deficit in the required balanced result[4] within three years after the fiscal year of it being reported, and accordingly conceive a plan of action (SFS 2017:725, 11:12). Currently, Region Skåne is faced with a three-year restitution claim due to reported deficits, of which a majority originates in the healthcare sector (Region Skåne, 2019). As previously mentioned, the order of priority in healthcare is comprised of three principles (Högberg & Falkenström, 2018). Firstly the principle of human dignity, which concerns equality and respect for patients, is mainly apparent among the healthcare workers who provide the care. Secondly, the principle of need and solidarity, which concerns care in due time and priority to the one in greatest need, is primarily attended to on an organisational level, such as healthcare facilities. Thirdly, the principle of cost-effectiveness, which concerns the reasonable relation between cost and effect, is for the most part considered at the managerial level.

The Swedish healthcare system. Clinical Studies Sweden (2019), a collaboration between The Swedish Research Council and The Swedish Association of Local Authorities and Regions (SALAR)[5], explains that the responsibility to provide good and equal care is divided between three different administrative levels, namely the national government[6], regions[7] and municipalities[8]. They describe that the three levels are governed by politicians

[4] We are using the term balanced result which is a translation of the Swedish word 'balanskravsresultat'
[5] Sveriges Kommuner och Landsting (SKL)
[6] We are using the term national government which is a translation of the Swedish word 'stat'
[7] We are using the term region which is a translation of the Swedish word 'landsting'
[8] We are using the term municipality which is a translation of the Swedish word 'kommun'

whom the Swedish population has democratically elected. Furthermore, the primary responsibility of the national government is to decide the general political agenda for Swedish healthcare, which is done primarily by legislating. One way of assuring that patients can receive care is by covering the majority of the patients' healthcare costs. Typically, patients only pay a small fee for healthcare until a high-cost threshold is reached, the maximum limit of what the patient must pay for medical care and prescription medicine, whereafter the patient receives healthcare without cost during a twelve-month period (Clinical Studies Sweden, 2019).

Debated issues. The evolution of care and the healthcare-organisation has been a topic of interest. The Swedish people voted for healthcare as the second most important political issue in the 2018 election (Lundberg Andersson, 2018). Meanwhile, many debate articles are posted weekly, with recurring topics being physicians' mental health, staff shortages and budget-related matters. The importance of the topic is clear, but the lack of a cooperative approach is also prevalent, as shown by the different opinionated writers and politicians that weigh in on the subject.

Ekström & Fridjonsson (2016) claim that many Swedish healthcare workers, like physicians and nurses, experience negative effects of moral distress weekly. The authors suggest one source to be that workers feel they do not have the time or resources to do everything they want to do for their patients. Ekström & Fridjonsson (2016) also suggest that moral distress may originate from situations where higher-ups and institutional rules actively hinder workers from performing.

It is also evident that parts of Swedish healthcare need to be more cost-effective, if not plain cheaper. Region Skåne offers a clear example of such an unsustainable situation. Their required balanced result deficit reached 1,8 billion SEK in 2018, which has to be "paid" back

within three years (Region Skåne, 2019; SFS 2017:725, 11:12). This challenge alone shows the need for cost-effectiveness measures in healthcare, but Region Skåne is not alone in their struggles. According to SALAR (2018), seven regions were expected to have a budget deficit in 2018. SALAR also mentions that costs have increased very quickly over the last five years.

Purpose and thesis question

The purpose of this thesis is to describe how physicians are affected by and deal with conflicting interests between patients and superiors, regarding personal ethics and cost-effectiveness measures. In order to do so, we examine how physicians in Sweden reason and act in their daily work, while focusing on the problem of differing objectives between the two principals. More specifically, how superiors might affect given care by attempting to control the physician's performance in the pursuit of saving money, while patients want the best treatment available. The findings from our study will provide an empirical basis for future research concerning Swedish physicians' insights into ethics and cost-effectiveness in medical acting. Also, the analysis will complement existing research by investigating a new context, challenging arguments made in previous studies on the subject of agency theory in the medical profession. Our conclusions will show what motivates physicians in healthcare organisations that lack financial incentives and what is necessary to consider when controlling them.

- How are physicians in Sweden affected by conflicts of interest between superiors and patients, in terms of personal ethics and cost-effectiveness measures?

REVIEW OF THEORETICAL BACKGROUND

An agency relationship is defined as a relationship, in which one party (the principal) delegates work to another party (the agent) (Eisenhardt, 1989a). Agency theory is concerned with what is called the agency problem, which is a conflict of interest that occurs when (1) the parties wills, wants and goals conflict, and (2) when it is difficult or costly for the principal to verify how the agent has performed their work (Eisenhardt, 1989a). This leads to the problem of the principal not being able to know if the agent has behaved correctly (Eisenhardt, 1989a).

Dual principal-agent model

Agency theory has been used to explain issues physicians face as a result of obligations to dual principals. Angell (1993) explains that physicians have to weigh the needs of the patient on one hand and society on the other. She elaborates how the situation has changed in recent times from physicians only acting in the interest of the patient, to now having other obligations that compete with their needs. Primarily, Angell (1993) claims that physicians now have an obligation to save money for society, meaning they have to weigh the benefits of expensive care against the cost for society. Langer et al. (2009) assert, in accordance with Angell (1993), that the physician performing medical actions must consider the cost of a wrongful decision with regards to both the patient and the health insurance or managed care organisations. Consequently, this balance can give rise to false incentives, resulting in the physician not performing in either parties' best interest.

Shortell et al. (1998) introduce managed care as a term for the physician being obligated to consider the needs of not only their current patient but also the needs of the rest the organisation's members. They also describe how physicians have to deal with conflicts

between these institutional ethics and their personal ethics, resulting in what Morley (2018) refer to as moral distress. Shortell et al. (1998) further argue that managed care organisations affect the physician's ability to fulfil the Hippocratic oath[9], where cost-control mechanisms at times compete with the patient's needs. Langer (2006) deems it necessary to characterise a physician-patient interaction as a trust-based relationship, in order to circumvent information asymmetries. In other words, the physician possesses vital knowledge in diagnosis and treatments that the patient does not, but lacks knowledge of the patient's living conditions which may affect the appropriateness of a remedy, making the physician dependant on the patient providing pertinent information.

The illustration below, which depicts the relationships in the medical profession, is a modified version of Langer's (2006) dual principal-agent model (DUPAM). The arrows show dependency, where the superior makes demands and depends on the physician, who in turn demands cooperation from the patient, who also depends on the physician's performance, making the physician-patient relationship an interdependent one based on trust (Langer, 2006). In the case of dual principals, differing objectives (known as the agency problem) do not only concern those between the agent and the principal, but also those between the two principals (Angell, 1993; Langer, 2006; Langer et al., 2009; Shortell et al., 1998). The dashed lines show how the relationships overlap and how this puts the physician at risk for conflicting interests between the principals (Langer, 2006). The employment relationship is explicit, defined and clear, while the fiduciary-relationship is implicit, implied but not clearly stated (Langer, 2006). He explains that the explicit contract implies agreements and stated objectives, guiding the physician's performance and enabling control mechanisms (as a substitute for trust). The implicit contract, however, cannot, due to the relationships nature, be

[9] The physician's sworn ethical code

comprised in an explicit contract, making it governed by trust rather than control mechanisms (Langer, 2006). Langer (2006) notes that agency problems are attributed to the agent, who is supposed to realise contractually agreed services, while the principal, and external observer, is obligated to attempt and solve the problems. Moreover, Langer (2006:667) quotes Ray Rees, in that "The main purpose of principal-agent theory is to characterize the optimal forms of such contracts under various assumptions about the information P and A possess or can acquire and thereby, hopefully, to explain the characteristics of such contracts which are actually observed". Thus, DUPAM can be employed to distinguish the optimal conditions for both the explicit and implicit contracts associated with the physician and subsequently be used to explain the observed attributes of the real contracts.

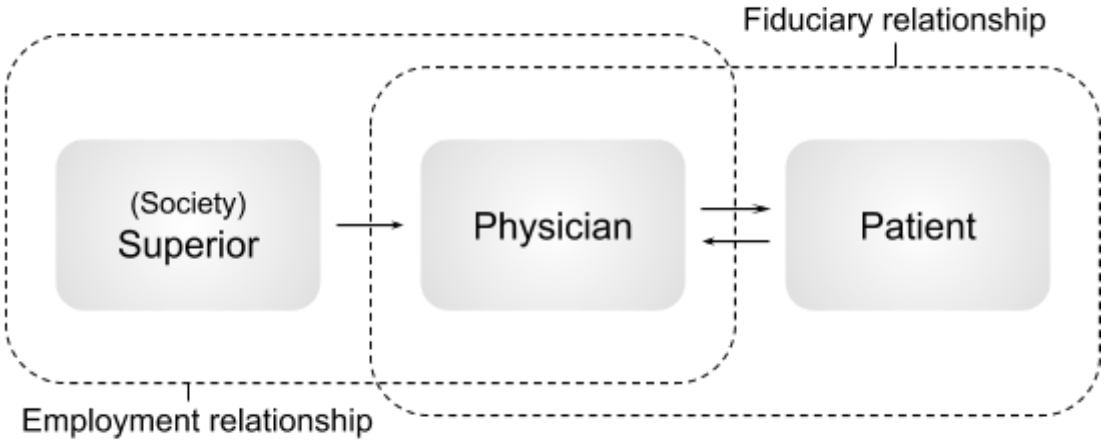

Figure 1. The physician in DUPAM

Central concepts

Increased pressure to improve cost-effectiveness. Langer (2006) denotes how the challenge of legitimising professional performance traditionally stands between the trustful independence in self-governed professionalism and its values, but that values change and now primarily concern cost-effectiveness, also being the case in the medical profession. Shortell et

al. (1998) conducted a study concerning the American healthcare system and found that many healthcare experts and practitioners view managed care organisations as a direct threat to their ability to fulfil the Hippocratic oath. Their arsenal of cost-control mechanisms (e.g. guidelines, financial incentives) forces physicians to consider not only the needs of the patient but also those of the organisation and the physician's own financial interest.

Angell (1993) points to rising expenditure for healthcare during the 1980s in the USA as a result of the healthcare system's features. She mentions the fee-for-service compensation system as the most prominent of these features. She further explains that fee-for-service means that patients pay piecemeal for treatment, which means more money for physicians who recommend extra treatment even if that treatment is negligible at best. Furthermore, Angell (1993) states that the rising expenditure, in turn, led to cost containment policies on the part of these large third-party payers, like the government and big business. Högberg & Falkenström (2018) describe how politicians, civil servants and healthcare CEOs express difficulties in fulfilling the ethical requirements of various policy documents in Swedish healthcare and how financial requirements are being prioritised instead, due to a marketisation of the healthcare system. The previous research points to cost-consciousness becoming increasingly prevalent in healthcare management and ethics being pushed aside, compromising the physician's ability to perform.

Cost-effectiveness as an accepted value. Langer (2006) explains how efficiency[10] (further on referred to as effectiveness) relates to professional performance as a contemporary issue affecting work organisations, social management and development, while not being an accepted value in professional ethics – which can be deemed as a fundamental issue for

[10] The difference between cost-efficiency and cost-effectiveness in the situation at hand is insignificant, therefore we refer to cost-effectiveness in order to reduce the risk of confusing the reader

professionalism. He argues that cost-effectiveness must be incorporated in the ethical code for the professional performance to be sustainable for the organisation, suggesting that cost-effectiveness is unaccounted for in the ethical values. Ethics make out the two most important legislated values of three in Swedish healthcare (1177 Vårdguiden Västra Götalandsregionen, 2018). However, according to Falkenström & Högberg (2018), cost-effective thinking gets precedence over ethics, resulting in a divide between the values where cost-effectiveness is overrepresented in the implementation of them, meaning that the values are separated. Although there is an apparent discrepancy concerning the acceptance of cost-effectiveness in professional ethics between the two studies, the aspect of cost in the medical profession as a value seems to be detached from the ethical values in both cases.

Information asymmetry. According to Arrow (1963), information asymmetry is a central economic characteristic of the healthcare system. Langer et al., (2009) point out that information asymmetries often are considered to be favourable to the agent, e.g. the physician has an information advantage over the patient. However, the discrepancy of information in the physician-patient relationship given the patient's ability to gather medical information through modern measures places, such as the internet, puts the physician in a new role by the patient who "undermines the monopolisation of medical knowledge as a traditional cornerstone of the trust-based relationship" (Langer et al., 2009:100). Furthermore, the authors attend to the concern that agent theory insufficiently distinguishes between knowledge and information. Langer (2006) identifies informational asymmetries between the agent and the principal as a problem within principal-agent relationships. Also, he finds that as the prime determinant for ineffectiveness and incentives for opportunism is information asymmetry, since it allows one party to act according to their wishes without their behaviour being discovered.

Moral hazard. Moral hazard refers to the problem of the principal not knowing for certain if the agent is going to act in accordance with the contract and if the agent has any incentives to do so (Eisenhardt, 1998a; Langer, 2006; Langer et al., 2009). Langer (2006) and Langer et al., (2009) explain that moral hazard occurs when there is an information asymmetry between the principal and agent which results in the principal not being able to monitor the agent's action accurately. Langer et al., (2009) argue that the moral hazard problem in the physician-patient relationship can lead to a division in the health market where physicians, due to adapting their medical actions to budgets as well as to the patient's needs, overtreat patients to compensate for a previous loss as fee-for-service would enable. Accordingly, despite being drawn to solve the information problem of management, the authors speculate that explicit contracts are insufficient as they can cause false incentives. Therefore, they argue that economic concepts are inadequate instruments for solely controlling medical acting and that relevant psychosocial incentives of the physician-patient encounter are to be taken into consideration as for investing trust.

Moral distress. Morley (2018) suggests three criterias that need to be met in order for moral distress to occur: (1) the experience of a moral event, (2) the experience of "psychological distress", (3) a direct causal relation between (1) and (2). This means that moral distress should be defined as the negative psychological distress directly caused by the experience of a moral event. The author admits that this definition is wider than other accepted definitions, but writes that it should allow for a greater number of "causes" of moral distress to be discovered. According to Morley (2018), moral distress is also known as ethical stress, which highlights its connection to ethics as a whole.

Morley (2018) explains that the term ‘psychological distress’ refers to negative effects on a physician’s mental health. Furthermore, the term moral event refers to events where the taken action might not correspond with a physician’s preferred action. This could be caused by institutional rules or policies, praxis, peer pressure or any other obstacle that might exist in healthcare and hinder a physician from following their code of ethics (Morley, 2018).

METHOD

Research design

We chose a qualitative-deductive approach to our case study, as defined by Bryman & Bell (2011). Our choice to conduct a case study is motivated by Bryman & Bell (2011) as this design’s purpose is to explain and describe a phenomenon by studying a case, which aligns with our thesis question and purpose. Conducting a case study is also motivated by Yin (2009) as a case study is preferred when the research question starts with how and consequently is explanatory. Since the purpose of our study is to shed light on a situation explained by agency theory, conducting a case study is therefore motivated. Due to the lack of previous research, concerning Swedish physicians’ challenges in managing demands from both patients and society, the study needs to be qualitative. Typically, a deductive approach is combined with a quantitative strategy (Bryman & Bell, 2011). At this stage, there is not enough data to conduct a quantitative study on the subject or enough knowledge of what information needs to be procured in order to conduct a quantitative study. A qualitative approach will provide the empirical groundwork necessary to conduct a future quantitative study of valid size. Also, a qualitative approach will grant a deeper knowledge and understanding of how physicians are affected by their obligation to multiple principals. An attempt at a quantitative approach would be educated guesswork without the groundwork. A

qualitative strategy with a deductive approach can commonly be deemed inappropriate since a small qualitative sample is not enough to verify or deny a theory and thereby provide a reliable result, which a deductive approach usually entails (Bryman & Bell, 2011).

Previous research in the context of medical professionalism has been made, using the theoretical framework for agency theory. However, the prior research does not apply to the context of Sweden, due to differing preconditions. Since the purpose of the study is derived from earlier research and acknowledged theories, the study will be deductive (Bryman & Bell, 2011). Assumptions and conclusions made in earlier work will be tested in our study, which is why the study cannot be inductive.

Collection of empirical data

Sample. The Swedish healthcare system was the subject of our study due to (1) the lack of previous studies conducted in the research context in Sweden, (2) the international interest in and perception of the quality of Swedish healthcare and, (3) the accessibility and practicality for us when conducting this study. Thus, making the Swedish healthcare system a distinctive case, which Eisenhardt (1989b) claims is preferable since the purpose of a case study is to further develop and replicate existing theory.

The selection of interviewees was targeted, and a snowball selection was used. Since our thesis question concerns how physicians are affected by conflicts of interest between their superiors and patients, it was important that the interviewees possessed the right knowledge and wanted to contribute. Thus, a snowball selection was necessary (Bryman & Bell, 2011). We contacted a member of the Council of Ethics directly who had held a lecture at Lund University School of Economics and Management on the subject of ethics in medicine. He provided us with contact details to suitable physicians. We also located potential interviewees

by contacting them per electronic mail through appropriate channels, such as the Swedish Medical Association and the Faculty of Medicine at Lund University. Also, each asked possible interviewee got the chance to recommend someone else for the study. The ability to generalise the case is limited when using a snowball selection, which can be seen as a disadvantage (Skärvad & Lundahl, 2016). However, a snowball selection is still appropriate in a qualitative study as the need to generalise is not as important as it is in a quantitative study (Bryman & Bell, 2011).

Data collection. The collection of data started when we contacted a member of the Council of Ethics via electronic mail. He provided us with contact information to practising physicians within Region Skåne, which led to four booked interviews. We also booked three additional interviews by contacting practising physicians who are also active (research or teaching) at Lund University. We found the remaining two interviews through the Swedish Medical Association and personal contact.

We constructed a theoretical framework to act as a basis for our interview-guide, which acted as a tool during the interviews assuring that we asked the right questions. The interviews were then held with the physicians. The interviews were semi-structured with the same set of questions which had flexible and open answers. The physicians were able to reflect and elaborate on the question and thus steer the discussion in a certain direction, in order to get as complete answers as possible, per Bryman & Bell (2011). The interviews focused on the physician's own experiences with ethics and cost-effectiveness in their work and the possible conflict of interest between them. Additionally, new questions that arose during the interview were asked since we discovered new topics that were of interest. The interviews were around an hour long, conducted in Swedish and were held at quiet and undisturbed places, either the physician’s office or in group rooms at the university.

The interviews were recorded with the interviewees' permission. The interviews were then transcribed in an intelligent verbatim style in Swedish, increasing readability while keeping the original spirit of the text, and then translated into formal English. We also sent the quotes we used back to the interviewee for review and confirmation, allowing them to suggest changes in order to make the answers as accurate as possible. The interviewees were anonymous in the study since the questions we asked could be considered sensitive. Therefore, the interviewees have been given fictional names in order to preserve their anonymity. Financial statements from Region Skåne, laws and regulations concerning the Swedish healthcare system have also been used in order to formulate a wider perspective about the Swedish healthcare system.

Organisation	**Name**	**Profession**	**Date**	**Duration**
Public hospital	Karl	Infection	23 April 2019	55 minutes
Private healthcare centre	Josefin	General medicine	23 April 2019	65 minutes
Public hospital	Jenny	Pulmonary medicine	25 April 2019	53 minutes
Public hospital	Sven	Orthopaedics, surgeon	25 April 2019	60 minutes
Private clinic	Daniella	Orthopaedics, surgeon	3 May 2019	47 minutes
Public hospital	Maja	Orthopaedics	6 May 2019	57 minutes
Public hospital	Oliver	Cardiology	9 May 2019	28 minutes
Public hospital	Jakob	Anesthesiology	16 May 2019	46 minutes
Public hospital	Tobias	Obstetrician	16 May 2019	68 minutes

Table 1. The interviewees.

Analysis of data

The data was thematically analysed and was done following Braun & Clarke's (2006) 6 steps. A thematic analysis was used because of the flexibility the method offers, and because we

wanted to discern similarities and patterns in the data (Braun & Clarke, 2006). We tried to be clear on how each step was conducted in order to facilitate an evaluation of the choices we made, to avoid misunderstandings that can occur due to the method's flexibility and free interpretation (Braun & Clarke, 2006).

Firstly, the interviews were transcribed and can be seen as a preparatory step for the data analysis. The transcription allowed us to familiarise ourselves with our data, which let us see patterns, similarities and spark ideas for the structure of the empirical data and the analysis. Secondly, the coding of the data started by choosing quotes from the transcriptions which we thought would be interesting and necessary for our analysis. The quotes were picked after patterns or similarities that we discovered during the interviews and transcription process, but also relating to the theoretical framework. When the quotes were collected from the data, we assigned each quote code words. The code words were based on the theory and similarities which we found in the quotes. A quote could get several code words, depending on what the physician talked about. For example, a quote might have been about prioritisation of resources. This quote would probably get the code words: *ethics, ethical dilemma, cost* and *cost-effectiveness.*

Thirdly, we discerned patterns amongst the code words. This was done by looking at the quotes and their code words, giving them a "phrase" that summarised the quote. The example from above would have gotten the phrase: *distribution of resources.* The different phrases were then divided into the code words and divided into groups with similar meaning. The phrase, *distribution of resources*, would then be mentioned in *ethics, ethical dilemma, cost* and *cost-effectiveness* and divided into a group with similar phrases. After this, we discerned themes and sub-themes amongst the phrases. We did not set a limit for how many of the physicians had to mention a thing before it became a theme. Instead, we looked at how

important it seemed to the physicians who mentioned it and if it seemed to be a problematic or challenging part of their job.

Fourthly, we reviewed the themes. We went back to the coding and checked if we had missed anything important and to make sure that the themes worked with the coding and all the empirical data. This was done by going over the quotes again to see if we missed to set any code words and to go over the phrases to see if they represented the quotes. Fifthly, we named the themes and sub-themes. We decided on a definition for the theme and what empirical data should go under which theme depending on the phrases and code words. Sixthly, we presented the empirical data. The empirical data was re-written in continuous text and quotes were extracted from the data set to further illustrate a point in the theme. The themes were presented in an easy-to-survey table to help us understand the data by showing any potential patterns or themes, as well as aiding us in creating discussion topics. The empirical data was then analysed and compared to the theoretical framework in order to see if we had found the patterns and similarities as earlier researchers.

Reliability and validity

Reliability. Since it is hard to pause a social setting and the healthcare system is under continual change, we see the external reliability of the study as something that needs to be under consideration while conducting it (Bryman & Bell, 2011). The replicability of the study is thus affected by the time period due to evolving social contexts, and because of the different answers semi-structured interviews can bring. However, we acknowledged this by giving clear descriptions of how the study was conducted in order to handle this critique, per Yin (2009). The interview-guide was another way of handling this in order to get similar responses. Another problem which might affect external reliability is the sensitive nature of

the questions, especially regarding ethics, which may elicit non-truthful answers by the interviewees (Bryman & Bell, 2011). We avoided those answers by making the interviewees anonymous in the study. Although the reliability of the study may seem weak, it was strengthened by the use of triangulation in the study (Eisenhardt, 1989b), as the physicians we interviewed had a different perspective on the question due to different specialities and experiences amongst the physicians. The quotes used in the empirical data were sent back to the interviews for approval, which we believe increased the study's reliability. The internal reliability of our research relies on us being completely in line with each other concerning theoretical concepts (Bryman & Bell, 2011).

Validity. The issue of internal validity has little bearing on the study because our approach is qualitative. A possible problem might arise from physicians misunderstanding important concepts when we interview them, but this is remedied by us researchers being clear and avoiding economic terms that might muddle interview answers. The concepts which are used in the study and interview guide are anchored in theory and research, which we think increases the validity. Additionally, this provides us with something to ground ourselves in when conducting our study. The external validity of our research could be deemed weak, considering the study is only concerned with a specific agent, the physician, and their perspective, disregarding the perspectives of their dual principals (Bryman & Bell, 2011). However, this is a purposeful delimitation of our study. Moreover, it is based upon the Swedish healthcare system, which in turn is created from the ground up by the Swedish society and as such is heavily influenced by cultural norms and values. Consequently, the research cannot be generalised across other social settings and countries.

RESULTS

The table briefly presents empirical findings regarding physicians concerns in their daily work and attitude towards the Swedish healthcare system.

Theme	Meaning	Evidence
Challenge in prioritising	The decisions of whom to give care or treatment before another patient	All of the interviewees expressed prioritising to be the most prevalent ethical dilemma in their work
Inconsistent medical acting as a result of increased pressure and ignorance	Inconsistent decision-making by physicians concerning their patients' treatment options, all medical factors equal	All interviewees with patient responsibilities talked about how they shape medical decisions to fit increasing patient-needs and demands
Gap in decision-making and understanding	Decisions being made several hierarchical levels from the operation it affects	All of the interviewees discussed decision-making being distant from the actual work, such as the guidelines for prioritisation
Organisational interference with physicians' ability to perform	Physicians' exposure to negative effects caused by the organisational factors, resource management and limitation of medical acting	All of the interviewees expressed their opinions on organisational issues, such as the decision-making processes, that affect their work situation

Table 2. An overview of the empirical themes.

Challenge in prioritising

All the interviewees made prioritising of patient-needs out to be the most common dilemma in their daily work, concerning ethics and cost. All said that they face different types of ethical dilemmas in their daily work. According to Karl, ethics are essential since physicians have the ability and the resources to prolong people's lives. According to Josefin, prioritising and other ethical dilemmas have become so common that she rarely reflects on the difficult choices she has to make daily, especially considering complex dilemmas' rarity. Daniella expressed that she feels like the ethical dilemmas she encounters and the priorities she has to make, can be problematic. She explained that it is especially "[...] wearisome when they [priorities and

guidelines] do not align with what feels right for her. This happens from time to time." Jakob further illustrates this:

> You have several sick patients, and you have to decide which ones to take care of, or at least take care of first. Lund also only has eight spots in the ICU. If it is full, then it is full. That is when you have to prioritise, who has the most benefit of intensive care. It can be pretty jarring because you know that if you do not admit this patient to the ICU, then they will die within the hour. So, of course, that becomes an ethical dilemma, when I decide who will live and who will die.

Josefin explained that prioritisation is about using the resources in the best way in order to help, not only as many patients as possible, but also the correct patients, the ones in more need to see a physician. She went on to describe that the resources are limited and must be distributed as effectively as possible; it even encompasses how much time is spent on the phone with one patient.

Karl described comparing the differing benefits of treating either children or the elderly. When it comes to children, there is no doubt that they are going to treat them because the physicians know that they have a good chance of recovering and experiencing a high quality of life again. However, with the elderly, the course of action is not as clear. The elderly may already have illnesses, and the physicians do not know for certain how well the treatment is going to work and what quality of life that person is going to get after the treatment. Instead of treating the patient, the physician may decide to relieve them of their symptoms. Both Josefin and Sven also addressed the same ethical dilemma concerning old people. Josefin gave a similar example but added consideration to the benefit to society as a factor.

Jenny explained that she does not face any “heavy” ethical dilemmas in her daily work, which she thinks is because of the department she works in. However, the ethical dilemmas she faces are more of an “everyday nature”. Other interviewees also expressed that the gravity of ethical dilemmas vary between specialities, where physicians treating sick children or life-threatening conditions are more likely to face challenging situations. Physicians not only have to divide the resources between their patients but also between departments by considering the bigger picture of all the patients. Maja and Daniella both claim that it is common for physicians to fight only for their own patients, but they also say that it is important to look at the bigger picture when dividing resources.

All interviewees expressed that they use guidelines in their daily work, but that they can find them problematic. Oliver, like the other interviewees, stated that "the guidelines are just guidelines, not law", and sometimes physicians deviate from them. Tobias claimed that physicians can make their own decisions and sidestep the guidelines, but they have to be prepared to motivate their choices to their colleagues. Jakob exemplifies this:

> I can give the most expensive of the expensive medicines if I want. However, if I do that it often triggers a situation, most often with colleagues. Rarely upward the hierarchical ladder, I would say.

Both Daniella and Tobias explained that they find the guidelines problematic because they cannot fit all patients perfectly into different prioritising groups. Daniella expressed this concern by saying: “We cannot expose people to inhuman queue times and suffering, despite their condition not being prioritised. It is difficult to decide [whom to treat] only with

generalised guidelines". Daniella also explained that it is problematic when the guidelines do not align with her values and assessments:

> For example, it has been decided, with substantial support from research, that patients with a hip fracture are supposed to have surgery within 24 hours. A hip fracture is defined as a fracture anywhere on an area stretching from the upper part of the femur to the actual hip bone. If a patient does not get surgery within 24 hours, the risks for complications rise significantly. If it is an older group of patients, a co-morbidity often exists as well. Then the duration of the care visit is extended, the surgery results worsen, the mortality rate goes up, and the patients might get a urinary infection and pneumonia. It is a huge win if they get surgery within 24 hours. So it has been decided that this group is prioritised before basically anything else. If it is a [hip] fracture, it is going to be fixed. It is almost only exposed vascular damage or gunshot wounds that get attention before [hip fractures]. If old patients, like Ester 93 years old, have the misfortune to fall in such a way that her femur or hip does not break at the hip, but lower down instead. Then she has a femur fracture that is just as straining on the body, with just a high risk of complications. She should be prioritised the same as the hip fractures, but then the guidelines miss her. No one raises their eyebrows if she has to lie in the waiting room for four, five or even six days while waiting for surgery. That makes everyone who works with this realise that it is a bizarre system when you lift out certain groups and give them a "skip-the-line" treatment. They should get the treatment, but not at the expense of others. I and most others think that you have to realise that another kind of prioritising has to be done.

Maja described the development of guidelines in her speciality:

> The system we have in Scania, is based in part on The National Board of Health and Welfare's (Socialstyrelsens) guidelines concerning ethical principles. We developed it in orthopaedics about 7-8 years ago, when we realised that the resources were not enough and we needed a tool to make priorities with. Today, this tool is used among all surgical procedures in Scania as the primary way to prioritise. It is a scale from 1 up to 7. 1 is life threatening and means having to save lives and 7 is the lowest priority. Since all surgeries are ranked according to this priority scale, it helps us to prioritise when there is a lack of resources. We perform the highest prioritised groups first, regardless of [physician] speciality, if possible.

Social support systems. The interviewees stated that they have somewhere to go or someone to talk to about the challenging decision they have to make in their day to day work life. However, the social support system is different at every workplace and varies from formal to informal outlets. Tobias exemplified this with 'peer supporters', physicians with specialist education who act as a support for physicians in challenging situations. Sven illustrated that they have an open dialogue between colleagues, which is especially helpful to the younger physicians who might not have enough knowledge and understanding. Tobias also said that it is important to offer formal support, particularly to the younger physicians who may not have developed their own way of handling such situations yet. Jakob stated that as a physician, you get trained to handle emotionally challenging situations, and that it is a natural part of the job. However, when facing a difficult situation you are not used to dealing with, it becomes challenging to handle. He went on to explain that there are people to talk to about those cases, but in practice, it falls short due to inability or lack of time to utilise.

Inconsistent medical acting as a result of increased pressure and ignorance

The majority of interviewees expressed that they at times feel predisposed to order tests or examinations that are not necessarily indicated by medical factors, but rather due to patient-wishes or concerns. This predicament was commonly viewed as an ethical dilemma among the interviewed physicians. They also conveyed that they experience society and patients to lack medical comprehension, leading to unrealistic expectations of physicians' performances and the healthcare system. Additionally, all of the interviewees expressed an increase in pressure to perform, partly due to lack of staff and partly due to patients' expectations. Several of the physicians explained that patients sometimes worry extensively and might be unsatisfied with the first assessment of their state of health. Josefin explained the reasoning behind additional tests:

> The patient often seeks medical attention at care centres because of a feared illness. The patient has their own perceptions that you have to use all existing technologies to ease their worries. I, as a physician, need to acknowledge the patient's worries and evaluate how clinically likely it is that they suffer from what they fear. I also have to offer what is cost-effective and reasonable, both investigation-wise and treatment-wise. This is a type of dilemma that you face daily.

Ordering of additional tests in situations such as the above is what we call unnecessary treatment, meaning medical actions were motivated by other factors than strictly medical ones. However, not meaning that said actions were unmotivated or unnecessary per definition. The additional ordering of tests might be considered positive, from a cost-effective

perspective, since worried and unsatisfied patients might continue to seek medical attention, as explained by Daniella.

On the subject of cost-effectiveness, Sven also explained that patients do not always understand the limitations of a treatment and yet demand to have said treatment, which often results in a disappointing outcome. In those cases, the treatments were unsuccessful all-around. All interviewed physicians with patient responsibilities stated that they form their decisions based on medical indicators and expected benefit and that they have underlying consideration of cost, what we call motivated treatments.

Daniella provided an additional example on how to form a medical decision while considering costs, that illustrates what all of the interviewed physicians expressed on the matter. She explained how they, as surgeons, always do what is best for the patient and more or less disregard the factor of cost; the patient's needs come first. However, if you are faced with two equal options of treatment or measures which differ in cost, you go with the less expensive one. Moreover, if you are faced with an option between two different screws that differ in cost, you go with the one you deem to be most beneficial given the circumstances. For instance, the expensive screw is more likely to have a more positive impact than the cheaper screw when treating a 20-year old, compared to treating a 90-year old. That is because a screw in a 20-year old body will most likely have to function properly for a longer time than a screw in a 90-year old body. Oliver expressed a similar mindset, although emphasising the importance of removing oneself from the equation and strictly act on medical indicators and justice.

Increased pressure caused by, and ignorance among, patients. Some interviewees expressed their impression of a rise in patient-demand and subsequent escalation in pace. This change of pace has been noticeable over time, as exemplified by Karl:

> That is why you were able to work several days in a row, because you often got 4-5 hours of sleep. But nowadays you no longer sleep while on-call because everyone works all the time. It is a completely different tempo. The patients are much sicker, and those who do not need in-patient care do not get in-patient care. Which means that it is a lot more intense and a higher tempo.

Daniella also explained the rise in patient-demand by the status of healthcare in large cities compared to sparsely-populated areas:

> In today's society, with the increased specialisation, I think there is a picture [of healthcare] that we cannot achieve or sustain. In rural areas, it works. I have worked at a primary care centre before, where the physicians and the care centre substitute for a hospital. It is the place to go. But in the bigger cities, you want to go to a hospital because you have bigger faith in it and you know that there will be more specialised staff. It concerns where to put resources really. If you open the doors completely, there is an insatiable appetite for healthcare among patients, so you have to draw the line somewhere.

Furthermore, Josefin explained that more people seek help at an earlier stage than before, due to a larger fear of illness. She noted that more people are seeking medical attention for stress symptoms and exhaustion, and called it: "[...] the single most common search cause that has increased the most in recent years". Moreover, Josefin explained that patients with these issues are more time consuming than those with more ordinary search causes, such as sore throats that only requires a standardised test. Josefin and four others talked about how their

workloads at times were too much and that there was too little time, which negatively affects their personal investment.

As illustrated by Josefin foremost, the increased pressure from patients impedes on physicians performance, leading to inconsistencies in their medical acting. This is caused both by more people seeking medical attention, as well as people not actually requiring care. This conclusion is further supported by an ignorance that permeates society and patients in general today when discussing societal and patient-expectations of physicians and care. Josefin expressed the following:

> The populace needs more support for helping themselves in some way. More faith in their own abilities to affect their lives. If even more people seek medical attention, as the trend shows now, then the wait times will become even longer, and expenses increase. If resources are unchanged, the risk is that personnel quits instead because of the high workload. Politicians often say that physicians should become more accessible, for example, on evenings or even 24/7. Increased accessibility also has a price, patients with illnesses who really would be fine with self-care take resources from patients with more serious illnesses. It might sound paradoxical, but a certain threshold might be needed for resources to be used correctly. Even if this goes against the politicians' current direction.

All of the interviewees talked about how their patients are becoming increasingly informed, although not necessarily informed with the right information. Tobias exemplified this by explaining how pregnant women read about conditions, treatments and medicinal substances in informal forums online and make up their mind about them, despite their physician telling them otherwise. He also talked about a pill that can induce childbirth, but due to the patient's ill-informed stance, a vaginal gel associated with more risk in comparison had to be used,

which goes against his ethical code. Sven also gave a similar example, but blames a lack of understanding rather than a lack of information, claiming patients demand to have surgeries even though he deems them unlikely to be successful. When discussing patients being informed, the physicians expressed how they must deal with setting the patients mind straight and how that can be difficult for both parties involved, whether it concerns denying unnecessary treatment or trying to correct their expectations. Jenny described such a situation:

> Ethical questions can be more about everyday ethics. How the patients themselves participate in treatments or medical investigations, and how I should approach that. A smoking patient with small children at home has unstable asthma, while at the same time will not use the prescribed medicinal treatment because they think it is too expensive, but can still afford to buy cigarettes. Then they think that it is my problem that medicine is too expensive, but they still buy cigarettes and smoke with a baby at home. It is an ethically unsustainable situation. The patient has a responsibility for themselves, but it extends to the baby. I, as a physician, have a responsibility to listen to what the patient wishes and wants, but maybe I cannot do that in such a situation. Such an obviously damaging and unhealthy behaviour which, in my own opinion, leads to abuse of the child. And I still have to try to sustain a healthy relationship with the patient.

On the other hand, all interviewees experienced a positive effect of their patients being well informed. When a patient has read information on the correct forums, has been able to evaluate and absorb the information, it means that the patient may have a more active role in their treatment plan.

Tobias described a noticeable trend concerning induced labour, with women requesting to be induced due to fear of waiting, despite the procedure being associated with

risks. He further explained that although there are requests, the procedure is mainly done in accordance with medical indicators such as high blood pressure, pre-eclampsia and post-term pregnancy. Moreover, he explained that patients seek medical attention in earlier stages than before, likely as a result of ill-information online, especially in regards to reduced fetal movements.

Gap in decision-making and understanding

All interviewees claimed that important organisational decisions are made at a different level than that of those they affect. More specifically, the physicians expressed that upper management does not consider the patient's needs enough when making decisions. Jenny explained that she could imagine an accountant not seeing the patient behind numbers when cutting costs and subsequently cutting treatments, which she deems to be a serious possibility that could affect her work. Oliver had more a positive outlook on the ways of the organisation, compared to the other interviewed physicians, expressing faith in his superiors and on how decisions are being made in the organisation. He explained that they, in his department, have been able to initiate changes. One example he gave, which came from the floor, was that you should prick a patient in the wrist instead of the groin when you do a coronary angiography. This allowed the patients to sit in a chair instead of laying in a bed which allowed for more patients to get the treatment at the same time, which increased productivity. Neither Jakob nor Tobias stated that they feel like they can affect decisions made on a higher level because of the distance to upper management. Daniella put forward an example of the divide between administrators and physicians:

> When the funds started drying up they, from the outside, started to micro-manage. It has led to a sad development where more and more resources and more money is spent every year on administration, in some kind of naive belief that the more you control and regulate, the cheaper healthcare gets. But the reality is the opposite. We who work on the floor and see how things should work and get organised, have very little to say in the matter.

Furthermore, Daniella stated that in her workplace, physicians are in the leading positions, resulting in knowledge of where resources are best put to use. Sven also expressed that the right people need to be in the right places, in order for the system to function. Tobias argued that it is important to have a superior, in all hierarchical levels, who understands the speciality and its needs, before they had a superior who failed to comprehend the physician's needs, for instance, in terms of operating space. He continued to explain that "[...] the farther you get [from the patients], the less understanding you have. Then we have the politicians, and they have zero understanding. It is abominable".

Karl, who has had a somewhat leading position for several years, explained that decisions are made with a different mindset than that of those who work closely with the patients. He explained that when working in a leading position, you consciously formulate goals in numbers and letters, but when working with the patient, you think of a holistic perspective, including emotions. He clarified that there must be a continuous dialogue between the two sides and awareness from the decision-making side of what is created and received on the physician-side, while the physician-side must understand that things are measured and controlled on the decision-making side. Maja, who seldom works with patients, affirmed that she, in her leading position, must consider the whole rather than the specific

when advocating for healthcare, resulting in possible tension between her and her subordinates.

> As head of a department, I have the mandate to be a part of the decision on which patients to treat. However, I cannot fight only for the patients that are coming to my department. I have to look at the whole picture, which means I have to accept that the resources dedicated to our patients are used for patients with higher priority. It can be seen as a sign of weakness internally. However, I strongly believe that the resources should be used where the need is the highest, according to the ethical principles previously mentioned. I feel it is harder to handle this internally, than upwards [in the hierarchy] and outwards.

Sven expressed concerns regarding the use of an expense-based budget, resulting in objectively good financial results when relatively few patients have been treated:

> The bigger problem is still the lack of hospital bed capacity and nurses. The weird thing is that because we have an expense-based budget, when the hospital bed capacity was lower and we could not perform as many surgeries, our red numbers turned to black because we could not treat as many. That is a bad moral in such an economy, one would think.

Daniella explained how guidelines, conceived at higher levels collide with medical assessments at times, as explained before concerning the example of the hip fracture. Tobias affirmed how expertise comes into play when dealing with medical assessments and how guidelines are not always optimal to follow. He explained that the guidelines can be helpful and a support for especially younger physicians, but that experience and a holistic perspective of the patient can form a different and tailored assessment.

Organisational interference with physicians' ability to perform

All of the physicians we interviewed discussed a gap between decision-making and understanding at higher hierarchical levels than healthcare personnel, as previously explained. Jakob explained this well:

> There are many things in society that only physicians are allowed to do, then you would think that maybe you would be a little freer, but you are really controlled. As a physician, you belong at the bottom of the formal hierarchical management structure within the healthcare organisation. Many might not admit it, but I think that there is a little friction there. That you belong to the strong profession and you are supposed to stand up for the patient and have the power [to do so], but at the same time, you are at the bottom of the formal management structure and are supposed to follow orders. That split is what I think makes it so challenging to be a physician today, that the financial management has become more palpable.

All interviewees talked about how other organisational components affect them, such as demands for savings, disapproval of medicinal substances, as well as compensation-incentives. All interviews considered, we found that physicians endure negative effects of organisational factors in terms of measures resulting in limitations of performance, including emotional strain, poorer cost management, quality of care and inefficiency.

All interviewees talked about the demands to cut costs not being in line with the profession since healthcare cannot be confined in numbers and kept to a budget without damaging the operation and also because it is impossible to value what is done (a life for

instance). From the interviews, it became clear that healthcare personnel are unsatisfied by the way the business is being conducted. Oliver, who works in a leading position, admitted that:

> One year we cut a little too much [expenses] on personnel, and it probably affected the organisation negatively. Generally, it can take very little time to break down an organisation, but it takes a long time to rebuild it again. So you could say that the organisation can be affected negatively if the demand for cutting costs becomes too big.

Josefin explained that they probably work harder than they should for things to be sustainable, resulting in resignations. She clarified that management could be short-sighted when attempting to maximise operations, putting unreasonable pressure on the personnel. Maja and Jakob described how healthcare personnel are affected by the vast desire to save expenses. Maja provided the example of how over-staffing for surgeries ceased in her department, resulting in empty operation-rooms and longer waits for surgery if the whole team is not complete for when surgery is scheduled. Furthermore, she explained that this way of organising is not cost-effective since resources could be, but are not, used. This also affects quality of healthcare when patients in need of surgery are turned away or forced to wait, which is an example of when organisational control mismatches with the profession. All interviewees deemed the matter of care delays for patients, an important issue. Sven described the situation:

> I do feel that we are undersized, which creates long queue times for people who have big problems. First, they have to wait maybe half a year to come to our clinic and then they may have to wait for years to be operated on. That is inhumane, yet has gradually increased over time.

The interviewees appeared to view the subjects of waiting lists and lack of resources as something bothersome, as issues out of their control. Josefin expressed that even though she works over-time occasionally and does more than what is required of her, she cannot offer her patients earlier appointments even if she wants to. Sven explained that he occasionally has to witness patients' conditions worsen as they wait for care, which is not only an ineffective use of resources but also emotionally draining, a situation similarly mentioned by Daniella.

Tobias and Jakob talked about how cost-confinement and red tape resulted in inefficient use of resources, as well as poorer quality of care, concerning medicinal substances. Both provided examples of how a medicinal substance is preferential in the opinion of the physician but is unapproved for, what they deem to be, illogical reasons. Jakob gave an example concerning medicinal substances for sedating patients:

> [...] we can do pretty much whatever we want. But there are some great examples of medicines that are considered expensive, which shows off the stupidly stingy behaviour. It is hard to explain because of how medically intricate it is. When you operate on patients, you sometimes have to administer drugs that make all the muscles relax and they become paralysed. When the surgery is finished, you want to keep the patient sedated until the drugs wear off, when you wake the patient you want them to be able to move and breathe. There is a drug that works in one minute by making the other drug wear off. Another way is to wait and keep the patient sedated until the drug is broken down by the body, which can take a lot longer. It is such a stupidly stingy move, that we cannot administer a certain medicine because it costs a lot, while in reality it only costs a fraction compared to the cost of keeping the patient sedated for an additional hour with personnel who have to wait at the side of the patient the whole time. Also, there are very few patients who want to be

> sedated for an additional hour. So it is only a stupidly stingy behaviour, that you want to decrease costs for medicine, but do not understand what it costs in the long run.

Tobias gave this example when discussing decisions that are not motivated by either cost or effect, but rather technicalities:

> [...] this Cytotec pill costs 2.5 SEK per pill, [...]. That means you can induce labour for 2.5 SEK, but it is not registered [for that purpose] which means my superior wants us to jump over to another medicine called Augusta that contains the same substance but costs 800 SEK. Today we induce labour in 25 per cent of all women, meaning that decision costs many million kronor per year.

Furthermore, all interviewed physician seemed relatively unbothered by the restitution claim and demands for cutting costs in general and expressed that they would continue to go about their business as usual, since they already work as they see fit, concerning both ethics and costs. Tobias stated "I am here to take care of the patients in the best way possible. I do not care about the changes". Jenny also explained that there is the threat of forced administration looming, if costs are not reduced, yet not even the threat of being let go affects how the physicians perform. Additionally, Tobias explained that during his 20 years as a physician, he has heard the same demands again and again, without change. However, for a short time, the hospital was run differently and the new operations manager wanted to make full use of the resources available, including an expensive X-ray machine which otherwise was used only a third of the day. Tobias explained that he experienced that this way of running operations was more effective in every regard, but that it was stopped by politicians with the argument that it cost too much.

Keeping with the topic of organisational measures to increase profit and effectiveness, several incentives for compensation has been tried, according to Maja. She explained that, for a while, surgeons were compensated for every surgery performed, which sometimes led to physicians reporting one surgery as several. However, all interviewees concur that physicians work in a profession where incentives are of an ethical nature. The interviewees expressed differing views on how invested physicians are in their work concerning working over-time or doing more than what is required. Daniella stated that physicians and their colleagues, i.e. nurses, take different personal responsibility for their patients. She asserted that if a physician works in a big hospital, it is easy for the physician to become anonymous and for the work to become impersonal. She also expressed that physicians and other colleagues do not take their full responsibility. She affirmed that when working in healthcare, you must be personally invested and not limit your responsibilities to the clock. If everyone takes their responsibility and works over-time once in a while, the waiting times to get an appointment to see a physician would be shorter. Tobias also provided an example of his commitment to the profession by saying: “I cannot think of any other profession that invests as much. [...] I have accepted that I give away many hours to society per week, I invest a lot”.

Maja and Jakob explained how there is a misperception of healthcare quality in our society, and that this misperception can affect healthcare personnel negatively. Maja explained that physicians dedicate their lives to something selfless, but is met by harsh critique presented to society by media, which she deems a fundamental problem. In addition, when we asked the interviewees why they wanted to become physicians, they all replied ‘because I wanted to help people’, which further illustrates the fundamental objective of the profession.

ANALYSIS OF EMPIRICAL DATA

The relationship between the physician and superior and the one between the physician and patient, are both to be regarded as agency relationships, per Eisenhardt's (1989a) definition. The agency problem is prevalent in both of these relationships, in terms of conflicting wills, wants, and goals as well as the difficulty of verifying the agent's performance.

In accordance with Angell (1993) and Langer et al.'s (2009) take on physicians' dual principality, the physicians we interviewed regularly weighed the needs of the patient on one hand and society on the other, concerning the optimal use of resources. Foremost, the physicians spoke on the issue of putting patients' needs first, though not at the expense of others unless necessary when prioritising. In contrast to Angell's (1993) assertions, our interviewees deemed this trade-off to be part of and necessary for the profession. Subsequently, we found that when the principals' objectives do not align, the physician favours the patient.

We have modified the DUPAM to include the medical profession as an essential factor. The dashed lines show how the relationships overlap and how this puts the physician at risk for conflicting interests between the principals (Langer, 2006), where we have found that the profession copes with the issue. We employ DUPAM to distinguish the optimal conditions for both the explicit and implicit contracts associated with the physician and subsequently explain the observed attributes for the real contracts. In doing so, we show what motivates physicians in healthcare organisations that lack financial incentives and what is necessary for attempts to control them.

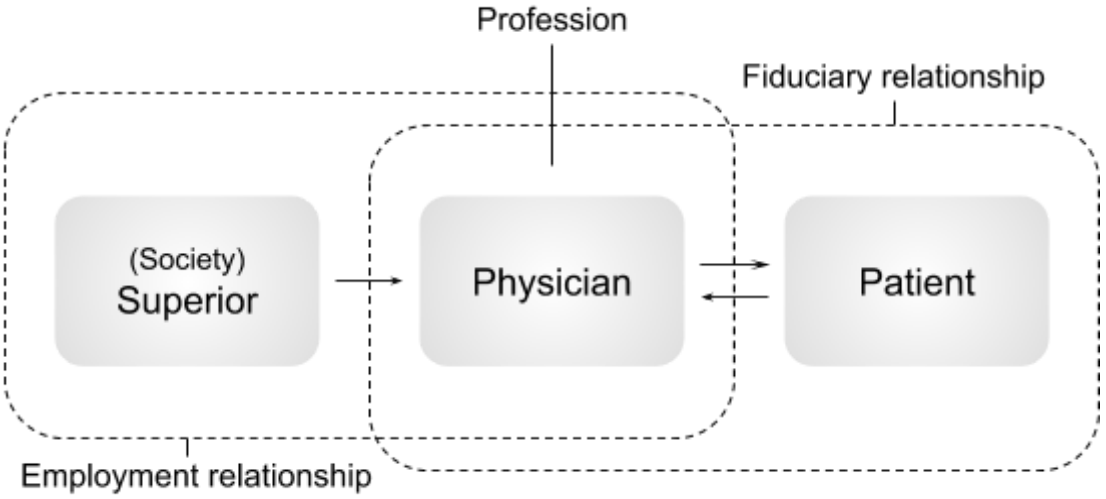

Figure 2. Reworked DUPAM with profession added.

Employment relationship

The explicit nature of the employment relationship implies agreements and stated objectives formulated by the superior, whose role is to monitor the physician, as explained by Langer (2006). However, our findings show that the employment relationship cannot be entirely explicit, as the superior expects the physician to perform in accordance with the profession, which makes the relationship partly implicit. Our findings suggest that difficulties exist in controlling the physician's actions, given the expertise necessary for professional performance. In situations where interests between superior and physician differ concerning medical actions, the physician merely motivates their assessment, which is difficult for the superior to dispute.

Consequently, our findings implicate trust to be necessary for the employment relationship as control mechanisms are an insufficient substitute. This conclusion is further supported by the ongoing shift from New Public Management to trust-based management in Swedish healthcare. In the following, we analyse the empirical themes *Gap in decision-making and understanding* and *Organisational interference with physicians' ability*

to perform, relating to the employment relationship in DUPAM. In doing so, we uncovered the presence of information asymmetry, moral hazard, increased pressure to improve cost-effectiveness and moral distress.

Gap in decision-making and understanding. Langer et al., (2009) point out that information asymmetries are considered to be favourable to the agent, referring to the physician having an information advantage over the patient. According to our findings, however, the employment relationship is also characterised by information asymmetries, not to mention between physicians as well. The gap between decision-makers and those they affect "on the floor" is typified by a lack of understanding for the medical profession despite a large portion of decision-makers being medically educated, according to our interviews. This is exemplified by Tobias criticising his previous operations manager. Also, Maja expressed that physicians in her department do not always understand her participation in decision-making.

When opinions differ in the employment relationship, it typically concerns prioritisation of patients, where superiors have set guidelines. There lies the risk of moral hazard when guidelines are not aligned with the physician's assessment, as the physician has the power to act in their own interest, concurring with Langer et al.'s (2009) claim. Although it was made clear in our interviews that although these guidelines are not law or required to be followed, physicians must be prepared to be questioned when deviating from them. When the guidelines do not coincide with the physician's assessment, a conflict of interest would normally emerge, as explained by Langer et al. (2009). However, in our interviews, it was clear that the physician will give precedence to their assessment as an implication of the profession and thereby avoid the negative effects of the conflict of interest between their superior and patient, although there are exceptions. One such exception is the hip fracture

versus upper leg fracture assessment mentioned by Daniella, where arbitrary guidelines go against ethical considerations.

Organisational interference with physicians' ability to perform. Increased pressure to improve cost-effectiveness (Angell, 1993; Langer, 2006; Shortell et al., 1998) in the employment relationship takes its most common physical form in termination of personnel, according to our interviews. In our interviews, it was evident that reduction of resources in terms of staff often harms the working environment as it results in an increased workload for the remaining staff and inefficiencies in the workplace. This is illustrated by Maja when she talked about not being able to over-staff in order to maintain the surgery schedule. It was also explained that unreasonable workload leads to a negative effect on physicians' investment in their work, further resulting in inefficiencies.

Cost-effectiveness being a value that competes with the trustful independence in self-governed professionalism for the legitimisation of professional performance, according to Langer (2006), was unsupported in our interviews. Although the physicians perceived there to be a challenge making optimal decisions (for the patient at hand given the patients as a whole), there was little to no difficulty in legitimising their professional performance, since the trustful independence at all times coincides with the profession's values, including cost-effectiveness. What we discovered was that the physicians motivated their medical actions based on the profession's values – treating patients as best they can without compromising others – which could in practice vary between physicians.

Shortell et al. (1998) found physicians to be forced to consider not only the needs of the patient but also those of the organisation and the physicians' own financial interests. When discussing the physicians' ability to perform, they experienced little restriction from the

organisation. Instead, they claimed to enjoy the freedom to act in accordance with their judgment, despite occasional limitations in terms of norms in decision-making and guidelines on prioritisation of patients and courses of treatment. The pressure to improve cost-effectiveness became apparent in situations where physicians feel forced to follow protocol because of cost despite it not being cheaper in the long run, which subsequently indicates a form of information asymmetry. Moreover, our findings suggest that physicians are motivated by ethical interests rather than financial ones, which is why their objectives serve both themselves and the organisation, despite the organisation not having (financial) interests aligned with the physicians'. Although Sweden does not use fee-for-service in public healthcare, financial incentives in the form of compensation per surgery have been tried, which resulted in moral hazard in some cases. Langer et al. (2009) assert economic concepts, such as financial incentives, to be inadequate sole instruments for controlling medical acting, and consequently, that psychosocial incentives, relating to work environment for instance, are to be considered by superiors when investing trust. Our findings entirely support this assertion.

Additionally, Angell (1993) points to the fee-for-service system as a main cause for the rising expenditure in US healthcare, which subsequently led to cost-containment policies on the part of large third-party payers, such as the government. According to our findings, however, the rising expenditure in Swedish healthcare is perceived to be a result of the rising age of the population among physicians, advancements in medical technologies and societal ignorance for the profession. Much like the USA, this has led to cost-containment measures on the part of a large third-party payer – the taxpayers. In accordance with Högberg & Falkenström (2018), we have found that there is a distance from ethics, the higher you go from the floor.

During our interviews, it became apparent that an organisation which, in the eyes of a physician, impedes on their professional performance will result in either defiance (moral hazard) or moral distress. An example of a moral event is described by Daniella when discussing arbitrary guidelines surrounding hip fractures and immediate surgery. She said that a similar injury a few centimetres down would have resulted in the same risk for the patient as an injury a few centimetres up. She expressed feeling restricted in her freedom to perform surgery on such a patient because of the guidelines. That means that the taken action, not performing surgery within 24 hours, is not what Daniella would prefer, which could result in moral distress, per Morley's (2018) definition.

Among the physicians we interviewed, moral distress appeared to be common in healthcare but varied among specialities due to what moral events are prone to occur in different specialities. It is evident that there are ways of coping with moral distress in the workplace, both of formal and informal nature, which aligns with Langer's (2006) description of psychosocial incentives. Guidelines set by superiors could be viewed both as a cause and a relief for moral distress, depending on experience, speciality and individual situation.

Fiduciary relationship

The implicit nature of the fiduciary relationship implies trust between the physician and patient for the work – providing care – to be performed in accordance with the patient's interests, as defined by Langer (2006). We have found the physician's professional values to be aligned with the patient's best interest, suggesting little need for control mechanisms implemented by the patient in this agency relationship, as the interests are mutual and therefore low risk for conflicts. From our interviews, we have gathered that the physician-patient relationship has changed towards increased patient engagement, whereas

before, the patient was a passive participator. In the following, we will analyse the empirical themes *Challenge in prioritising* and *Inconsistent medical acting as a result of increased pressure and ignorance*, relating to the employment relationship in DUPAM. In doing so, we uncovered the presence of information asymmetry, moral hazard, increased pressure to improve cost-effectiveness, cost-effectiveness as an accepted value and moral distress.

Challenge in prioritising. In contrast to what both Langer (2006) and Högberg & Falkenström (2018) found on the matter of cost-effectiveness as an accepted value in professional ethics, we found that ethics and cost-effectiveness are very much one and the same for physicians. Mainly, this is evident in prioritisation of patients and to an extent resources, as well as the fundamental values of the profession. This was clear in the example of improving coronary angiography in order to increase productivity. Physicians act in accordance with ethical values, that are in part legislated. Due to information asymmetries and contradicting interests between the physician and superiors, moral hazard is prevalent in the employment relationship. In the fiduciary relationship, however, the legislation ensures that the physician acts in the best interest of the patient as well as the values of the profession. Numerous examples were provided in our interviews, showing moral difficulties in acting according to patient-wishes. This is illustrated by Jakob and the example he gives on prioritisation of patients with life-threatening conditions while having limited resources. These difficulties can be viewed as moral events, in accordance with Morley (2018).

Inconsistent medical acting as a result of increased pressure and ignorance. Increased pressure to improve cost-effectiveness (Angell, 1993; Langer, 2006; Shortell et al., 1998) in the fiduciary relationship takes its most common physical form in more people seeking medical attention, according to our interviews. We found inconsistencies in medical

acting to be the result of increased pressure in terms of workload and responsibilities, and ignorance in society concerning the need for medical attention and lack of understanding thereof. Both of these factors appear to be consequences of increased medical awareness and fear. This has lead to a reality where patients demand different treatments than their physician would recommend as a result of (mis)information, a variant of information asymmetry, obtained online.

Consequently, this has created a conundrum for physicians concerning how to treat patients optimally. Swedish law dictates that patients can have a significant say in what treatment they receive, which means that patients can force physicians to deviate from optimal treatments to treatments connected to higher risks and higher costs instead. We also found that the physician's medical knowledge was undermined because of the patient being informed, as Langer et al. (2009) did. Moral hazard does not always exist in the fiduciary relationship, because physicians cannot deviate from what their patients want, as mentioned before. Additionally, patients nowadays know what they can demand from physicians to a larger extent. When patients make no attempt to understand the processes or understand their disease, every decision is left up to the physician whose goal is the same as the patient, to make them well. The increased misinformation and convictions amongst patients can give rise to moral distress for their physicians. This is illustrated by Tobias' example on the pill and the vaginal gel to induce labour. In this case, the patient's strong will forced Tobias to act against his assessment.

Contrary to what Langer et al. (2009) said but, in line with Langer (2006), we found that information asymmetries are more problematic than favourable for physicians nowadays, especially if the patient has read information on the wrong forums. Also, there might be a lack of understanding rather than lack of information for the patient, which most certainly will

affect both the patient and the doctor, supported by Langer's (2006) assertion of information asymmetry's inadequate definition. We also found, in line with Langer et al. (2009), that the physician's role has changed over time due to patients being informed and prepared. Today, the physician must deal with setting the patient's mind straight, which can be difficult for both parties involved, whether it concerns denying unnecessary treatment or trying to correct their expectations.

Profession

Although the interests of the superior and those of the patient should be the same, it was apparent in our interviews that they may diverge, leaving the physician in the middle. However, we found that the profession and its values prevent an active conflict between the agent and the superior, in most cases, as the physician gives precedence to the interest of the patient. Also, a divergence between the interests of the physician and superior was evident. Sven illustrated this in his statement concerning the organisation's way of measuring outcome where the inability to treat patients due to lack of resources result in good measured outcome since the department stayed within budget. He, as well as others interviewees, expressed this to be an issue and an example of bad moral in the healthcare system, as the organisation's way of conducting business is not beneficial to the profession. We have discovered trust to be essential for both the employment relationship and the fiduciary relationship due to the nature of the profession which entails expertise and understanding. Meaning the explicit contract is insufficient for controlling the physician as the implications of the profession cannot be conformed to a contract as a whole.

Additionally, the superior's directives must coincide with the interests of the patient in order to affect the physician. In our interviews, it was evident that the physician will continue

performing the way they deem fit, with little interest in organisational changes. Due to changing demands from patients and the development of medical care, the superior must rely on the physician to perform in accordance with the profession's values in order to secure quality of care. Likewise, the implicit contract must be based on trust from both parties, indicating a societal need for counteracting ignorance for the profession.

DISCUSSION

Conclusions

In this thesis, we have shown how physicians are affected by and deal with conflicting interests between their patients and superiors, in terms of personal ethics and cost-effectiveness measures. Our conclusions show what motivates physicians in healthcare organisations that lack financial incentives and what is necessary in order to control them accordingly. We have found trust to be an essential characteristic for both the employment relationship as well as the fiduciary relationship. In addition, we found that the profession protects the physician from direct conflicts in the agency relationships and that the physician always will give precedence to their patients' needs, ultimately resulting in little conflict between the patient and superior. Also, in order for directives and organisational changes to have an effect on physicians, the changes have to be in the best interest of the patient and in line with professional values. Furthermore, cost-effectiveness permeates the professional values, as physicians strive to use resources in order to help as many patients as possible, without compromising others. Below follows a summarising table of our conclusions.

Theory	Findings	Conclusions
Dual principal-agent model (DUPAM)	Physicians prioritise the patient always (fiduciary relationship), despite organisational involvement (employment relationship).	Physicians will resist directives from superiors not in line with the optimal outcome for patients. The profession prevents actual conflict between the two principals, as precedence is given to the fiduciary relationship with the patient.
Increased pressure to improve cost-effectiveness	In the employment relationship, it takes form as the termination of personnel and in the fiduciary relationship the form of more patients to attend to.	Physicians have no difficulty in legitimising their professional performance, since the trustful independence at all times coincides with the profession's values, including cost-effectiveness, despite increased pressure to cut costs. Like the US, Sweden's healthcare costs are rising, but not as a result of fee-for-service. Similarly to the US, the expenditure of cost has led to an increased pressure to save money for a third-party payer.
Cost-effectiveness as an accepted value	Cost-effective thinking is incorporated in the profession, in order to treat as many patients as possible, visible in the fiduciary relationship.	Cost-effectiveness is an accepted value amongst physicians in Swedish healthcare.
Information asymmetry	Is found in the employment relationship and among physicians, and also in the fiduciary relationship because of ignorance and fear amongst patients.	It is indicated that there is a form of information asymmetry when the guidelines set by superiors diverge from the physician's assessment. Patients are more informed but unable to comprehend the information, which negatively affects their quality of care. The term information asymmetry does not separate knowledge and information.
Moral hazard	Is prevalent in the employment relationship and relates to diverging interests between superior and physician concerning patient-needs.	The physicians are difficult to control since they are motivated by ethical incentives rather than financial ones. Moral hazard does not exist in the fiduciary relationship, due to its ethical nature and legislation.
Moral distress	In the employment relationship, the physician is free to act on their assessment despite guidelines from superiors. In the fiduciary relationship, moral distress is prevalent but varied amongst specialities.	Exists (rarely) in the employment relationship when the physician has to go against their judgement. In the fiduciary relationship, it depends on a lack of resources because the physician has to prioritise and due to the patient's power to demand treatment, which goes against the physician's recommendation.
Profession	Physicians will always act according to their professional values and have little regard towards organisational changes. Physicians believe that the professional values permeate the organisation.	In order for the organisational changes to have an effect on the physicians, the changes have to be in the best interest of the patient and in line with the professional values.

Table 3. Conclusion of the analysis.

Interpretation of results

Our findings suggest that there is work to be done on a societal level as ignorance and lack of understanding for the profession impede the physician's ability to perform. The fact that physicians give precedence to the fiduciary relationship before the employment relationship indicates that the physician will be difficult for the superior to control unless their goals and methods align with the patient's best interest. This not being the case for the restitution claim, as superiors mainly have numbers in regard when cutting costs, affecting quality of care. It is further suggested that NPM, as it focuses on financial performance, is an inadequate governance method. Since ethics motivate physicians, financial incentives are also insufficient to control medical acting. This is further supported by the risk for false incentives, resulting in a negative effect on quality of care, as established by both previous research and our interviews. The critique that has been vocalised in media concerning the inadequacy of performance-based management (NPM) as it overlooks the patient, misallocate resources, attend to matters unrelated to patient-care, leading to ineffective efforts to improve quality of care and cost saving (Agerberg, 2014a; Agerberg, 2014b; Björgell, 2017), is supported by our findings. Despite experiencing much freedom in their work, we saw a risk for moral distress as physicians feel limited and unable to see all the patients they want to, mainly due to lack of resources, which aligns with Ekström & Fridjonsson (2016).

Our impression of the trust reform is that it represents a step in the right direction, regarding how to manage Swedish healthcare. The motivation for the reform is to incorporate healthcare personnels' knowledge and experience in the governance, which is what we have found to be a missing factor in management during our interviews. At the same time, many physicians seem uninterested in organisational changes, as they have seen unsuccessful

attempts at change come and go. We assess that the reform has to focus on the patient instead of financials, as well as convey how it might contribute to the physician's' ability to perform as they deem fit, if management wants it to succeed.

Possible shortcomings and the generalisability of the study

The purpose of the study is to describe how physicians are affected by and deal with conflicting interests between patients and superiors in an organisation that lack financial incentives, using Sweden as an example. However, our conclusions might not be generalisable to other healthcare systems with similar structure, given the cultural denominator and historical development. Also, our findings are extracted from nine physicians, which entails the risk for the results not being entirely representative for the whole of Sweden. Also, the spread of physician over specialities would be interesting to examine further. For example, the three orthopaedists we interviewed expressed very similar views, which were a contrast to those of the one cardiologist's. Commonly in our interviews, physicians expressed views to be sometimes exceptions to specialities, suggesting that a similar study to ours being conducted targeting other specialities would show a discrepancy in results. However, considering that we were interested in individual physicians' experiences, we do not consider this concern an issue. Also, we made no attempt to discern differences between public and private employers as principals, which could be of interest in future research. Moreover, we have found a discrepancy in what is being presented in media and what is perceived by common physicians.

The implications of the study and possible future research

The presented results of our study are a smaller part of the collected data. We believe that further research definitely could be done with change management as the focus. Even though we did not focus primarily on change, we think that we still gathered enough data to answer a similarly sized research project on the subject. Change management, according to the data we collected, has a long way to go in Swedish healthcare.

We hope that our study shows politicians and other higher-ups in the Swedish healthcare organisation the massive gap between physicians and politicians concerning knowledge, insight and understanding for the healthcare organisation and what keeps it working. It should also help politicians understand how their suggestions for change in the healthcare organisation are received by physicians, and how they should shape such suggestions in the future.

Our study provides a solid ground to build upon if future researchers want to expand on our work by studying other research contexts, such as other healthcare organisations that lack financial incentives or want to take a closer look at our own modification of the DUPAM, the profession. With the knowledge and data contained in our study, it will be much easier to produce a quantitative study to gather data more extensively, with a standardised approach.

FINAL REMARKS

First of all, we want to thank the participants of our study, the physicians. Without them, this study would never have happened. We can safely say that we have a newfound respect for them and the fantastic work they do daily.

We also want to thank both Olof Hallonsten, our supervisor, and Stein Kleppestø as well. Olof, for showing us everything we did right, and Stein, for showing us everything we did wrong. Stein gave us advice at the beginning of the writing process which has permeated our whole thesis. Olof gave us guidance throughout our study which kept us on the right track, enabling us to deliver this thesis.

REFERENCE LIST

SFS 2017:30. Hälso och sjukvårdslag. Stockholm: Socialdepartementet. Available online: http://rkrattsbaser.gov.se/sfst?bet=2017:30 [Accessed 10 April]

SFS 2017:372. Lag om stöd vid klagomål mot hälso- och sjukvården. Stockholm: Socialdepartementet. Available online: http://rkrattsbaser.gov.se/sfst?bet=2017:372 [Accessed 10 April]

SFS 2017:725. Kommunallag. Stockholm: Finansdepartementet. Available Online: http://rkrattsbaser.gov.se/sfst?bet=2017:725 [Accessed 25 April 2019]

1177 Vårdguiden Västra Götalandsregionen. (2018). Prioriteringar i vården, Available Online: https://www.1177.se/Vastra-Gotaland/sa-fungerar-varden/lagar-och-bestammelser/prioriteringar-i-varden/ [Accessed 9 April 2019]

Agerberg, M. (2014a). Detaljstyrning tar fokus från egna kvalitetsprojekt, *Läkaretidningen,* 15 May, Available Online: http://www.lakartidningen.se/Aktuellt/Nyheter/2014/05/Detaljstyrning-tar-fokus-fran-egna-kvalitetsprojekt/ [Accessed 24 April 2019]

Agerberg, M. (2014b). NPM var en syndabock ingen hade hört talas om, *Läkartidningen,* 29 April, Available Online: http://www.lakartidningen.se/Aktuellt/Nyheter/2014/04/NPM-var-ensyndabock-ingen-hade-hort-talas-om/ [Accessed 24 April 2019]

Angell, M. (1993). The Doctor as Double Agent. *Kennedy Institute of Ethics Journal.* **3***:*279-286.

Arrow, K.J. (1963). Uncertainty and the welfare economics of medical care. *American Economic Review.* **53**: 941–973.

Björgell, P. (2017). Vården utgår inte längre från patientens behov, *Dagens samhälle,* 24 May, Available Online: https://www.dagenssamhalle.se/debatt/varden-utgar-inte-langre-fran-patientens-behov-17177 [Accessed 16 April 2019]

Björnberg, A., & Hjertqvist, J. (2018). Sverige inte längre sjukvårdens föregångsland, *Göteborgs-Posten,* 29 January, Available Online: https://www.gp.se/debatt/sverige-inte-längre-sjukvårdens-föregångsland-1.5111621 [Accessed 15 April 2019]

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology.* **3**: 77-101.

Bryman, A., & Bell, E. 2011. Business Research Methods. 3rd edition. New York: Oxford University Press Inc.

Clinical Studies Sweden, (2019). The Swedish health care system. Available Online: https://www.kliniskastudier.se/english/sweden-research-country/swedish-healthcare-system.html [Accessed 12 April 2019]

Diamant, B. (2019). Läkare: Därför är svensk sjukvård både dyr och ineffektiv, *Aftonbladet,* 13 March, Available Online: https://www.aftonbladet.se/debatt/a/OnGgQ3/darfor-ar-svensk-vard-bade-dyr-och-ineffektiv [Accessed 15 April 2019]

Eisenhardt, K. (1989a). Agency Theory: An Assessment and Review. *The Academy of Management Review*. **14:** 57-74.

Eisenhardt, K. (1989b). Building Theory from Case Study Research. *The Academy of Management Review*, **14**: 532-550.

Ekström, D., & Fridjonsson, E. (2016). Sjuksköterskors upplevelse av etisk stress: en litteraturöversikt. BCs thesis, Sjuksköterskeprogrammet, Ersta Sköndal Högskola, Avaliable Online: http://esh.diva-portal.org/smash/get/diva2:1051625/FULLTEXT01.pdf [Accessed 9 April 2019]

Frank, R. (2013). What Sweden Can Tell Us About Obamacare, *The New York Times*, 15 june, Available Online: https://www.nytimes.com/2013/06/16/business/what-sweden-can-tell-us-about-obamacare.html [Accessed 5 March 2019]

Hasselbladh, H., Bejerot, E., & Gustavsson, R. 2008. Bortom new public management: institutionell transformation i svensk sjukvård. Lund: Academia Adacta AB.

Höglund, A., & Falkenström, E. (2018). The Status of Ethics in Swedish Health Care management: A Qualitative Study, *BMC Health Services Research.* **18**:608.

Langer, A. (2006). Trust as a criterion and heuristic approach to sociopolitical consultation. *Current sociology - SAGE journals.* **54**: 663-678.

Langer, A., Schröder-Bäck, P., Brink, A. & Eurich, J. (2009). The Agency Problem and Medical Acting: An Example of Applying Economic Theory to Medical Ethics. *Medicine, Health Care and Philosophy - A European Journal*. **12**: 99-108.

Lundberg Andersson, H. (2018). Ny mätning: De är viktigaste valfrågorna, *Expressen,* 9 May, Avaliable Online: https://www.expressen.se/nyheter/val-2018/ny-matning-de-ar-viktigaste-valfragorna/ [Accessed 10 April 2019]

Morley, G. (2018). What is “moral distress” in nursing? How, can and should we respond to it?. *Journal of Clinical Nursing.* **27**:3443–3445

Pearl, R. (2017). Healthcare’s Dangerous Fee-For-Service Addiction, *Forbes,* 25 September, Available Online: https://www.forbes.com/sites/robertpearl/2017/09/25/fee-for-service-addiction/ [Accessed 9 April 2019]

Regeringskansliet. (2018). Tillitsbaserad styrning i välfärden – idag tog civilminister Ardalan Shekarabi emot Tillitsdelegationens huvudbetänkande, Available Online: https://www.regeringen.se/pressmeddelanden/2018/06/tillitsbaserad-styrning-i-valfarden--idag-tog-civilminister-ardalan-shekarabi-emot-tillitsdelegationens-huvudbetankande/ [Accessed 25 April 2019]

Region Skåne, (2019). Region Skånes årsredovisning 2018. Available Online: https://www.skane.se/siteassets/organisation_politik/publikationer_dokument/ar18.pdf [Accessed 12 April 2019]

Shortell, S., Waters, T., Clarke, K. & Budetti, P. (1998). Physicians as Double Agents: Maintaining Trust in an Era of Multiple Accountabilities. *Journal of the American Medical Association*, **280**: 1102-1108.

Skärvad, P-H., & Lundahl, U. 2016. Utredningsmetodik. 4th edition. Lund: Studentlitteratur AB.

Ström, M. (2018). Väntetider och överbeläggningar växande problem i svensk sjukvård, *Läkartidningen,* 30 January, Avaliable Online: http://www.lakartidningen.se/Aktuellt/Nyheter/2018/01/Vantetider-och-overbelaggningar-vaxande-svenska-problem/ [Accessed 12 April 2019]

Swedish Institute. (2018). Healthcare in Sweden, Available Online: https://sweden.se/society/health-care-in-sweden/ [Accessed 9 April 2019]

The Swedish Association of Local Authorities and Regions, (2018). Ekonomirapporten, December 2018: om kommunernas och landstingens ekonomi, Avaliable Online: (https://skl.se/download/18.28a68ed6167c0a9a9d611fe4/1545312813660/Ekonomirapporten-december-2018.pdf [Accessed 8 April 2019]

Yin, R. K. 2009. Case Study Research: Design and Methods. 4th edition. London: SAGE.

APPENDIX

Appendix A: Interview guide

Vi studerar sista terminen på ekonomikandidatprogrammet på Lunds universitet. Vi har inriktat oss på företagsekonomi med specialisering på strategic management. Vi håller på att skriver vår kandidatuppsats som handlar om kostnadseffektivisering och etik och dess verkan på läkare i Sverige. Detta har undersökts tidigare, framförallt i USA, men inte i Sverige. Vi vill därför ta reda på hur läkare hanterar etik- och kostnadsfrågor i sitt dagliga arbete, speciellt nu när Region Skåne har gått ut med att de har ett återställningskrav på 1,8 miljarder som ska återbetalas på 3 år. Enligt lag ska etik tas i första rum men en studie från 2017 visar att man på managementnivå i svenska vården istället prioriterar kostnadsfrågor.

Från våra intervjuer vill vi kunna bilda oss en uppfattning om hur läkare *påverkas* av aspekterna etik och kostnad. Vi vill därför att du förankrar dina svar i din arbetssituation genom att ge exempel då vi kommer att intervjua olika slags läkare med olika bakgrunder. Vi är alltså intresserade i dina personliga åsikter och erfarenheter. Du kommer att vara anonym i uppsatsen men dina svar kommer att spelas in och transkriberas. Vissa av frågorna kan uppfattas som känsliga och vi förstår därför om du inte vill svara på dessa fullt ut, men vi uppskattar ändå så fullständiga svar som möjligt. Intervjun kommer att vara mer som ett samtal där vi ställer frågor till dig, men du får gärna utveckla. Dock kommer vi kanske att avbryta din tankegång om vi känner att det går åt fel håll och därmed styra samtalet i rätt riktning. En person kommer att styra intervjun medan de andra två kommer att anteckna och hålla koll på tiden. Vi kommer vara klara innan kl __. Vi tänker oss att vi börjar med en lite enklare fråga om dig för att sedan gå in på mer detaljerade frågor.

Intervjuguidens struktur

Syftesbeskrivningen visades inte för respondenten. De okursiverade frågorna ställdes till respondenten som huvudfråga och de kursiverade frågorna användes som utvecklingsfrågor. Frågorna kommer att anpassas och omformuleras efter intervjuerna.

Respondenten

Syfte: Att skapa en bild om respondentens yrkesroll och som person

Kan du berätta om dig själv och vad du gör?

- *Hur ser en vanlig arbetsdag ut?*
- *Hur länge har du jobbat här?*
- *Hur har din karriär sett ut?*
- *Hur länge har du varit på samma arbetsplats? Funderar du på att byta?*
- *Skulle du säga att du investerar mycket i ditt arbete?*
- *Hur ser din relation ut till patienter? Ex regelbundna patienter, nära kontakt*
    - *Hur pålästa är dem? Händer det att de vet mer än du eller inte tillräckligt?*

Varför blev du läkare?

Etik

Etik på arbetsplatsen

Syfte: Att skapa sig en bild över hur läkaren ställer sig till etik i sin yrkesroll

Hur ser du på etik i ditt arbete?

- *Ställs du inför etiska dilemman regelbundet i ditt arbete? Ge exempel*
- *Hur hanterar du tillfällen då du ställs inför etiska dilemman?*
- *Finns det ett tillräckligt fokus på etik på din arbetsplats? Varför, varför inte?*

Informationsasymmetri

Syfte: Att få en uppfattning om läkaren upplever konflikter på grund av asymmetrisk information

Känner du att du besitter makt i förhållande till patienten och arbetsgivaren?

- *Känner du att du hamnar i konflikt mellan arbetsgivares och patienters olika krav och behov? Ex patienttid eller extra tester*
- *Känner du att dina chefer och andra på sjukhusets management-nivå har insikt i och förstår ditt arbete? Alltså, besitter du mer kunskap och information om ditt arbete i förhållande till din arbetsgivare?*
- *Har din arbetsgivare insyn i ditt arbete på ett sånt sätt att de lätt kan kontrollera din arbetsprestation?*

Etisk kod

Syfte: Att få en bild för att se om läkaren upplever konflikter inom etik på arbetsplatsen

Har du någon gång gått emot befintliga riktlinjer eller regler på din arbetsplats för att kunna göra något du anser etiskt rätt?

- *Känner du att det finns saker du måste utföra eller göra i ditt arbete som går emot din etiska kod? Gör du dem ändå?*
- *Finns det något du är orolig för att du kommer behöva utföra i framtiden som går emot din etiska kod?*
- *Hur stor roll spelar din personliga etiska kod för dig under en vanlig arbetsvecka?*

Kostnadseffektivitet

Kostnadseffektivitet på arbetsplatsen

Syfte: Att skapa en bild om hur kostnadseffektivitet appliceras på arbetsplatsen

Hur arbetar du med kostnadsmedvetenhet?

- *Vi har haft svårt att hitta information gällande hur ni kostnadseffektiviserar. Kan du ge exempel på åtgärder som du har åtagit för att minska kostnader?*
- *Hur arbetar ni med kostnadseffektivisering på din arbetsplats?*

- *Känner ni att avvägningen mellan kostnadseffektivisering och patientens behov påverkar patientens behandling antingen positivt eller negativt?*

Läkarens uppfattning

Syfte: Att få en uppfattning om hur läkarens upplever kostnadseffektivisering

- *Är du intresserad av eller insatt i ämnet?*
- *Känner du att ditt arbete påverkas på grund av kostnadsbesparingar?*
- *Känner du att kostnadsåtgärder går i linje med ditt arbete, att de som utformar dem förstår arbetet?*
- *Har du någon påverkan på de kostnadsåtgärder som existerar på din arbetsplats?*
- *Går du någonsin medvetet emot finansiella mål, t.ex. för att ge bättre vård eller liknande?*
- *Upplever du att det är svårt för dig att uppfylla de etiska krav som ställs inom din organisation på grund av de finansiella krav som finns, t.ex. kostnadseffektivisering?*

Förändringar

Syfte: Att få en bild hur läkarens roll har och kommer ändrats på grund av kostnadseffektivisering

Känner du att ditt arbete har förändrats på grund av kostnadsbesparingar?

- *Känner du att eventuell förändring har skett på rätt sätt och på grund av rätt anledning?*
- *Hur känner du att situationen skulle ha skötts istället?*
- *Upplever du att skillnader i kostnadshantering har förändrats under din karriär? Varför?*
- *Region Skåne har backat 1808 mnkr de senaste tre åren, tror du att ännu fler kostnadseffektiva åtgärder kommer utföras nu? Hur tror du de kommer påverka ditt arbete? Tror du att det kommer ha en betydande påverkan på vårdens kvalitet?*

Känner du någon gång att du hindras från att utföra ditt arbete som du vill? Varför?

Har konflikter mellan etik och kostnadsfrågor förändrats under din karriär?

Eventuella problem med patientrelationen pga arbetsgivare, hur kan det förändras?

Begrepp

- Kostnadseffektivisering – syftar till åtgärder organisationen vidtar för att minska "onödiga" kostnader, kostnadsbesparing

- Etik – innefattar moral och personlig värdering, inkluderar även "läkarkoden"