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Original Article

Collective and decentralized management model in public hospitals: perspective of the nursing team[1]

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This research aims to present the implementation of the collective and decentralized management model in functional units of a public hospital in the city of Ribeirão Preto, state of São Paulo, according to the view of the nursing staff and the health technical assistant. This historical and organizational case study used qualitative thematic content analysis proposed by Bardin for data analysis. The institution started the decentralization of its administrative structure in 1999, through collective management, which permitted several internal improvements, with positive repercussion for the care delivered to users. The top-down implementation of the process seems to have jeopardized workers adherence, although collective management has intensified communication and the sharing of power and decision. The study shows that there is still much work to be done to concretize this innovative management proposal, despite the advances regarding the quality of care.

Descriptors: Nursing, Team; Organization and Administration; Communication; Power (Psychology); Health Management.

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Modelo de gestão colegiada e descentralizada em hospital público: a ótica da equipe de enfermagem

Esta pesquisa objetivou apresentar a implantação do modelo de gestão colegiada e descentralizada, em unidades funcionais, em um hospital público do município de Ribeirão Preto, SP, segundo a visão da equipe de enfermagem e da assistente técnica de saúde. Trata-se de estudo de caso histórico-organizacional, na vertente qualitativa, que se utilizou da análise temática de conteúdo, proposta por Bardin, para a análise dos dados. A instituição adotou a descentralização de sua estrutura administrativa a partir de 1999, mediante a aplicação da gestão compartilhada, o que possibilitou algumas melhorias internas, com repercussão positiva na assistência prestada ao usuário. A implantação verticalizada do processo parece ter prejudicado a adesão dos trabalhadores, embora a gestão colegiada tenha intensificado a comunicação, o compartilhamento do poder e da decisão. O estudo aponta, apesar dos avanços em relação à qualificação da assistência, que muito há que se fazer para se concretizar essa proposta gerencial inovadora.

Descritores: Equipe de Enfermagem; Organização e Administração; Comunicação; Poder (Psicologia); Gestão em Saúde.

Modelo de gestión colegiada y descentralizada en hospital público: la óptica del equipo de enfermería

Esta investigación tuvo por objetivo presentar la implantación del modelo de gestión colegiada y descentralizada, en unidades funcionales, en un hospital público del municipio de Ribeirao Preto, SP, según la visión del equipo de enfermería y de la asistente técnica de salud. Se trata de un estudio de caso histórico organizacional en la vertiente cualitativa que utilizó el análisis temático de contenido propuesto por Bardin para el análisis de los datos. La institución adoptó la descentralización de su estructura administrativa a partir de 1.999, mediante la aplicación de la gestión compartida, lo que posibilitó algunas mejorías internas, con repercusión positiva en la asistencia prestada al usuario. La implantación vertical del proceso parece haber perjudicado la adhesión de los trabajadores, a pesar de que la gestión colegiada hubiese intensificado la comunicación, el compartir el poder y la decisión. El estudio apunta, a pesar de los avances en relación a la calificación de la asistencia, que hay todavía mucho que hacer para concretizar esa propuesta administrativa innovadora.

Descriptores: Grupo de Enfermería; Organización y Administración; Comunicación; Poder (Psicología); Gestión en Salud.

Introduction

The complexity of hospitals and their daily reality, permeated by conflicting interests, has appointed the need to seek theoretical frameworks for hospital micro-policies, as well as to try out new hospital management forms[1].

Current management systems, particularly with their Taylor and Fayol-style components and emphasis on formal and top-down structures, no longer attend to managers, workers and especially users' expectations. In these management models, apparently, the more people mangers supervise directly and the larger the territory they act on, the stronger the guarantees of management control, annulling any decisions workers make about the work. Due to this conception, nurses are almost always distanced from patient care, as they end up getting involved in bureaucratic administrative activities, more directed at institutional interests, relegating client care and direct presence among the nursing staff to the background.

It should be taken into account that nurses are privileged professionals, because they have the opportunity to interact directly with clients, improving practice by offering more qualified care[2]. Nursing practice, however, is strongly influenced by the organizational model the institution adopts. Most institutions are organized in the light of the classical management approach. Change in this practice is needed, in line with innovative management models. Nowadays, nurses are being called upon to share a task directed at users and daily work at the units, which will demands skills and clinical knowledge, as well as the overcoming of the scientific management style to a more flexible and sensitive management. In this case, a broader view is needed on the possibilities of work, not only by nurses, but by the entire multidisciplinary team, paying attention to what is truly important: the construction of a new way to produce health, valuing user welcoming and satisfaction of their needs. Therefore, relational processes need to be valued, which expresses the essence of live work, and knowledge and know-how need to be used to produce quality in the system[3-4]. Nurses should seek support in simple and valuable nursing aspects to transform bureaucratic task into sensitive practice aiming for patient care[5].

In new management models, organizational charts become simpler, with a view to establishing more direct organizational proposals, although the mere process orientation of those charts or decreased hierarchization alone do not overcome the relations of power, domination and control. The collective or participatory management model addressed the decentralization of the organization through the implementation of autonomous functional units, with less hierarchy and greater decision power, connected with the top of the structure through coordinators[6-9]. These functional units are projected based on teams, with shared responsibility and a dynamic power balance, constructed in the decision process itself[6-9]. "The decentralized sectors are independent modules, but their interdependence is guaranteed by a minimum of absolutely shared values and an intensive communication system"[6]. Contemporary proposal emerge with a view to power and authority decentralization, aiming for the elaboration of shared problem-solving strategies, with simpler and more direct information systems.

In these more contemporary management models, nurses should practice innovative management, seeking means to permit a better care quality, greater team satisfaction and the achievement of organizational goals[10].

Hence, this research is justified by the belief that the management style adopted in most hospitals today is outdated and needs to be transferred to a more flexible form, which values and motivates people more. In view of the above, the following research problems emerged: In view of the study hospital's administrative restructuring, how did the change process in the management style occur? How does the nursing team perceive the implementation of the collective and decentralized management model?

This study aims to present the implementation of the collective and decentralized management model in functional units, as well as to identify the nursing team and the technical health assistant's perceptions about this implementation at a public hospital in Ribeirão Preto – SP.

Method

This is a qualitative historical-organizational case study[11], based on the theoretical-analytic framework of the collective management model.

This study was accomplished at a public hospital in Ribeirão Preto – SP which, as from 1999, started to bet on the decentralization of the administrative structure, through the application of collective management, focused on collective planning, with representatives from multiple professions.

Data collection involved nursing team professionals from the Emergency Department and Intensive Care Center. The justifications for choosing these units were: 1) the researcher's closer contact with these functional units as, when the implementation of the Collective Management model started, she participated in these groups as an observer; 2) the understanding that these two participatory management groups could provide support for analysis, due to the researcher's greater proximity with work in these areas.

In compliance with National Health Council Resolution 196/96, approval for the research project was obtained from the institution's Institutional Review Board (Process No 3068/2008). To participate in the study, subjects were asked about their interest and availability and signed the Informed Consent Term.

The research subjects were the nurses, nursing auxiliaries and technicians and the technical health assistant at the hospital. Criteria to include the professionals were: presence at the hospital at the time of data collection and admission date before or in 1999. The latter criterion was adopted because it was important for them to have participated in the management model transition process. Eleven nurses, one nursing technician

and 26 nursing auxiliaries were interviewed, as well as the technical health assistant, totaling 39 participants.

Data were collected in January 2009, after previous scheduling according to the research subjects' availability. The study involved two phases. In the first, documents on the hospital's organizational structure were analyzed. In the second, semi-structured interviews were held. The interview script was submitted to face and content validation, involving four Nursing Management experts. Interviews were recorded with the interviewees' consent and anonymity was guaranteed. The researcher collected the data with the support of another faculty member.

Among different techniques proposed for data analysis, thematic content analysis according to Bardin was chosen, which is organized in Pre-Analysis; Material exploration: Treatment of obtained results and Interpretation[12].

Results and Discussion

The institutional research scenario

The research institution works on a permanent shift regimen, and serves as a referral institution for patients in urgency and emergency situations, primarily at the tertiary care level. At the entry door, a clinical stabilization room is available for patients in severe conditions, a trauma room for accident victims and boxes for care delivery for non-traumatic urgencies in less severe patients[13]. In addition, the hospital offers specific hospitalization areas with intensive care beds, a Burns Unit, Semi-Intensive Care Unit, Isolation Unit and clinical and surgical nursing wards.

At this institution, the management group that took office in May 1999 wanted to enhance the distortion of the established hospital administration system as, in the last thirty years of organization life, a single administrative model had been used, focused on classical management[14-15]. From that moment onwards, the proposal to decentralize the administrative structure started to be put in practice through the adoption of collective management principles[16].

The hospital was then segmented into thirteen functional units: Welcoming; Emergency Department; Adult Intensive Care Unit; Pediatrics; Neuro-Clinic; Surgical Clinic; Surgical Center; Burns; Clinical Pathology Laboratory; Nutrition; Infrastructure / Maintenance / Hygiene and Cleaning; Pharmacy; Urgency and Emergency Teaching Center[14].

Hospital management includes the Coordinator, designed by the institution's superintendent; the Planning and Technical Accountability Team, the Operational Accountability Team, the Functional Unit Management Board, including the Managers and the Management Team and the Operational Support Group. Unit Managers and Deputy Managers need to have a higher education degree, be working in a higher-level function and be elected by a simple majority among Management Team members.

It is known that the organization of the work process, without any risk level assessment, aimed at balancing the disproportionality between staff and patient numbers, in combination with the deficient physical area, reinforces professionals' dissatisfaction[17]. Thus, it is important to highlight that, little by little, the architectural and technological organization at this unit gradually adapted to the new needs. A great increase occurred in the number of beds, especially for critical patients, as well as the redefinition of area occupation and the implementation of a humanization and worker training program[16].

The implementation process

For the sake of a successful implementation of a management model, focusing on the decentralization of actions and group participation in decision-making, it is fundamental that the stakeholders perceive the need to change. As from the moment when the democratization of institutional life becomes part of management and workers' ideas, a broad discussion is needed on the aspects involved.

Declaring the project is also a moment to construct a minimum consensus for workers to guide their practices from that point onwards; it means the search for better alignment around management's objectives[18].

The analysis of empirical material permitted the recognition of cores of meaning and, next, their regrouping into the categories "Top-down implementation and disinformation of institutional actors", "Advances deriving from the implementation", "Rumbling deriving from the implementation process" and "The return to the Traditional Management Model". These categories, taken from the cores of meaning, produced two large thematic blocks. The first refers to the institutional actors' criticism against the way the process was conducted (Top-down implementation and disinformation of institutional actors), and the second relates to the acknowledgement of some positive changes that can be attributed to the new way of doing management (The advances deriving from the implementation).

Top-down implementation and disinformation of institutional actors

One of the most important aspects was the "strategy" the hospital manager used to put in practice the collective management model. Although he appoints that a clear need for change existed in the institution, as it had been going through negative exposure due to the problems faced[16], it is acknowledged that internal discussions with a view to preparing the administrative reform were not held on a large scale.

According to a majority of the interviewees, there was no time for articulation with the stakeholders, in the attempt to understand group needs and comply with the premise that is implicit and essential in this model, i.e. that it should be a collective construction. It is known that human resources represent a critical component for the design of new management paradigms in health services, especially in nursing. Everyone recognizes that any organization's performance depends on its staff[19].

I think that... the team was not well informed, the framework was not well established at the time, it's... it was implemented, there was not much respect for each person's space, time to learn. (E2)

The implementation was not done very openly, it's... We were just informed about the implementation and... the change went through... It was done like, practically overnight. (AE10)

It is observed that errors occurred in information and, what is more, in planning for change, as the group of workers did not participate in this important phase of "thinking over" the proposal and "putting it in practice".

It should be explained that effective communication is one of the premises in this collective management model[6-9,14]. When proposing a model that is based on flexible and decentralized structures, one should think less intensively of top-down communication, and primarily of horizontal or lateral communication[20].

The decision is still top-down, like the implementation... (ATS)

So, I think it was something that came very top-down. There was a person who took interest in changing the model, but he didn't change the heads' ideas, and then the immediate heads and the employees so, at bottom, it continued top-down. Who was down here and didn't have follow-up… had no idea what was happening, saw the thing in a much more… gross way. (AE12)

It is clear that the implementation process happened top-down. The Technical Health Assistant (ATS), responsible for the entire hospital's nursing team, highlights that the process preserved Taylor/Fayol-like characteristics, which probably implied that not all workers complied over time. The ideal in this collective management model is to make the group want to participate, to become a "member of the team" but, therefore, it is fundamental for them to manifest their interest in change and, mainly, to know the premises that guide the model.

This perceived lack of information about the change and that it happened top-down is enhanced to the extent that they explicitly report not knowing about each group members' responsibilities.

Because today we perceive that the staff does not know what participatory or collective management is... What are the limits, what are each person's obligations and duties? (...) Because today, for example, the manager performs the same function as operational head and accumulates functions, so what is manager and what is operational head are kind of mixed, so things kind of lost limits, and everything is very tied to one single person... (E2)

Knowing each member's role in the management group is, according to the interviewees, a paramount factor for employees to know whom to report to. One might say here that the new organizational chart, with new lines of authority and decision, seems to make workers confused, when they take the previous organizational design as a reference framework, with its well-established command and control lines.

In this respect, a study carried out at the same hospital demonstrates that the proposed organizational structure receives support from a team of supervisors and technical heads for each professional category. Each supervisor or technical head plays the role of supporter, equipping hospital care practices and providing his/her team with orientations and actions to regulate professional practice[15]. The same study, however, does not provide further details on the responsibilities of each element in the management group, nor about how practices and the necessary orientations were equipped.

All abovementioned aspects contribute to make large-scale involvement and co-accountability for the proposed actions unfeasible, which can hamper management transposition and, consequently, decrease the quality the institution wants to achieve.

Advances deriving from the implementation according to the nursing team and technical health assistant

According to the interviewed institutional actors, there are advantages to this way of managing daily work in comparison with the previous way. The hospital's increased visibility is highlighted, facilitating the view of interdependence among the different production

units. It ends up being a true education process for the managers, who progressively change from "unit heads" into actual managers. It facilitates the construction of consensus around the proposal to qualify and defend the hospital[4].

The professionals also perceived various advances regarding management reorganization. One of them refers to user attendance:

Ah, there is a lot of difficulty here when, the physicians know it too, you are going to transfer a patient, it's full here and there is no place to put the patient, for example… You arrived here, you called the floors and the staff said like: ah, you can't come up with the patient now because the bed is dirty. Ah! Two or three hours to clean a bed, come on. When the other arrived here and took charge, I think patients went faster, you know, that's one of the things that improved. (AE1)

The statement reveals some signs of improvement in care delivery, as the manager remained closer to the functional units, not allowing patients to stay in observation beds if any hospitalization beds were available. It should be taken into account that users should occupy a central place in this implementation process of the management model, and that their interests and needs should be attended to in the best possible way and according to the resources available at the hospital.

Another acknowledged positive aspect refers to the functional units' autonomy.

Most of the problems raised during the meeting, we manage to solve at the ICU. (AE9)

The different units' autonomy regarding internal decisions is fundamental, allowing management to deal with the most urgent problems, mainly related to institutional policies.

It is important to highlight autonomy in terms of financial resource management.

They had (autonomy to spend). The administrative coordinator controls these resources, then, when there's a request he receives it, if the resources are available the coordination office can take charge of an amount, divides and purchases. For example, today, a new freezer arrived for the emergency department. The units did that very well. (ATS1)

One of the most commonly reminded difficulties regarding public hospital management is the lack of autonomy in support areas, such as material and equipment purchases for example, as well as the delays in this process due to excessive regulations[18]. At the study hospital, this does not seem to represent a problem, as resources were transferred to the functional units. Governability regarding more complex processes, however, such as human resource hiring, are still under the hospital's responsibility, indicating the limits of the intended autonomy. This may be one of the reasons for workers' lack of compliance, as if they perceived the limits in the actual disposition (and possibility) of power decentralization.

Moreover, regarding the advances deriving from the implementation of the collective management model at this institution, intensified participation in discussions should be emphasized.

I think that, for the auxiliaries and technicians… we had some more freedom to say what we felt, what we thought and that was something I think we didn't have before. (AE3)

In this model, problems tend to be solved in a more agile and adequate way. That is the case because of professionals' greater autonomy and power to enhance problem-solving abilities inside the unit. To the extent that people participate in proposed solution, there is a trend to achieve more adequate solutions, as individuals experience these problems directly in their daily work[20-21].

Another point that should be highlighted is the communication process.

(...) everything used to be more restricted, for example, some routines continued among the nurses, they were not passed on to the auxiliaries and technicians, that changed because the nurses are communicating more, they are asking the auxiliaries and technicians to participate in the alterations too... (E3)

At that time (implementation), communication was better, there was more interaction between the medical team and the nursing team… Access was better, the patient was attended better... (AE12)

In this innovative management model, the communication process should be greatly intensified, especially inside and among units. The statements reveal that the nursing auxiliaries started to feel that professionals were closer. It seems that the "information" turned into dialogue, which also permitted advances in user care.

Lateral communication means direct communication, without intermediation, seeking a joint and creative solution to any bottlenecks that may emerge[9]. The interviewed workers report on easier communication inside the unit during the initial period in the implementation of this management style.

It should also be highlighted that this way of doing management provokes changes in power and decision-making relations among professional corporations, particularly by granting greater visibility and acknowledgement to nursing work.

I think that nursing ended up getting more, more united, because before I think that, like, the physicians were quite

dominant, right. Nursing gained greater room, today nursing manages to solve, decide on its problems without physicians' interference. (AE7)

It is important to underline how bothersome the physician's presence remains for the nursing team. According to the statement, power relations between the corporations were rearranged in such a way that nursing is able to solve new problems, beyond those it normally faces, without having physicians intervene. It should be emphasized, though, that in a participatory model, in principle, the Nursing Service's activities in the traditional logic should be relativized, as it is not always easy to break the corporation's vertical command lines[1,22]. Anyway, the vertical command and decision lines were mitigated. Provoking alterations in this way of functioning definitely meant changing an entire system of relationships and commitments.

Some employees reported that problems started to be solved faster after the implementation of the collective management model.

Ah, I think one may say that it was solved faster, yes, but, again, I repeat, depending on the manager, the person who committed to and made efforts to solve the problems, because he is the bridge between the functional unit and the coordination, so, that evolved. (ATS1)

Contemporary models consider functional units as autonomous teams, with a view to a less strict hierarchy and more biased authority borders[6-9,23]. In principle, this would permit solving many problems in a faster and more effective way. That is so because the team knows and experiences the problems, can set priorities and understands the need for more immediate solutions. As underlined in the above statement, however, it depends on the manager's characteristic. If that person is committed to the unit, the bridge with the board is readily established, articulation is set up and there are more chances of solving the problem. This arouses reflections that, perhaps more than "structures", the set of relations and meetings ends up prevailing in daily hospital reality, which strongly depend on their actors' leading role, turning the hospital into a precarious and contingent order or a "negotiated order"[23].

Final considerations

The implementation of the collective management model occurred in an autocratic way, but nevertheless permitted internal improvements at the hospital institution under analysis, with positive repercussions for user care delivery, mainly during the first years of change. The nursing team's perception of this process is that, soon after the implementation, participation in meetings and decisions increased, which apparently enhanced the groups' motivation. They report, however, that compliance with the model was strongly impaired, as the team's training/orientation about the premises guiding collective action was incipient. Thus, the nursing team knew neither whom to report to, nor the responsibilities of each member in the management group. This important finding is closely related with the more imposing attitude of the people who idealized the proposal, who implemented it independently of the need the multidisciplinary team perceived. This means that, despite knowing and experience the care difficulties the institution had been going through at the time of the implementation, all professional categories were unaware of the organizational set that contribute to or even enhanced these difficulties.

True organization, resting on daily practices, hardly ever corresponds to the formal organization design. Therefore, to produce transformations in an institution, a long discussion process is needed, involving listening between the multidisciplinary team and the board, producing new consensuses, always guided by an ethical-political project that is minimally shared among institutional actors.

The implementation of collective management, in addition to the implementation of the Unified Medical Regulation Central in the city, permitted an internal rearrangement inside the hospital which, despite difficulties, led to some reorganization of the space, and definitely of care. The manager's proximity with the functional units and greater autonomy in problem solving and financial resource management permitted advances regarding care qualification.

A large part of these facilitating effects occurred during a certain time, culminating in the idealizer/coordinator's departure. The category representatives' participation in multidisciplinary meetings, as well as the easier communication inside the unit, the decentralization of power and decision making gradually decreased after this professional left. This fact goes against the model's premises and appoints some limits to its implementation in actual organizational contexts.

Despite the difficulties faced, however, the advances the functional unit teams reached or discerned should be highlighted, regarding the implementation of a management model that emphasizes co-accountability, participation of the group of workers in search of care qualification and greater motivation to perform activities.

A research on the difficulties faced since the implementation of this innovative management model

is ongoing with a view to a better understanding of the process as a whole, in the attempt to contribute to improvements in the organization of multidisciplinary team work and care production, including the nursing team, due to its essential presence in hospital life, integrating and making healthcare feasible.

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