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Economic Rationalities and Notions of 'Good Cure and Care'

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ABSTRACT

The development of the health care system in Switzerland has recently been driven by different processes such as economic rationalization, bureaucratization, or digitalization, while maintaining professional notions of 'good cure and care.' Drawing on qualitative data from a Swiss acute hospital, we analyze how potentially market driven modes of governance manifest themselves in the everyday activities of nurses and physicians. We show how professional understandings of 'good cure and care' remain persistent and intermingle with logics that we call economic rationalities, manifesting in the four interrelated issues of financial pressure, bureaucratization, time pressure, and staff shortage.

KEYWORDS

Switzerland; economic rationality; health care; hospital; bureaucratization; staff shortage

Media teaser: How do potentially market driven modes of governance manifest themselves in the everyday activities of nurses and physicians in a hospital? How does it relate to professional understandings of "good cure and care"?

"Why must we always note down so much? I am a physician, not a trained scribe," a senior female anesthesiologist in her mid-fifties lamented (shadowing, January 2019). Similar complaints about the increase of administrative duties and the lack of time spent in the primary field of responsibility were omnipresent when we talked to nurses and physicians during our fieldwork in a medium-sized Swiss public acute hospital. Within the last two decades in Switzerland, nursing education has been both differentiated and academicized, while the profession of medicine has been marked by a feminization and specialization. In both fields, a general staff shortage has led to the recruitment of foreign-trained health care personnel (Hostettler and Kraft 2020; Merçay et al. 2016). The Swiss health care sector has further been driven by ongoing processes of digitalization such as electronic medical records, digital health services, or telemedicine, new forms of reimbursement, increasing administrative work, and the management approach of economic efficiency and quality assurance (Madörin 2007, 2014a).

Research on hospitals in Switzerland and elsewhere, like on other organizations working within health care, has demonstrated that economic rationalities have gained massive importance, while the significance of the health care sector's core product, the production of health, has decreased (Binswanger 2016; Juven 2018; Le Galès and Scott 2008; Madörin 2014a; Mei 2017; Schwiter et al. 2018). Thus, there are strong critical perspectives on neoliberal transformations within the health care sector. We were inspired by these debates as they tackled a mode of governance driven by economic interest, which permeated large parts of society and thus became structural. However, for our understanding of how economic rationalities manifest in a Swiss hospital, a neoliberal lens reduces the scope of analysis and potentially obscures the complex interplay of the different logics we have identified in the field.

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In this article, we trace such modes of governance driven by economic rationalities, as they are detectable in the hospital's administration and management levels, and as they trickle down to the level of daily practice. Such modes of economic governance apply price stamps and profitability to all issues and activities, and deeply affect the daily tasks and interactions of health care personnel in hospitals. We aim to look closely at the daily practices of health care personnel in a Swiss hospital to understand the values, norms, and rules, structuring everyday work situations. We aim to understand how (economic) modes of governance increasingly manifest themselves in the everyday activities of nurses and physicians. We will explore how this logic of economic rationalities, that become visible in financial pressure, bureaucratization, time pressure, and staff shortage, intermingle with the nurses and physicians' personal notions of "good cure and care." Thus, we will show how health professionals react to those (economic) modes of governance through acts of acceptation, modification, counteraction, and reinforcement.

The two notions, one, of market driven modes of governance and, the other, of "good cure and care," are used as labels for logics that are often not clearly differentiable. For instance, the quality notions of efficiency in market logics can also be considered as part of "good cure and care." Indeed, what constitutes quality and how it can best be achieved (in a sustainable way) is a subject of discussion among health care personnel and is negotiated in daily working routines. Nurses and physicians' individual understanding of "good cure and care" – based on their education and professional experiences – might also differ. Nevertheless, the nurses and physicians we talked to shared an understanding about the relevance of safety, dignity, independence, privacy, and communication. Therefore, we use the logic of "good cure and care" as an emic category that emerged from our data.

In the next section, we outline the anchor points for our understanding of such modes of (economic) governance inspired by the debates on neoliberalization, and we justify how we use the concept throughout the article. As we aim to analyze the context-specific articulations of modes of governing, we provide contextual information about Swiss hospitals and explain the setting of our case study. We then outline our empirical approach, which is based on interviews and shadowing. Specifically, we have conducted an institutional ethnography of a Swiss acute hospital. The main section then explores modes of governance from the insights we obtained in the studied hospital. We thereby focus on the primacy of economic rationalities and how they result, first, in financial pressure, second, in bureaucratization and recent forms of management, and, third, in a lack of time and staff shortages. The conclusion then points toward the aspects of contextual articulations, and how a search for specificities provides a deeper understanding of the complex interplay of economic rationalities with other, often already existing notions, such as quality and professional training.

(Economic) modes of governance – practices and processes

Different scholars have advanced the term neoliberalism for different purposes at different times. The fuzzy and elusive concept of neoliberalism is not monolithic and cannot be predefined (Rodgers 2018). Generally, anthropologists tend to analyze how neoliberal practices are represented and disseminated globally, and how they play out differently at the individual and collective levels in different parts of the world (Hilgers 2011: 358).

Drawing on Foucault, Brown (2015: 30) conceives of neoliberalism as "a governing rationality extending a specific formulation of economic values, practices, and metrics to every dimension of human life." Neoliberal language and disseminated practices of governance "make that [neoliberal] irrigation much more powerful than simply ideology on the one hand or state policy on the other" (Cruz and Brown 2016: 83). Values "including self-reliance – and a continuing emphasis on individual asset-building as a means of gaining competitiveness through the shoring up of human capital" are also part of that governing rationality (McRobbie 2016: 121) Understanding neoliberalization as a "way of doing" (Foucault 2004: 323; cited in Hilgers 2011: 358) means to focus on different modes of governance (Morningstar 2020: 5–8) structuring and influencing most spheres of social life.

Neoliberalization is therefore seen as a field of specific governmental techniques (Ferguson 2010), and such a perspective encourages scholars to critically approach the transformative character of those practices and processes as they are represented in a variety of programs and projects, that become manifest in uneven spatial and temporal developments and context-specific struggles, rollbacks, and flawed experiments (Brenner et al. 2010; Peck and Nik 2012). Consequently, it becomes important to evaluate closely the specific effects of this "way of doing" in concrete contexts, such as the one we studied.

Rodgers' (2018) argument draws on Brown (2015: 35), who states that neoliberalization has penetrated all aspects of society in a "termitelike" fashion. Neoliberalization is a structural factor, detectable in nearly all domains of life and society, yet especially in public organizations where principles and practices of "new public management" have been introduced (Ward 2011).

Those governing rationalities have been applied in the analysis of the increasingly important economization and management logics in the health care sector (Day 2019, Madörin 2014a Juven 2018; Mei 2017; Schwiter et al. 2018). A look at the current literature used in key management training courses for physicians and nurses in Switzerland provides insights into the rationalities and positive framing of managing change, as well as the pressure to gain skills to be more efficient and increase quality (Graham et al. 2013; Lavoie-Tremblay et al. 2018). These points can be read as manifestations of an economic mode of governance. For the sake of an analysis grounded in our data, we will trace such economic rationalities as they manifested themselves in physicians' and nurses' daily work in a Swiss hospital, and how they mixed with and altered other logics, such as the notion of "good cure and care."

Recent transformations in Swiss hospitals

With respect to the coverage of its health services within a public health system, Switzerland is among the countries that provide the most resources per capita (OECD 2015). Special features of the Swiss health care system are, first, that the population contributes directly and at a high percentage to the health care system through compulsory private health insurance; second, that direct democracy mechanisms allow the electorate a say on public-health decisions; and third, that the 26 administrative divisions of the country also have a high level of autonomy in the health sector. In 2015, 202,000 health care personnel worked in 189 Swiss hospitals that provided – together with specialized clinics – 38,000 beds (H+ 2021: 18–19) for a population of 8.33 million.

Swiss hospitals are also influenced by more general trends, some of which affect the health care staff. The profession of medicine is marked by a process of feminization, with more women than men having finished their medical studies since 2005 (Ammann et al. 2021, Kraft and Hersperger 2009: 1823; Riska 2008), and by specialization. In nursing, we see a process of increasing differentiation among nurses due to the various educational possibilities. There are nurses with a vocational training of two years, but also highly trained nurses, specifically in anesthesia, emergency, and intensive care. In nursing, men can increasingly be found in managerial functions and in those specialized fields (Lindsay 2007).

At the same time, there are transformations occurring at the organizational level. These partly relate to the increase of what are often framed in terms of efficiency and cost reduction, and to the growing importance of health care management in hospitals (Madörin 2014a). Many hospitals in Switzerland have, for example, adopted lean management, "a set of principles and tools employed by contemporary management consultants to eliminate waste and promote value – often for the sake of efficiency," initially developed for the Japanese car industry (Hauge 2019: 54).

Another transformation is the flat-rate payment instead of payment per hospital days. In 2007, the Swiss parliament passed a law "to change reimbursement from a fee-for-service per diem system to a prospective payment system based on diagnosis related group (Swiss DRG) respectively" (Kutz et al. 2019: 2). The introduction of the DRG in 2012 had the aim of reducing the length of hospital days, thereby reducing costs, while also, initially, reducing administration by reporting diagnosis-related

costs instead of single services, by billing same DRG cases equally. However, the DRG and its specific implementation, that is, how much should be paid for a specific diagnosis, is highly contested. Repeatedly, the Swiss parliament and various organizations within the health care sector have discussed how it might be reformed. In their evaluation study, Widmer, Spika and Telser (2015), for example, show that it generates systemic inequalities depending on the size, structure, or mandate of a hospital. In November 2020, the Swiss Federal Council accepted an adaptation of the DRG (Admin 2020).

Issues around economic rationalities in the Swiss health care sector are also debated in relation to elderly care (Schwiter et al. 2018), or more generally by the feminist economist Mascha Madörin (2007, 2014a, 2014b), and in the Journal of Swiss Physicians (*Ärztezeitung*). There, Wille, Glarner and Schlup (2018: 224, authors' translation), for example, make specific suggestions on how to "use resources more efficiently." Angerer, Hollenstein and Liberatore (2016: 1, authors' translation) see two contrasting logics structuring Swiss hospitals – on the one hand, the massive pressure to reduce costs, and, on the other, "high demands regarding the efficiency, quality of service and safety of the patients." Addressing these opposing logics, the *Swiss Academy of Medical Science (SAMW)* argues that by applying economic rationalities of management, the reform of the health care sector is doomed to fail, not least because it neglects the ethos and professional values of the medical and nursing professions (SAMW 2019: 10). As we will demonstrate, many of the research participants expressed similar concerns.

These developments not only influence hospitals as organizations, but also physicians (and nurses) in their daily work. During the yearly meeting of the *Association of Leading Hospital Physicians in Switzerland*, the members repeatedly expressed their unease with regards to how the flat rate payment had increasingly brought economic rationalities into medicine: "Leading physicians view with suspicion the increasing dominance of economists in Swiss hospitals" (Oggier 2016: 6, see also Eichenberger et al. 2012).

The problematic side of the economization of health care has also been discussed beyond the Swiss case. Claims such as "bad economics imperil health" (Labonté and Stuckler 2016), or that the "hospital is not a factory" (Madörin 2014b), point toward the impossibility of imposing purely economic rationalities on the health care sector. But research also points to how economic rationalities increasingly structure the hospitals as organizations, along with their personnel (Juven 2018). Le Galès and Scott (2008: 4), for instance, were puzzled by the fact that in Great Britain, hospital management and staff suddenly used "entrepreneur discourse and practices" and that they rigorously applied "norms, practices and sanctions" that are typically used in competitive markets. All actors in the hospitals fundamentally adapted their behavior to maximize effectiveness and efficiency because people and units were either rewarded or sanctioned for their performance.

Methods

We followed two strategies for data collection. To situate the researched hospital in the broader field of the Swiss health care sector and in current debates, we first conducted 10 expert interviews with persons working for various organizations within the field of health care, as well as 13 interviews with physicians and nurses who work in different health institutions. In addition, we collected media articles, governmental documents, magazines, and reports by different actors and organizations within the health care sector. These sources constituted the background of the research. Second, for the data presented here, we conducted an institutional ethnography (Smith 2005) of a Swiss public acute hospital that offered a broad spectrum of medical supply, with approximately 250 beds and about 80,000 patients a year (ambulatory and stationary).[1] The overall aim of this project was to analyze how social differences are negotiated between and among nurses and physicians in their daily working lives (for more information see Ammann et al. 2021, 2020). Our initial focus was not on aspects of economization and bureaucratization. However, as the research participants brought up that topic repeatedly, we began to pay closer attention to it.

Inside the researched hospital, we conducted 15 interviews with members of middle and senior management, and collected documents such as regulations, guidelines, and the hospital's newspaper. The main body of data was generated through shadowing (Czarniawska 2014; McDonald and Simpson 2014), an ethnographic method that is extremely apt when researching institutions (Gilliat-Ray 2011; Quinlan 2009). Between August 2018 and February 2019, we shadowed 34 different nurses and physicians in the anesthesia, cardiology, and emergency wards. When following the health care professionals for half a day each, we had conversations with them and observed the daily tasks they accomplished by focusing on the interactions among health care personnel.

Throughout the process of data gathering, we closely collaborated with the hospital's CEO, the head of the HR unit, as well as the chief physicians and nurses of the three researched wards. To communicate the project's results, we organized meetings and workshops with the hospital management and the members of the involved wards. We also published an article in the hospital's newspaper to inform all employees of our findings.

Tracing (economic) modes of governance in everyday work situations

The (economic) modes of governance – manifest in elements such as digitalization, bureaucratization, increasing time pressure, the lack of personnel, or the demands of liability – that have increasingly entered Swiss hospitals heavily impact the research participants' work. The nurses and physicians we observed and talked to use different and ever-changing strategies to react to and cope with the daily, and in part novel, demands. Sometimes they accept or reinforce those transformations, while in other instances they creatively and subversively try to circumvent or even counteract them. For example, the staff we worked with in the researched hospital may consider that the increase of digital administrational processes helps to facilitate the exchange of information among the health care personnel, improve patients' safety, or protect themselves from liability claims. At the same time, all the research participants complain frequently about the increase of bureaucratic work.

Financial pressure

The impact of economic rationalities in Swiss hospitals has been to frame most of the activities we observed and discussed with our interlocutors in terms of "price and profit" (Rodgers 2018: 8). These economic rationalities are strongly represented by the standardization of payment through the DRG. Swiss feminist economist Madörin (2014a: 50; authors' translation) is highly critical of the fact that "The difference between costs actually incurred and standardized costs (DRG) is now the decisive criterion for the profitability of hospitals, irrespective of the effectiveness and expediency of treatment for individual patients." She argues that this is especially problematic for nurses, as their work is considered to be a mere "cost factor" (Madörin 2014a: 61; authors' translation). As physicians are the ones who prescribe operations and treatments, they acquire the position of generating billable cases, while the work of nurses, although important, is in most cases not seen as the origin of billable cases.

Indeed, because staff costs make up more than half of a hospital's overall expenses, the pressure to reduce the wage bill has been and still is increasing (Madörin 2014a: 56). Dubois and Singh (2009) observe that a hospital might thus replace highly trained and rather expensive nursing staff with less qualified and consequently cheaper staff. The economic rationalities behind employing nursing staff at lower costs is obscured by the often-invoked skill and grade mixture, which is needed for a ward to function well (Dubois and Singh 2009). According to the nurses with whom we spoke, this reduced the quality of care, as different grades of nursing have different competences and cannot all perform the same tasks with the same quality standard. Consequently, a discrepancy exists between economic rationalities and the nurses' holistic perception of care, based both on what they have learned in their professional education and on their practical working experiences of how best to take care of a patient. As we will show, this is intrinsically related to a perceived time pressure in the research participants' daily interaction with the patients.

Interviewed physicians also criticize the effects of the DRG, as it fails to do justice to patients with heightened needs. In one interview, a senior female physician working in the psychiatry ward of a big university hospital, criticized the general tendency in Swiss and other western societies to economize everything. She saw this development also in health care and said: "If a patient needs further treatment no one is paying for, I still prescribe it. In such cases, the well-being of the patient is my priority. Even though I know I will be criticized when we make the accounts" (interview, May 2018). This quote is an example of how health care personnel sometimes counteract and circumvent economic rationalities and follow the reasoning of the well-being of the patient. What added to her reaction is the fact that she was one year before her retirement and was thus no longer interested in climbing the hierarchical ladder. Consequently, the effects of economic rationalities in hospitals – which, as Le Galès and Scott (2008) aptly describe, reward and punish individuals, wards, and whole hospitals – are not relevant to her anymore. For individuals, such rewards consist mostly in career advancement and financial incentives, for wards in additional personnel resources, and for hospitals, in a good reputation that is crucial for staff recruitment, and in a better positioning vis-à-vis the regional authorities who decide about resources or even hospital closures.

Generally, the DRG transforms quickly treated cases into efficiently managed cases, from which the hospital can achieve the most earnings. Meanwhile, cases involving slow treatment that requires a lot of listening, waiting, talking, trying, and perhaps also erring, represent inefficient cases. Typical examples include pediatric and psychiatry wards, where interdisciplinary work as well as complex situations with patients and families result in more time-consuming treatment. German physicians recently called to exclude pediatrics from the DRG because of this (Ärzteblatt 2020).

Due to the political pressure to save money in the health care sector, hospitals must increasingly operate based on the "outpatient before inpatient" rule, and thus reduce the lengths of patients' hospital stays. At a staff meeting, the male CEO praised what the hospital had achieved in this regard so far: "Outpatient treatment will be the future," he stressed (notes, August 2018). According to physicians and nurses with whom we spoke, the rule of outpatient before inpatient often led to a decrease in quality. In some situations, complications that make readmission necessary could have been prevented by keeping a patient a day longer in the hospital, they argue. Current research points to the same conclusion: "In adult patients hospitalized for a medical condition in Switzerland, Swiss DRG implementation appears to be associated with an increase in readmission rates and lower in-hospital mortality but is not associated with the decrease in length of hospital stay [. . .]" (Kutz et al. 2019: 10). At the same time, one could also argue that hospitals need to envisage more cooperation with care solutions outside the hospital, and to move toward integrated forms of care that bridge institutional gaps, and therefore also bridge care gaps between hospitals and ambulant care providers.

We recorded many concerns about economic rationalities, as the research participants regularly spoke about the topic in interviews and during our shadowing of them, without being specifically asked. At the same time, our data illustrates that health care personnel have increasingly adapted to this logic. A male specialist nurse in his late thirties told us that because the hospital was in the red, its management trained them in not forgetting to bill every item, as the hospital made a deficit the year before: "They have shown us that also small things, like forgetting to bill a syringe, might in the long run cause a loss of several thousand Swiss francs" (shadowing, August 2018). A female nurse in her fifties shared the following story as she reflected, during a short break between two patients, upon the consequences that the increasing economic rationalities had on her profession in general, and on herself in particular:

> I have learned not to put myself under too much stress. Once, I dropped a very expensive ampoule and it burst. "This costs twice as much as I am earning in a week", I thought. This episode marked me, I will never forget it. I often ask myself what the overall economic pressure is doing to us in the long run. (Shadowing, December 2018)

These two examples illustrate both how nurses are highly aware of the cost factor for the hospital, and how they have internalized the prevailing way of economic thinking, thus potentially reinforcing it. However, the example of the older physician working in a hospital's psychiatric ward also

demonstrated how economic rationalities could be bypassed. Her individual position, of being just a few months away from retirement, provided her with the possibility of not only criticizing those practices and procedures, but also actually ignoring them and focusing more on what she personally considered to be "good cure and care."

Bureaucratization and new forms of management

Apart from imposing financial pressure, there are also new tasks and priorities in comparison with other patient-related duties. As shown in the introductory quote, the time needed to document medical information has significantly increased in recent years. We have repeatedly been told that older nurses and physicians generally criticize (digitalized) documentation, while younger ones have already been prepared for it in their training and thus more easily accept the need for documentation and link it more directly to notions of quality and transparency. Consequently, a generational gap is apparent, as a female leading nurse in her mid-thirties pointed out: "Someone who has just finished training or someone who has started with lean management, has fewer problems with documentation than older staff" (interview, March 2019, see also Ammann et al. 2021).

There is a generational gap in the acceptance of documentation, and at the same time there is also a more profound problem in imposing management principles. Such principles (e.g. lean management) were developed in a completely different setting, where things could easily be counted, such as in factories. These principles are problematic when one attempts to translate them to a difficult-to-quantify environment, such as health care (e.g., Beckert 2020; Labonté and Stuckler 2016; Widmer et al. 2015). The problem lies in the profound differences between the car manufacturing industry, for example, and the type of work carried out in hospitals (Madörin 2014b). Although lean management has been constantly adapted to the local situation of the researched hospital and its different wards (interview with a female ward manager in her mid-thirties, May 2019), the hospital remains a place in which human beings take care of other human beings, instead of controlling machines and producing factory items (Madörin 2014b).

What constitutes the basics of health care work has sparked tension between nurses and physicians on the one hand, and the administration on the other. The importance of management and administration has increased in recent years, with more emphasis on management skills for leading physicians for instance, or the increase in personnel in administration. This does not mean that the logic of "good cure and care" is opposed to digitalization and documentation (see e.g. van Eijk 2019), but the latter have become more prominent in the last years. The research participants regularly complained about the amount of time that goes into administration, which takes time away from delivering bedside care. During the shadowing units, we could observe that the administrative tasks indeed took a lot of time, not least because of the various digital systems used in the hospital setting. In our example, the system used for patients' medical histories and the system used for billing were not linked, so physicians and nurses needed to register cases and treatments twice (shadowing, young male expert nurse, September 2018). While this relates to the need to put a price tag on every action and therefore relates to economic rationalities, it also points out a poor integration of digital systems. A recent survey of Swiss physicians (Trezzini et al. 2020) shows that administrative loads are generally increasing, and that health care personnel argue that hospitals should transfer administrative work from physicians to administrative staff.

In the researched hospital, the billing system sometimes leads to almost Dantesque situations, as the following example demonstrates: The senior female anesthesiologist that we quoted at the beginning of this article, had to go to the emergency ward to perform resuscitation. While the crew from the emergency ward was conducting the resuscitation, the anesthesiologist stood nearby in case she had to intubate the patient. In the end, the patient died without her intervention. Later, the physician struggled to bill her services because she, in fact, did not know how to bill "being on standby and waiting until my services are needed." It took herself and the deputy chief physician a considerable amount of time to figure out how to complete the billing information (shadowing, January 2019).

How does one bill just standing next to the patient while doing nothing from the point of view of the billing system, as in this example? Or, more generally, how does one monetize the intangible dimensions of care? The above example points to the economic rationalities of a hospital that must pay its staff at the end of every month: the health care personnel must bill all activities including waiting and observing. The billing can take a considerable amount of time – time that is spent in front of a computer and not at the patient's bedside – and the act of billing itself cannot be billed.

Nevertheless, the standardization of processes in general, and of documentation in particular – especially in its digitalized form – also have positive effects in terms of transparency and safeguarding. It makes work visible and supports time analyses as well as the labor needed to complete each individual step of the treatment. It can also simplify storage and ensure the timely availability of patients' medical histories. This can complement the oral transmission when patients are handed over from one shift to the next, or from doctor's practices to hospitals. Proper documentation also facilitates information flow between wards as well as between the professional groups of nurses and physicians who are treating a specific patient. Therefore, health care personnel no longer have to spend time and energy deciphering what someone has illegibly scribbled on a piece of paper; in short, digital patient histories are especially useful for (interdisciplinary) collaborations and exchanges, and may increase the quality of cure and care.

Although regularly criticized, the bureaucratic processes of documentation and digitalization are accepted after some time and are often praised as being helpful. Thus, the nurses and physicians accepted and even appreciated these practices and processes in their wards. At the same time, the combination of bureaucratization and digitalization resulted in nurses and physicians spending much time in front of their computers instead of directly interacting with the patients and with other nurses and physicians. Again, there remains the question of whether the time-consuming practices of documentation need a better implementation and adjustment of processes and digital support systems, or whether the problem lies rather in an over-emphasis on documentation instead of working at the patient's bedside.

Lack of time and staff shortage

Another aspect that interferes with notions of "good cure and care" is the lack of time. The research participants seldom linked this issue with the patients directly. Rather, they described the increasing time pressure as a result of expanding administration, bureaucratization, and the general staff shortages (especially in nursing) that wards face. It is a general fact that in hospitals, the process of curing and caring can be planned only to a certain degree. Uncertainties exist regarding the number of patients, their personalities, and the specific development of their health conditions. In certain wards, such as in the emergency ward, hectic moments and a constant prioritizing of what the nurses and physicians must do first are part and parcel of the daily business, as emergencies cannot be planned, and as patient peaks occur at unforeseeable moments. For some, such as the following male expert nurse in his late thirties, this is actually the reason why he liked to work there: "Here in the emergency ward, we do not have ordinary stress; it comes in waves. Here, we have hectic moments without breaks, but then again, we can take longer breaks when the situation is calm" (shadowing, August 2018).

However, the health care personnel in the researched emergency ward were also struggling with a general lack of staff. The female chief physician of the emergency ward who was in her late forties told us, for example, how tired she was with continuously underscoring that the hospital should first and foremost care for the wellbeing of its patients, but also care for its personnel: "According to the HR, I should dispose of 7.4 full-time jobs, but I only receive 6.7. I have partially given up in this regard." (interview, October 2018). Due to economic restrictions, many hospitals did not dispose of the necessary financial means to pay enough staff to reduce the prevailing time pressures. Most Swiss hospitals constantly struggled to prevent net losses at the end of the year. Therefore, a lack of staff and its direct consequence for personnel – time pressure – were reinforced by economic

rationalities. On the one hand, personnel had more time-consuming activities due to digitalized administration and documentation that reduced the amount of time needed to provide cure and care. On the other hand, personnel costs were a major cost factor in hospitals and therefore under continuous pressure.

Time pressure in everyday medical practice is often felt most directly when gaps in staff planning need to be filled. For the health care personnel with whom we spoke, the question of whether they jump in is always an ambivalent one, as the following female expert nurse in her early fifties explained:

> In the last five years, there was always a list where you could fill in your name to replace colleagues who were sick for a longer period of time. This is a dilemma: on the one hand you want to support your colleagues, loyalty to the team is important because you know that working with too little staff is generally a problem and especially dangerous for the patients. On the other hand, I solve problems for which I am not responsible. (Shadowing, October 2018)

The problems that the nurse addressed occurred at the level of the hospital administration and were linked to management practices that were far beyond her influence. She could only help out, but she could not change the general lack of staff.

The issue of lack of staff is also linked to a general staff shortage among health care personnel, even more pronounced in nursing, which constitutes a well-researched topic (e.g. Buchan and Aiken 2009; Marć et al. 2018; with regard to Switzerland see (Golz and Hahn 2020; Lobsiger and Liechti 2021). Although many countries in the Global North seek to mitigate the problem by recruiting health care staff from the Global South (e.g. Aluttis et al. 2014), Switzerland attracts most of its foreign-trained nurses and physicians from neighboring countries due to the wage differential, overall living conditions, historic relationships, and shared languages. For instance, two out of five nurses working in Switzerland possessed foreign diplomas in 2015 (Merçay and Grünig 2016: 2). In addition, 36% of the physicians working in Switzerland in 2019 gained their diplomas outside the country (Hostettler and Kraft 2019: 453). These numbers reveal that Switzerland is not educating enough medical staff at the same time as too many nurses and physicians are leaving their profession prematurely (Lobsiger and Liechti 2021). Consequently, the country relies heavily on foreign-trained professionals.

Hospital staff we talked to and shadowed often developed their individual adaptation strategies to live with time pressure and lack of staff. Given the physical and emotional demands of their work (Golz and Hahn 2020), physicians and nurses try to protect themselves emotionally, as they cannot always meet all of the various demands regarding the prioritizing of tasks (see, Maria et al. 2013), especially in compliance with their own standards of "good cure and care." Another strategy is to work part-time and thereby secure some time to recover from job-related stress and to enable emotional work that is suppressed during working hours. However, some, like this female expert nurse in her mid-thirties, "learn to make compromises and still go home satisfied" (interview, March 2018), and thereby find a way to live with co-existing logics. Others leave the hospitals or quit their jobs altogether.

Another element of time pressure is overtime; nevertheless, the tendency to work overtime has been reduced significantly in recent years. The senior physicians with whom we spoke appreciated the fact that nowadays, they do not work 80 or 90 hours per week anymore. This was quite common for physicians one or two generations ago, until, in 2005, the Swiss Working Hours Act set a maximum working week of 50 hours for assistant physicians. Recent research demonstrates that even though the overall working time has been reduced, assistants and chief physicians are still working overtime (Pöhner 2018; VSAO 2020). When we asked a female assistant physician in her early thirties whether she liked her work in the emergency ward, she said yes, but, at the same time complained that they had too little time off: "After four late shifts we only have one day off, then we continue again straight away. If this goes on for five weeks, you get tired in the long run. We also do a 12-hour service. Thus, we do not have enough free time to recover" (shadowing, November 2018). The topic remained high on the agenda in interviews and during shadowing. Generally, more flexible working models are increasingly

being requested by a growing number of women (and partly also men) entering medicine, as well as the members of a younger generation who no longer define themselves solely by their work or prestige (Ammann et al. 2021; Kraft and Hersperger 2009;).

The ultimate strategy for coping with these challenges is to exit the system, or at least the hospital, to work in other health care organizations. As a recent study has shown, 42% of the nurses and 31% of the physicians working in Switzerland had quit their jobs, and the number of women leaving their professions is higher than that of men (Lobsiger and Liechti 2021). A former hospital nurse in her late fifties provided her perspective on this strategy of leaving and reported the clear need for radical change in the system: "It just takes time if you want to talk to people. The doctors are always on the run. They have a lot of patients and a lot of administrative work to do. We [nurses] are stuck. It should work differently. A rethinking would be needed" (interview, March 2018). This former nurse apparently saw spending enough time at the patient's bedside as a characteristic of "good cure and care." Leaving the system was the option this former nurse took. In the researched hospital various nurses and physicians of different ages confided in us their doubts about how long they could continue their work. For example, a young, female physician in training said: "What are the long-term consequences if we always have more than seven patients allocated to one physician? Then it becomes too much and the workload becomes too big. Today, there are hardly any physicians who give up their lives for their profession. At the same time, the expectations of the society and the patients themselves are rising" (shadowing, November 2018).

These experiences hint to a possible vicious circle: The lack of health care personnel increases the time pressure faced, and this leads to burnouts, high fluctuation, and generally to dropouts, which again increases the time pressure in daily cure and care, but also in management questions regarding staff recruitment and knowledge circulation among staff. The search for work with less time pressure and regular working hours is a main factor for those individuals who leave the system. However, even more importantly, staff also always relate their unease to concerns about "good cure and care":

> I also find it difficult, and it is the reason why so many drop out: in the training, we learn a lot of values about how to look after patients and how to treat them, and that is not possible in everyday life. This is very frustrating because you cannot do your job the way you want to and have learned it, and that is a reason for many to change (interview with a former female nurse in her early forties, March 2018).

Conclusion

In Swiss hospitals, nurses and physicians are confronted with, and work according to, different logics. On the one hand, economic rationalities linked to processes of digitalization, bureaucratization, administratively intense forms of reimbursement, and rationalization, have penetrated Swiss hospitals in a "termitelike" fashion (Brown 2015: 35), and have heavily transformed the daily work of the healthcare personnel by "stamp[ing] price and profit" on everything (Rodgers 2018: 8). On the other hand, the work of nurses and physicians in Swiss hospitals is driven by their own intrinsic motivation and professional understanding of "good cure and care." While the notion of "good cure and care" seems, at first sight, to oppose rationalities that quantify and economize, there are nevertheless aspects of these recent developments that can be adapted and used to support a professional understanding of the work of nurses and physicians.

Such examples can be found in the more centralized and standardized ways of documentation, such as check lists, manuals, documentation of the patients' medical histories and their own specific working activities, clear (safeguarding) regulations, or a more thoughtful handling of daily needed materials. Such techniques facilitate, at least in the management's words, transparency, uniform and secure handling of patients' data, information exchange, along with interdisciplinary and interprofessional collaboration. At the same time, those (economic) modes of governance result in time-consuming documentation, sometimes inefficiencies, and at times an almost overwhelming emphasis on billing, as the example of the physician who struggled to bill after being on stand-by illustrated. Physicians complained about all

the (online) paperwork they must do instead of carrying out the work for which they have been trained. This leaves healthcare personnel frustrated because they can hardly uphold the professional standards of quality they have been introduced to during their training. While the constant documentation is linked to processes of digitalization, documentation for liability issues and transparency, there are also potentials in digitalization to simplify documentation. The question remains whether the problem lies in the process of documenting itself or whether it is a question of adjustment and technical implementation.

The financial pressure, the increase in bureaucratic duties, the overall time constraints, and the increasing staff shortage, are having major impacts on physicians and nurses working in Swiss hospitals, although less heavily than in other national health care systems that are more profoundly marked by economic transformations. While all the healthcare personnel we talked to emphasized their love and dedication for their professions, simultaneously, many of them complained about the increasing difficulties they faced to administer "good cure and care." The insistence on economic rationalities, such as to maximize effectiveness and efficiency, marginalized the basic needs of staff members, which makes nurses and physicians vulnerable to feeling emotionally and physically exhausted or overworked, and not being able to handle the complexity of their daily work with the necessary professional care (Akyol 2020). The concept of lean management, for example, that has been introduced in some wards of the researched hospital, was developed in factories, where efficiency can be increased by reducing costs by the unit. This can unfold a difficult notion of counting, measuring, and evaluating something that can hardly be measured solely in economic terms (McRobbie 2016: 122): the issue of *good health* and *good treatment* (Madörin 2007, 2014a).

Our analysis has shown that the interplay of economic rationalities and notions of "good cure and care" mingle in complex ways. Economic rationalities and all the developments that have come along, such as digitalization or transparency, can be used by physicians and nurses because they support their notions of quality and they can see an advantage in these techniques. At the same time, much protest that is currently being voiced by personnel in hospitals and in the health care sector in general (an initiative to improve financial conditions for training and working for nurses was accepted by a popular vote on November 28, 2021), derives from the financial pressures that impact their daily work. While the economic rationalities function with a sense of quality coupled to notions of efficiency and cost effectiveness, they seem to be difficult to link directly to the professional quality standards of nurses and physicians. Much depends, therefore, on how such (economic) modes of governance are implemented and adapted to specific professional contexts and to local circumstances and practices, as well as to the diverse professional, generational, and other groups of staff, that form the health care personnel in a specific hospital. In addition, it is also important to not understand hospitals as isolated players; they are to strengthen cooperation with each other, with out-patient care providers, and to see health care as a network of actors. In the same vein, it is paramount to focus beyond the powerful lens of neoliberalization that potentially blurs the sight of detailed and specific contextual analysis when looking at current developments in Swiss hospitals and beyond. Concretely, this means to discern the economic rationalities and the various techniques and developments that come with it, to understand in-depth how they affect in complex interrelated, and intermingled ways, the practices of cure and care in Swiss hospitals.

Note

1. For reasons of anonymity, we do not give more precise information about the hospital. For the same reason, we do not state in which linguistic region it is situated.

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