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The process of defining the hospital care profile in federal hospitals in the city of Rio de Janeiro, Brazil

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Abstract *This article analyzes the process of shaping the care profile of federal hospitals in the city of Rio de Janeiro. This is a qualitative, descriptive study that draws on semi-structured interviews with hospital administrators. Data analysis used the Collective Subject Discourse approach. Managers believe this process is the result of a set of emerging strategies, proposals and need for change, which result in adaptive reactions that hospitals develop with no coordination between them to resolve problems identified by professionals and managers. The process is analyzed much more from a political point of view than from a rational and systemic one. Some of the experience with the hospital mission, such as the focus on a strategic approach, already signals a more collegiate approach to defining the profile of care, where the hospital is one component of an integrated network of services, with a decision process that is less incremental and more integrating.*

Key words *Healthcare planning, Hospital administration, Healthcare service management, Organizational change*

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Introduction

The hospital is the strategic space for reorganizing the healthcare system. It is where much of the care is provided and concentrates most of the financial, material and human resources. Hospitals are also highly visible to society.

In recent years, important factors such as changing epidemiological, demographic and social profiles, an increase in the use of technology, population aging and a need for greater integration across the different services of the healthcare network have required changes in the model of care, which have directly impacting hospitals and their role in the system[1,2].

In discussions about the role of hospitals, one of the main issues has to do with the profile of care provided by each hospital unit in the network, as this has a major impact on the model of care available within a given geography[3,4]. The care profile comprises the full range of care or services provided by the hospital. Change means introducing a new service, a new disease/condition or a new technology, as well as excluding, reducing or expanding the range of services offered.

This situation has led to a major discussion of hospital administration and the need to find suitable tools and better management that will broaden the capability of hospital administrators to handle the problems these organizations face.

We believe that by analyzing changes in the care profile of hospitals from the viewpoint of hospital administrators, we will be able to determine how hospitals define their care profile, and the factors and players involved. This effort should help identify and improve planning mechanisms and breakthroughs that will enable a more rational and collegiate definition of this profile, favoring an offer of services that is better matched to the needs and demands of the population.

The question that gave rise to the study was: "How does change happen in hospitals, and how is the care profile defined?"

Organizational strategy, planning and change: basis for analyzing the process used to define the profile of hospital care

Analyses submitted since then are based on strategy and organizational change theories, and on academic output related to organizational theories and strategic management. For this reason we present the following considerations on these themes.

Strategy Definition and the Process of Organizational Change

According to Motta[5], organizations have two views of change. One of them is evolutionary, where change simply emerges – it is not intentional and will happen regardless of any guidance or direction. The other is intentional and planned, seeking to break from the organization's current situation or position based on a decision to change.

Thus, if we admit that change is the product of pre-defined ideas, overall planning of the process will be more highly valued. If, on the other hand, we believe that problem solving is necessary because it creates new ideas, an important element of change is the reaction to problem situations. Finally, considering that change emerges from circulating ideas, one tends to work with models that are less dependent on management programs. Three categories emerge from this analysis: strategic intent, adaptive reaction and continuous learning.

The main characteristic of a change process based on **strategic intent** is precisely the fact that there is intent to interfere in reality. Based on an analysis of the organizational context and external environment, it is assumed that, led by a planning process, organizations are able to deploy change and go from their current strategic position to a fully new perspective.

Adaptive reaction arises from identifying problem situations and the need to provide planned responses to these organizational problems. Change is faced based on concrete problems, *which does not mean that change planning is discarded, but innovation planning is reinforced based on the problems that exist. Believing in change means monitoring problems, as innovations are the fruit of concrete responses and the challenges imposed on companies*[5].

In the case of *continuous learning*, change emerges from innovative ideas that are already available within the organization and come from employee experiences. This outlook works with elements of the learning organization theory, where learning is viewed as the essence of change[6,7].

According to Mintzberg[8-10] there are four ways to define a strategy. While in many cases a strategy is used merely as a plan, the author also works with the definition of pattern, position and perspective.

The first definition is strategy as a plan. Mintzberg believes this is the most common un-

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derstanding in a number of fields, from military through management, and has two essential features: *the strategy is developed before the actions to which it applies, and is developed in a conscious and purposeful manner*[9].

The second part of the idea is that if a strategy can be intended, as in the case of a plan, actions may also be derived from it. In this case, certain actions recur, configuring a pattern, as they are effective at resolving a problem. Thus, consistent behavior makes the strategy the result of a pattern, regardless of whether or not it was intended.

Based on these definitions of strategy we can say that in the case of a plan one works with an intended strategy that is the result of a human project, and in the case of a pattern, with a strategy that is the result of human actions.

Thus two different concepts emerge regarding the origin of strategies in organizations. One is that strategies are deliberate, when there is prior intent, and another is that strategies emerge and develop with no intent. Within a given environment of deliberate strategies these may or may not become a reality.

A position strategy regards a specific product in specific markets. In administrative terms, this definition is of a market strategy, a niche where resources are concentrated.

The change process itself is addressed using three basic approaches: the planned change, the led change and the developed change, all of which may be developed at a more micro or macro level.

A planned change involves a set of elements to be followed, which may range from a macro level, such as strategic planning, to a more micro level, in the case of improvements in quality or staff training.

A led change is guided by a person or group of people with the authority to monitor and ensure change. A developed change just happens, it is organic and led by people outside the institution's core of authority, and are not formally managed as are the other two types.

The work of Mintzberg[10] and Motta[5] converge, although they differ in terms of the terminology used. Thus the concepts of how change emerges, whether intentional or evolutionary, formal and planned or informal, if arising from management or individuals and groups, are all present in the classifications of both authors and, if taken as extremes, could be represented as follows in Figure 1.

Organizational outlooks, strategic management and profile of care

According to Lima[11-13], another author that looks at hospital organizations, the definition of objectives of hospital organizations has a natural perspective, as it depends on the external environment, on the priorities of the federal government, technological developments, epidemiology and population demand. Thus in a natural perspective the organization is viewed as a living organism that creates interdependent relationships with its internal sub-systems and the external environment to ensure its survival.

As a result of this systemic vision, that these organizations are part of a network, goals cannot be defined internally alone, but require external regulation to ensure the integration and balance of the system as a whole.

The different people and groups that make up the organization must also be considered, as it is they who, based on individual and coalition goals, on a process of negotiation and dispute, will define the organization's goals from a political point of view.

A rational perspective is required to enable organizations to clearly define their goals, rather than use generic coals that do not contribute to management decisions and actions.

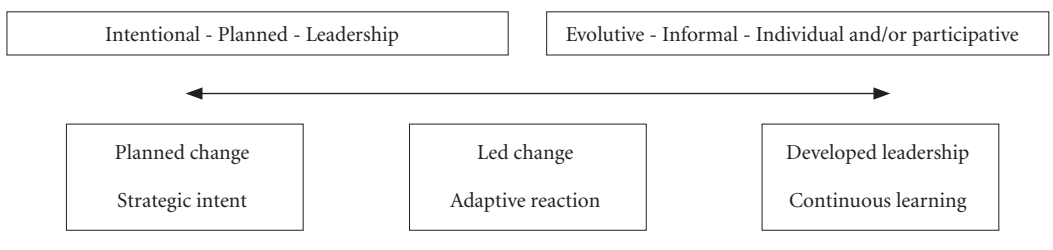

Figure 1. Concepts on the format and leadership of organizational change.

Thus, according to Lima[11], it is based on an integrating perspective that public healthcare organizations may be better understood, as they present characteristics of each of the different visions of the organization.

A focus on strategic management of healthcare, developed originally by Cremadez and Grateau[14], and studied by Rivera[15] and Artmann et al.[16] since the 1990s, considers that healthcare organizations have characteristics that keep them from developing a management project based on an ideal standard. This standard should, when defining the mission, consider criteria of economic rationality, recognizing the external environment as a resource, and the need for internal integration and negotiation with the network.

These characteristics lead to two results: an incremental decisional practice, and an organization that is centered on itself and its own environment, perceiving the external environment as a constraint.

The decisional practice is incremental because *decisions are made in series as a function of momentary pressure of the different hospital players, with no view of the whole*[17]. There is no strategy formulation process prior to the decision, as the decision is a-hoc, with a juxtaposition of goals.

The focus on strategic management suggests an integrating decisional practice involving a larger number of players in the operating platform that defines the strategies, based on continuous planning of collective projects within collaboration networks.

As a proposed methodology it presents the *strategic approach,* which proposes to *rationally define the hospital mission*, *positioning it within the ideal perspective of a coordinated healthcare network*[15]. This focus includes the hospital as a proactive organization, focusing on the outside environment and questioning a vision of self-sufficiency and the intention to cover all areas of service.

To this end, a definition of a hospital unit's mission is negotiated with the network and other establishments, thus transforming potential unjustified competition into collaboration.

Methodology

This effort is a study of multiple cases using a qualitative approach and methodology based on information collected in semi-structured interviews[18].

The field of investigation is made up of hospitals under federal management in the city of Rio de Janeiro: Hospital Federal do Andaraí, Hospital Federal de Bonsucesso, Hospital Federal de Ipanema, Hospital Federal da Lagoa, Hospital Federal dos Servidores and Hospital Federal de Jacarepaguá (Cardoso Fontes), which refused to participate.

Seventeen interviews were recorded with the authorization of interviewees, and later transcribed, resulting in 10 hours of recorded conversations and over 100 pages of transcription. Study participants are listed below, and are identified using codes in the outcome of this effort. Hospital 1: Medical Coordinator, Head of Surgery, Head of Ambulatory Care and Head of Services; Hospital 2: Medical Coordinator, Head of Surgery and Head of Emergency Services; Hospital 3: 2 Heads of Service and the General Manager; Hospital 4: 1 Head of Service and the General Manager; Hospital 5: Medical Coordinator, Planning Coordinator, Care coordinator and, in the Department of Hospital Management (DHM) we interviewed the Coordinator of Care and the Coordinator of Planning. The number of participants varied between units, depending on how long it took for the unit to agree to participate in the study, and the availability of interviewees. The main subjects selected for this study were: Hospital Director, Coordinator of Care and Coordinator of Planning. Where these positions did not exist, or the holders were unavailable, the heads of service or department were included as participants.

To organize the data gathered in these interviews we used the Collective Subject Discourse (CSD) developed by Lefrève et al.[19].

According to those authors, CSD is a technique to organize qualitative data that resolves a major impasse in qualitative research, to the extent that it provides systematic and standardized procedures to combine statements without reducing them to quantities[20].

This technique consists of analyzing the content of the interviews, extracting the core ideas or anchors and key expressions, based on which we search for similarities to build one or more summary discourses.

These four elements - Key Expressions (KE), Core Ideas (CI), Anchoring and Collective Subject Discourse are considered the operators of this approach[20]. Key expressions are portions of the discourse that should be highlighted by the researcher, and correspond to the essence of the content in the discourse under analysis.

Thus the collective subject discourse may be defined as a summary-discourse created with elements of discourses of similar meaning combined in a single discourse.

Results

Below are the results of the study split into two blocks: the process of hospital change and strategy definition, and the design of the care profile and organizational perspectives. In each block, the function of Analyzing the Collective Discourse was made up of themes that contribute to a better understanding of the outcome.

Change processes in hospitals and strategy definition

When we discussed the main changes the interviewees perceive in the recent care profile of each hospital, we found two core themes in the collective subject discourse: the first are the changes themselves, both perceived and mentioned by managers, and the second is made up of a set movements that, unlike the perception of change, were made to resist change (Chart 1).

Four different discourses emerged from the core ideas in the first theme, revealing the perception of change in the changing patient profile, a change that results from an increase or decrease in supply, and the direction towards higher complexity services.

The first discourse reveals a perception among interviewees that there have been changes in recent years, and units are prioritizing the development of activities or services of increased technological complexity.

CSD 6 - Discourse on change and prioritizing high complexity services

...we started to prepare a strategic plan, looking to better define the care profile, and some of the services organized themselves to serve higher complexity cases. The maternity service for example, created a neonatal ICU and also started to handle pediatric transplantation.

The pediatric ICU is a distinction that helps qualify the Hospital. The coronary unit allows us to handle cardiac disease. But there are also similarities, such as in orthopedics. This also happened in the past, at some point this was built here.

Patients started coming in, cases became more complex and we started to care for these patients. This resulted in an increase in high complexity surgeries.

In the first core idea, change is presented as being the result of a decision made by players involved in strategic planning, and subsequently some of the services started to shift the focus of their activities.

The second part of the discourse mentions a number of existing technologies that are a competitive advantage for a given unit. In the perception of these managers, this points to a set of services in which more should be invested, as they already have a level of added complexity and the investment has been made to organize the services.

When managers are asked about how the selection of the areas of the current care profile was made, they mention a process that happened *historically, over time.*

Another discourse based on manager perception of change is the increase in demand and change in population profile.

CSD 7 - Discourse of the changing patient profile and increase in demand

Cancer is epidemic among the population. The greatest demand is for vascular surgery. Another demand that has increased significantly and become a public health problem is chronic renal disease. The population is aging and there aren't enough hospital beds. There is a glaring increase in the number of elderly people around the world, and with the diseases of aging, when things get complicated they end up in the emergency room.

In this discourse, the main changes are the population demographic profile - an increase in the elderly and chronic problems. This has caused an increase in demand for hospital units; as the healthcare system does not have a suitable structure to care for this population, they resort to hospital emergency rooms.

CSD 8 - Discourse of the change in supply due to expanded and new services

This grew slowly, at first all we had was clinical nephrology, then we opened a dialysis unit, and then started to do transplants. Burn victims for example, a group of plastic surgeons decided to create a service, a tiny nucleus that grew. In bariatric surgery we had a surgeon that decided to be a pioneer in this area, and now it's one of the largest in the country. So it's a very personal thing...

Regarding the addition of services, in addition to patient demand we have federal managers

Chart 1. Summary of the CSD regarding recent changes in hospital profiles.

Theme 1 - Changes in recent years	
CSD 1 - Discourse on change and prioritizing high complexity	CI 1 - Change by increasing the complexity of services provided, based on a strategic plan
	CI 2 - Change due to the increase in specialization based on the increased value of higher complexity areas identified in the strategic approach
	CI 3 - Change due to increased complexity to differentiate the network and continued teaching
CSD 2 - Discourse of the changing patient profile and increase in demand	CI 4 - Change as an increase in the demand for emergency, vascular disease, chronic renal and cancer care
	CI 5 - Changes in the demographic profile due to population aging
CSD 3 - Discourse of the change in supply due to expanded and new services	CI 6 - Changes in service by medical initiative that subsequently expands and becomes a reference
	CI 7 - Change resulting from added services as the network is unable to serve its patients or at the request of the MoH
CSD 4 - Discourse of the change in supply due to the loss of services or municipalization	CI 8 - Changes due to the loss of professionals resulting from limited investment in technology
	CI 9 - Change due to services lost because the professionals involved retired or moved to another unit
	CI 10 - Changes caused by municipalization and the lack of investment in the hospital
	CI 11 - Change caused by municipalization that left the hospital depleted, with no equipment, input or staff
	CI 12 - Change caused by municipalization and a decrease in the complexity of supply
	CI 13 - Change due to MoH investments to recover hospital and resume services
Theme 2 - Resistance to change	
CSD 5 - Discourse regarding the resistance to changes in care profile and internal changes in the services	CI 14 - Resistance to changing the hospital profile to a university hospital
	CI 15 - Resistance to proposals for service reforms made by at the central level
	CI 15 - Resistance to proposals for service additions made by at the central level
	CI 17 - Resistance to adding services at the hospital

deciding to introduce services. This is reiterated in the determination of the greater manager, and that had to be incorporated even if the unit professionals or management agree to structure this service in the hospital.

Services that grow and expand due to physician initiative and the individual desire of professionals to perform a given activity is significant evidence in the discourse, and results in the service expanding its supply within the network and becoming a reference.

The following discourse, by a coordinator of care, is highlighted as it is a good example of the question of changes in the supply of services as something that is not necessarily explained by population demand or management decision.

We have services in the hospital that imploded and nobody knows why, others grew and became huge services, and others shrank, and there is no reason one can point to: - Oh, the population didn't need that. I don't believe so, I believe that these expertise just left randomly.

Change frequently emerges in the discourse as something that happens, either in creating a service *as something very personal*, or a decrease in the supply as *random evasion*, linked to medical professionals and not to a decision made by hospital management.

CSD 9 – Discourse of the change in supply due to the loss of services or municipalization

Municipalizaiton was chaos. The city did not invest in the hospital, it just wanted the SUS passalongs. We ended up with a hospital that was falling apart. The number of beds reduced. Ultimately the hospital came to a halt and the emergency service was eliminated. The federal government intervened and rescued it. New investments were made. The number of surgeries started to climb again.

We realize that some of the changes in the care available are linked to external definitions, in this case specifically, to the period in which hospitals were managed by the city government. In some way or another, all of the interviewees in hospital units that experienced the municipalization process said this was a period in which there was a decrease in services offered due to the lack of investment.

CSD 10 – Discourse regarding the resistance to changes in the care profile and internal changes in the services

In 1963, 64 there was a move to make this a university hospital but the professionals were against it and managed to thwart the idea.

The hospital started out with two surgery services - General Surgery 1 and 2. There were several initiatives to merge them but nothing ever came of it... Then you walk into a meeting room and the entire service walks in with the director: "I brought my professionals so they can state their disagreement... It just didn't change because the hospital has a tradition built on the high complexity surgeries performed by the doctors...

This discourse is a movement of resistance to proposed changes, and was found in the discourse of players in several units. One of the interviewees mentioned that the main movement in the institution, since it was created, is not change but the resistance of a group of employees who diverged and made it impossible for the project that would transform it into a university hospital to go forward.

In this case, the care profile of the hospital was not only the result of strategies for change, but of the strategies developed over time by a diverging group to impede change, bringing to light conflicting positions of the players in the organization and the scenario of which they are a part[21].

Design of the care profile and organizational outlook

The previous theme presented the main changes observed by the interviewees. Based on these changes we will attempt a deeper analysis of what led change to happen and how they define the care profile of the units (Chart 2).

CSD 16 - Discourse of the change process from the point of view of the Hospital Management Department (HMD)

We don't really have suitable planning yet because we go in bursts... We are experiencing a very disorganized healthcare system, which reflects in the population that goes to the units in search of all sorts of services. Because this demand, hospitals also grow in a disorganized manner, offering services in an attempt to minimize huge waiting lines. Oftentimes each units is trying to cope with its demand within its own universe, even if the services double in size. Most hospitals have no planning center.

In the perception of the HMD, change is not the result of an intentional process, but primarily the result of a need to meet demand, leading units to develop certain services and incorporate certain technologies. Hospital managers have the same perception.

CSD 17 - Discourse of the change process from the point of view of the hospitals

I believe the units organize themselves based on a number of things, but not much is the result of central planning. I believe that we adapt to needs as they arise. Normally we end up with things that really don't have an owner. The healthcare units develop their own expertise based on their healthcare professionals, and this leads to the disorganization we now see.

Most of the heads of service que interviewed, when asked about what led to change, repeated this same type of expression, showing that changed happened and was not necessarily led by any authority, and are seen as *sort of ownerless*.

Chart 2. Summary of CSD regarding the determinants and factors that interfere in changing the profile of care.

Theme 1 - The care profile and the unit planning structure	
CSD 6 - Discourse of the change process from the point of view of the Hospital Management Department (HMD).	CI 18 - Change is not the result of planning, but of individual of hospitals intent on serving their demand
	CI 19 - Hospitals use no planning tools or methodology
	CI 20 - Most hospitals have no structured planning center.
CSD 7 - Discourse of the change process from the point of view of the hospitals	CI 21 - Change is not the result of planning, it merely happens
	CI 22 - The planning structure is incipient, and is more centralized in management
	CI 23 - Hospitals have initiatives for improvement and support from independent consultants
	CI 24 - Projects are provisional and change as management changes

One question that stands out and emerges in both discourses is a perception that the process happens in isolation at each unit, due to the search of individual professionals or managers for solutions to their problems or to remedy the population's health, or because there is no integrated process across the city, state and federal units. Another recurring topic is the perception of duplicate offers between units.

Discussion

When we analyze the discourses, retrieving the three configurations of change proposed by Mintzberg and Lapel[10] (planned, led and developed), we find that most of the changes perceived in recent years were developed, meaning they happened without necessarily being led by managers internal or external to the units. This is seen in the way managers describe change as something that happened and was not planned or monitored by groups or people in authority within the institution, which would be the case in a planned change.

One may also say, based on the concepts of the Mintzberg[8,9] strategy, that the units have created their care profile primarily through emerging strategies, with no decision or guidance prior to developing services or making changes to them, such as in a deliberate strategy. Motta[5] points to this question when he states that units tend to promote change all the time, with no idea of the direction they are going in or path they are following.

The only initiatives that seem to have been configured from more deliberate positioning strategies are those resulting from independent consulting efforts to apply planning methods. Their main role has been a search for orientation and leadership, privileging high complexity.

The other core ideas, although they too include a perception of change, at least in the increase of complexity, the areas that make up the hospital's care profile, and that became more complex, did not emerge from a decision or plan, but from consistent behavior over time, the addition of new technology and the increase in demand, which characterizes a strategy defined from a pattern.

This becomes clear when we realize that the discourses, both for increased and reduced supply, are primarily provoked by changes in the decisions of the medical professionals, when they decide to start a new activity or leave the team.

Considering the three approaches to change proposed by Motta[5] – strategic intent, adaptive reaction and continuous learning –, it is fair to state, based on analyses of changes viewed as necessary by managers, that the pattern of intentional change in federal hospitals is adaptive reaction, where the development of new ideas is primarily the result of the need to solve problems, rather than the outcome of a planned process to interfere in the organization's growth and development.

According to Mintzberg et al.[10], strategy development is addressed by often referring to change. Therefore, it has to do with change and not continuity.

However, what we see in the discourse of these managers is that in hospitals, this type of movement happens not only in the case of change, but strategies are also developed as resistance to change.

This resistance is seen both to more radical changes, such as the transformation of a unit into a university hospital, and to more incremental changes at the level of services or care profile. However, resistance seems to emerge primarily to avoid imposed strategies, which points to the fact that if the care emerges as the result of changes that "just happen", it also emerges from strategies that allow the units to resist change proposed from outside.

These discourses also indicate a need for deeper analysis of how strategies are molded within hospital organizations, based on a political perspective and the fight for power. The difficulty to introduce structural changes, arising from an intentional process, may be related to the fact that there are different power clusters within institutions, and the fight over projects results in the movements to resist change we found in this study.

Regarding management perception on the process for defining the care profile, this emerges as being not very rational or systemic. Units do not have planning tools that support these processes, and in most hospitals planning teams are incipient or relatively inactive.

The perception of the outside environment is that the system is disorganized, and that this interferes in the possibility of a more integrated approach to designing the care profile. Each unit incorporates technology and attempts to meet the demands of the population on its own, with no planning. This sends us back to the decision making process, which as shown in the strategic approach, is still incipient in hospital organizations, as managers make decisions on an ad-hoc basis and in response to pressure from different players, with no formulated institutional strategy[15,17,22].

According to Lima[11,23], the process of setting goals in government organizations has a natural perspective, due to their dependence on the environment. This dependence is found, for example, in the connection between these institutions and the goals and changes at the upper levels of government and the other units located within the territory.

Regarding interference in the development of the institution's care profile, what emerged from management discourses were spot decisions to introduce a given service, but there was no reference to a policy for federal units that would in some way guide hospital activities or changes.

Still with regarding natural perspective, hospitals are subject to other environmental factors, which in the discourses were recognized only as the pressure of demand and the pressure to add new technologies.

However, considering the characteristics of government organizations and the healthcare model, other units in the system should also be one of the factors taken into consideration when defining the care profile[24].

What our analysis of the results reveals, is that today this process is still made on an ad-hoc basis by the hospitals, and the responsibility for solving problems is not shared by the units, resulting in processes that are fragmented and mismatched across hospitals.

To meet the demand of a given territory, and abide by the criteria of economic rationality, integration and complementarity within the healthcare system, it is important that the players with governability participate[16,21,24,25] in the process, helping define organizational goals, including the involvement of the professionals themselves, as these have a major influence on defining the care profile of hospitals[8,9,17].

According to Dussault[26], the best type of management for these organizations would be more of a collegiate and consensual model, and not an authoritarian one. Such a model would involve professionals in formulating goals.

In a strategic approach, leading the process in a participative manner is in opposition to an approached based on rules and guidelines, showing that se secure player accountability, projects must be the result of communicative processes and negotiation[16,24].

Regarding the risk of a possible *politicization* of management via political appointments, a reality in these units, Dussault[26] suggests that, to minimize institutional instability, projects be debated, with clear rules and agreements that respect the goals defined.

This possibility would minimize the negative effects of politicization of management in these units, and the very external authority, as well as the process of changing the dominant groups within hospitals, which wears down the formulation and credibility of planning processes, as projects are never made operational or are discarded at each change in management.

Final Considerations

The definition of the care profile of a hospital is a critical aspect, both in terms of internal development strategy and its position in integrated healthcare networks.

Considering the configuration of the healthcare system in Rio de Janeiro, with all spheres of government managing care providers, and where federal hospitals have been passed along between the spheres of management, creating a central management unit that could combine the units could benefit the local system.

However, the central authority cannot focus only on the changes that emerge from the need to solve problems, but tries to enable them by confronting the hospital units, as the trend will be to resist such changes.

In this case, some of the imposed changes could yield incremental or even more radical changes in the configuration of internal systems, occasionally reverting to duplicate offers, but the rationale of shaping the care profile and leading unplanned, non-systemic change would continue to prevail.

In hospital organizations, understood as professional organizations, the important role of internal players is already recognized[27] for defining and implementing the institutional mission, which requires the development of shared and communicated strategies, collective plans and continuous negotiation.

The discourses regarding resistance to change show that the dimension of power[21] within hospital institutions must be further explored in future studies, expanding the observation of how strategies are created and the care profile of hospital organizations shaped.

Collaborations

L Binsfeld helped analyze the data and design and write the article. FJU Rivera and E Artmann worked in critical analysis, also helped draft the article

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