A Resource Based View of Palliative Care Teams

Keywords: *Operations, RBV, Healthcare*

Abstract

Much has been written on the practice of managing operations in the manufacturing sector and, increasingly, in the service sector. The focus of much of this work is still however on those organizations motivated by the need to compete and generate a profit. The existing literature on the strategic management of operations may well have failed to influence many managers in the field. This paper attempts to look at the role of managing operations in what may be an even more difficult field, the area of palliative care in not-for-profit organizations. It is possible to think of the organization as a productive function, and this may ground one approach to strategizing within the operations function. An alternative perspective conceptualises the organisation as a governance structure, and in this form, the process of strategizing within the operations function is problematic. This paper reviews the role of managing operations, based heavily on the resource based view of the organisation, and uses material based on the experiences in palliative care organisations to illustrate aspects of strategizing within the operations function.

Introduction

Organizations can be usefully thought of using a number of frames. Bolman and Deal (1997) for example use four contemporary frames for their discussion of organizations; a structural frame, the human resource frame, the political frame, and the symbolic frame. Hatch (1997) refers to frames that are linked to some temporal epoch; the classical frame, the modernist frame, the symbolic-interpretive frame, and the post-modern frame. These alternative frames are not necessarily competitive approaches to understanding organizations; it would be more appropriate to see them as ways of bringing different aspects of a complex reality into a learning based process that, it is hoped, will lead to better performing organizations. This paper will use the Resource Based View (RBV) of the firm to examine management practice in the area of palliative care.

The RBV of the organisation, is grounded in the seminal work of Coase (1937), and elaborated by a range of contemporary researchers (Barney, 1996; Gagnon, 1999). Gagnon (1999), in particular, argued that the RBV of an organization offered an interesting theoretical perspective for research into operations management. While some of this paper will be directed at an exposition of the RBV of the organisation, the main objective of the paper is to use this perspective to examine aspects of operational management in the area of palliative care. This application is somewhat unusual, partly

because the area of palliative care is dominated by organizations that are nominally not driven to generate a profit. They are however required to achieve outcomes through the use of limited resources, and so the RBV may provide useful insights into their management practices.

Managing Operations

Coase (1937) argued that an organization adopts a structure that is a response to the cost of effecting transactions in the value chain of a particular product or service that the organization provides. Key aspects of this structure are the size of the organization and how transactions within the value chain are to be managed. Three options are identified; hierarchically (within the organization), through some form of joint venture, or via the market. The dynamic nature of the organisation, in response to the need to constantly assess the relative costs of the three options, determines the roles of management. Coase, (1937 p. 351) identified two roles for managers; "Initiative means forecasting and operates through the price mechanism by the making of new contracts. Management proper merely reacts to price changes, rearranging the factors of production under its control." The first role, the development of new contracts, is a strategic role, a role that is in the modernist frame. In this role the manager must see the whole organization in its environment; an open systems view of the organization. The second role noted by Coase (1937); reacting to price changes and rearranging the factors of production, is consistent with a closed systems view; the classical frame. The resources used to effect transactions are a given, the role for managers is to make the most efficient use of these resources. The practice of managing operations is widely regarded as placing a much higher emphasis on the closed system view, the classicist perspective; the modernist or strategic perspective is left to other elements of the organisation.

Voss (1995) and others use the term operations strategy to identify the role they wish to influence and study. The competitive strategy of the organisation is used to define the operational strategy and, importantly, the absence of an operations strategy is associated with poor performance (Ward and Duray, 2000). Concepts have also been developed, such as quality and flexibility that enable managers to identify and articulate the competitive capabilities for a business unit. The concepts and

processes that have been developed clearly offer operations managers a range of techniques to improve the function through a strategic approach. Despite the wide range of literature in the area, there appears to be a limited adoption of the strategic perspective by managers in the operations area. Research into continuous improvement projects for example indicate that operations based improvement projects seem to occur without an integrating framework that would be expected in the presence of an active operations strategy (Jenkins, Hyland and Sloan 2000). These managers appear to be performing the task as a caretaking function, caring for assets provided by chance through some strategy of normative response, or by the initiatives of some other part of the organization.

Elements Of The RBV Of The Organisation

Coase (1937) explored the question of why individual organisations could still survive, rather than having all organisations consolidating under the pressure of economies of scale and Penrose (1959) continued to use the same approach when examining the factors that influenced the growth of organisations. This has evolved into work that explores the desirable attributes of assets, now termed resources. One outcome of this work is the concept of core competencies as outlined by Prahalad and Hamel (1990). These core competencies are the resources that enable sustainable competitive performance. In the context of a hospice, nominally a non-competitive sector not driven to declare a profit, it is proposed that these core competencies enable efficient and effective performance.

Transactions must be executed and controlled from within a governance structure. This is the legal and operational system that manages the value chain for the organisation that is in focus, the single economic organisation. Briefly, the boundary of a organisation is set by the capacity of the organisation to execute transactions internally at a competitive cost, in comparison to the cost of executing the transactions with another organisation, or through the price mechanism; a market governance structure. As organisations become larger, the cost of maintaining control via hierarchical governance structures forces the overall cost of the transaction to become unfavourable compared to other alternatives. An organisation can sustain itself through the execution of a set of transactions that can be exchanged for a value that is greater than the cost of the transactions. This generates excess value, and this provides the organisation with the capacity to achieve increased outcomes for a given

level of resource consumption. In executing these transactions the organization will need to use an array of resources or assets.

It is a strategic decision whether or not a transaction should be governed hierarchically, via partnership, or via the market. This choice will be influenced at least by the three attributes of the transaction-resource mix (Williamson, 1985); the specificity of the resources used, the frequency of the transaction and the level of uncertainty in the demand for the transaction. Specificity is the key attribute. Resources developed for a single transaction, that cannot be used for alternate purposes are highly specific. Decisions to accept high levels of specificity, in the pursuit of the lower cost structures, often available via more specialized resources, will be tempered by the uncertainties of future demand for the products of the new asset.

The terms assets, resources, activities, competencies and dynamic capabilities are widely used in literature for example Williamson, (1985) and Barney, (1996). Barney (1996) settles on the use of the term resource, suggesting that the difference in meaning behind the other terms does not add much to the debate. While this argument is convincing for the equivalence of the terms asset and resource, it is not so convincing for the other concepts. Competency and capability need to be differentiated. Competency is a demonstrated ability to effect a transaction. This might require a resource, but it might also require skills that are not necessarily formalized or made explicit. Capability is the possession, but not execution of a competency or bundle of competences.

The organization exists, as a unified organization, because the costs of the governance structures are lower in this state than those that would need to be developed to control one based on market structures. Resources will then be assembled to achieve results that cannot, for a lower price, be achieved by a third party. Arguing from the transaction view of the organisation, this will be achieved via the development of a set of resources that are highly specific to the identified transactions. Barney (1996) proposed that resources could be evaluated using a set of four criteria; value, rareness,

imitability, and organisation Resources that fail to meet these criteria might be more effectively governed via market systems.

Resources that are more abstract, the skills of nurses in a particular area for example, are resources that are likely to be rare and difficult to imitate. The capability to develop these resources is deemed in recent literature to be a critical skill for organizations. Teece (2000), for example, argues that dynamic capabilities are crucial to sustainable competitive performance. This means that organizations need a management structure that can look to the future and develop and assemble resources to meet the needs of some unknown future; develop governance structures in the terminology of Williamson (1985), as well as efficiently operate the existing resources of the organisation. The challenge for managers is the degree to which the two roles, developing governance structures and controlling efficient operations can be incorporated into a single function. Managers controlling operations need to identify the transactions and their attributes, to assemble the appropriate value chain, and to effect the transactions. This at the highest level will require an ability to define the system of governance for the whole value chain of the organization.

Palliative Care

The contemporary palliative care environment is one of "active and compassionate care primarily directed toward improving the quality of life for people who are dying, and toward supporting patients and families as they incur multiple losses" (McDonald and Krauser, 1996). This environment is attended by a number of professions including nursing, medicine, pharmacology, physiotherapy, occupational therapy, social work, pastoral care, grief counselling and administration. This is a manifold environment where people are the centre, not diseases, where care results from the understanding of the causes of suffering (Barbato, 1999) and where multi-profession teams work collegeately so that the primary issue becomes and remains patient comfort (Meyers, 1997). The quality of life of people at the end of their lives is an issue of relief of suffering, whether the cause is physical, emotional or spiritual; known or unknown (McDonald and Krauser, 1996). The patient is central in the ethics, philosophy and practice of palliative care (McDonald and Krauser, 1996). The

patient's end-of-life state and central role in efforts to manage that state makes the patient a participatory member of the palliative care team who maintains a level of autonomy and control in relation to the other team members (McDonald and Krauser, 1996).

CASE STUDIES

The research reported here used a number of in-depth, exploratory case studies to explore the role of operations management in palliative care. The data collection for these case studies involved a series of interviews with managers and teams and visits to observe the operations of teams in palliative care hospices. This was an iterative process of data collection. The case studies for this paper are two palliative care organisations in Sydney. One is a freestanding organization in Sydney with approximately 40 beds. The other is a palliative care unit embedded in a small hospital, with approximately 20 beds. These organisations are among six taking part in research into innovation management in palliative care and employ professionals from a number of disciplines, as listed above. For administrative purposes professionals are grouped within their disciplines. For operational purposes professionals are allocated to multidisciplinary patient care teams. There are two methods of allocation. Professionals are allocated to patients at a weekly formal meeting of all professionals where each patient is discussed. Professionals can also be allocated to a patient on an *ad hoc* basis if the patient's situation requires. Teams are not permanent and the composition is driven from an understanding of the patient's situation. Professionals are often members of multiple patient care teams simultaneously. The operating environment within this organization is one where work is often complex, and where the great majority of tasks require collaborative effort. This work can only be effectively carried out through the use of a good deal of *ad hoc* communication.

Consider the case of a patient whose pain appeared unmanageable, regardless of the medical and nursing efforts made to bring it under control. In passing, a nurse heard the patient speaking about a pet, a dog that had been left unattended at the patient's home some three hours travel from Sydney. The nurse immediately informed members of the multidisciplinary team attending to this particular

patient about the reference to the dog and the patient's apparent concern for the animal's welfare. A member of the team contacted a friend working in healthcare in the patient's hometown. The friend travelled to the patient's address and found the dog in good condition being cared for by neighbours. The dog was bathed and then driven to Sydney by the friend. The dog and the patient were reintroduced and within a small number of hours the patient's pain was manageable. This story was given as an example of holistic care.

The behaviours through which care is delivered are broadly divided into three groups: First, locating the patient socially and culturally secondly, understanding the patient's situation as the basis of care. And thirdly, maintaining the multidisciplinary patient care team as a collaborative entity. Locating patients socially and culturally is not always simple because patients will at times select the carers that they prefer rather than the carers appropriate for different aspects of the end of life process. This seems especially the case in terms of choosing carers with whom to communicate on values based issues. Communicating on these issues is important because it is part of a process of making meaning of the end of life experience. A story is told in one of the case study organisations by a social worker wishing to indicate that the patient is the centre of the care delivery process and wherever possible the patient's needs and requirements will be accommodated. The story is one of the social worker coming to awareness, through personal observation and through ad hoc communications from other professionals making casual observations that a particular patient seemed to spend relatively long periods of time communicating with the tea lady. On speaking with the tea lady the social worker was informed that the patient and the tea lady had families that originated in the same part of the world, in the same small town. Because of this, the tea lady appeared inherently more trustworthy to the patient that any of the professional carers, particularly with issues of family and approaching death. The social worker, and other carers, then used the tea lady to gradually introduce them to the patient, not necessarily as carers but more as trustworthy by association

An understanding of a patient's situation and changes in the situation will often be ascertained through a great deal of *ad hoc* communication. Often professionals will relay the results of casual observation

of patients that they may not be specifically tasked with caring for. This type of observation across professional and team boundaries is expected and encouraged, with the caution that practice across boundaries is not. However, as with the story of the tea lady, patients will sometimes self-select a particular carer with whom to communicate matters outside the professional expertise of that carer. Nurses for example are the professionals most frequently in contact with patients. As such they are often the receivers of much information relevant to other professionals. At times nurses describe not being able to leave a bedside because the patient has begun to relate details of issues that more properly belong with the social worker. Knowing that the social worker is not available they are not willing to stop a communication that may have taken some days to get started. As far as their time allows they will stay with the patient and listen, then find and brief the social worker about the communication. If the social worker cannot be found, both case study organisations maintain a book that professionals use for noting this type of occasion and the nurse will describe the communication in the book. The social worker, on returning to the ward, or sometimes between patients, will commonly check the book, as will the other professionals. Members of a number of professions tells similar stories about being with a patient because their particular skills are necessary at the time and then being co-opted by the patient for another purpose, not related to their professional skill set. The story is told to illustrate the fact that as a professional palliative carer one is expected to listen and observe on behalf of other professionals when the situation arises and then to report the occurrence and any observations arising from it as soon as is practicable.

To optimise the usefulness of the care delivery behaviours professionals utilise a small number of tools. When multidisciplinary team members interact with patients and patient-based carers they utilise tools such as trust, to remove socially based uncertainties that could prevent the generation and exchange of knowledge and information and the generation of meaning and openness to provide a discourse related to the situation and the honest communications necessary. Dialogue is also used, to exchange knowledge, information and meaning and to understand the values and attitudes related to those things. Power sharing provides a way to maintain the patient's centrality, facilitating the

generation of knowledge and information about the patient's situation. This tool also facilitates collaborative operations between the patient and the organization.

When multidisciplinary team members interact away from patients and patient-based carers another, slightly different set of tools are used. Narrative, is primarily used between professionals when exchanging knowledge and information about patients, situations and results of care efforts, between teams and individuals while away from formal organisational communication opportunities. Dialogue is primarily used between professionals when exchanging knowledge and information about patients, situations and results of care efforts, between teams and individuals while utilising formal organisational communication opportunities. Trust and distrust are both used in the management of ambivalence within the multidisciplinary team.

Conclusion

Much of a typical organization's strategy is set by the competitive context of the business. Successful companies require unsuccessful companies; not only do companies need to do well; they need to do better than the identified competition. The RBV view of the organization expects partners in economic relationships to have the potential to act in opportunistic ways. Intel, or at least its CEO, Andrew Grove for example, was committed to the view that only the paranoid survive; the palliative care organization may not accept this view. The sector is currently not-for-profit, and not competing for a limited market. This may affect the way in which the tension between efficiency and effectiveness plays out in the acts and structures of the organization. The profit motive usually modulates the tension between efficiency and effectiveness. Operations managers will be fighting for long lead times and low inventories. Costs, market share, levels of service with consequent market share will enable managers to find a balance. The economic dimension in the not-for-profit sector is still crucial as it is the need to achieve efficient use of resources and effective delivery of service that will determine the success of the organization. They do not however have the brutal simplicity of profits and market share to let then know how 'successful' they are. The different economic dimension should also affect the governance structures that can be effectively used to achieve the ends of the organization and the sector

Palliative care serves the needs of a society, and a social group. At the societal level the effectiveness of the function could be related to the market penetration of the function. At the social group level the effectiveness is related to the impact the function has on the experiences of that social group. This social group of course pivots on the experiences of the person who is dying, but this agent interacts with a wider group. Whereas the hospital sector can afford to concentrate on the patient, the palliative care facility needs to set its scope wider. In the two cases discussed in this paper it is evident that a number of aspects of the operations of a palliative care team can be understood in terms the RBV of the firm. Barney's VRIO scheme in particular appears to offer explanatory power of the effectiveness dimension for the operation. The role of value of the resource is clearly important. Palliative care is a specialized section of the overall health care sector. It is however the interaction of valuable basic resources that leads to the emergence of rare and difficult to imitate complex resources and capabilities. The unique feature of these resources in the context of palliative care however is that these resources support effectiveness independently of competitiveness.

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