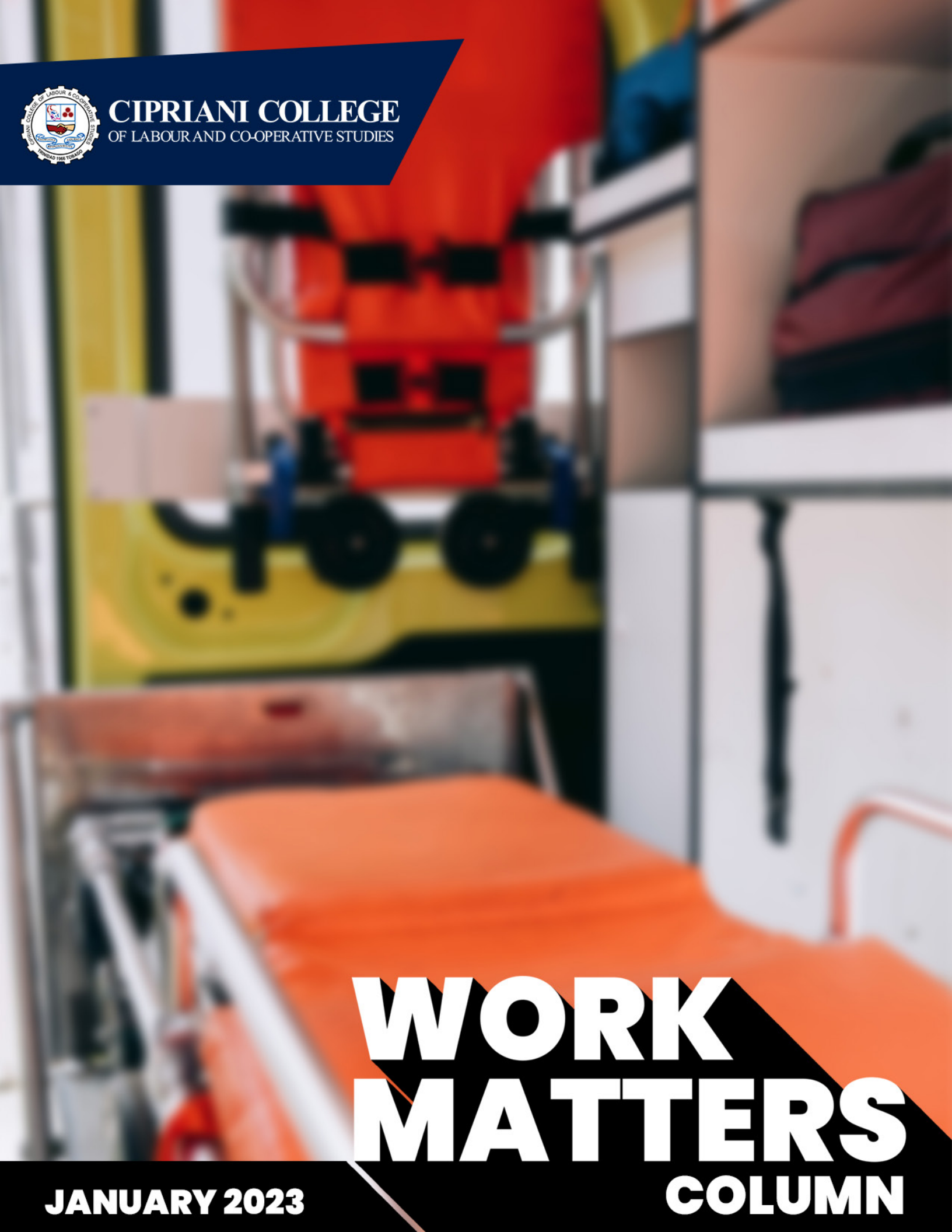

CIPRIANI COLLEGE
OF LABOUR AND CO-OPERATIVE STUDIES

WORK MATTERS COLUMN

JANUARY 2023

Regonialization and its Impact on the District Hospital in Trinidad and Tobago.

Like all district hospitals, the Port of Spain General Hospital is a total institution with a culture that defines the roles and lived experiences of healthcare providers and their patients. The hospital is a powerful, complex organization with professional norms, disciplinary practices, and social regulations.

In the 1990s the health care paradigm shifted in Trinidad and Tobago, a country with a welfare economy, to an economy that is structured along the lines of Multinational Corporations and Neoliberalism economics. Health reforms were implemented specifically to create efficiencies by attempting to imitate the private market in the public sector. The introduction of 'user pays' for hospital stays in the early 1990s drew public ridicule and was abandoned, as the corporate model failed to improve the hospital's financial performance. Attempts to improve the hospital through the use of aggressive management systems, subverted health professional/ management relationships by attempting to drive unrealistic financial goals, service quality and culture.

While the public health sector was not privatized and remained in public ownership, private sector business practices and culture were embedded in public organizations. The experience of the next two decades reflected continuing underinvestment, and the determination of funders to push financial risk onto local services or the community.

Despite some retreat from neoliberalism after the year 2000, there has been persistent marginalization of health professionals through the dominance of rules and guidelines over clinical judgment. Those with means can access private surgery while those without are often unable to access the care they need through public hospitals, and in 2018, private hospitals reported performing 50% of all elective procedures.

The countervailing powers framework sets the healthcare system into motion by situating bids for power by the private medical profession, government, and other stakeholders in a political-economic framework. This is in contrast to the professional dominance and de-professionalization frameworks, which are 'unidirectional concepts' that do not capture the dynamic engagement of health professionals with other parties in the healthcare field.

The regionalization process of the health services in Trinidad and Tobago is related to the marginalization of members of staff in the health care system, and is symbiotically increasing the insecurity of working in the nursing profession.

One force that acts as a countervailing power on doctors' professional dominance is increased patient power. Patients today have increased consumer power and increased access to information technologies, and participate in health social movements. But beyond consumer power and legal rights, is a cultural expectation that patients should be treated as collaborators in their care. This cultural trend is referred to by many names, including patient-centred medicine, patient autonomy, and patient empowerment. In order to link this trend to its heritage in health social movements, I refer to these related concepts as patient empowerment, and is widely held as an ideal type of medical care.

Sociolinguistics has identified a professional dominance paradigm by showing how doctors used subtle markers of authority to control the direction of the conversation in patient encounters with only occasional resistance from patients, which was characterized as remarkable. Some doctors use medical jargon in the encounter to secure patient agreement to a treatment plan, present therapeutic options to patients, or constrain patient participation in treatment decision-making . so we find that even techniques that appear to promote shared decision-making can instead undermine patient participation; while some doctors can vary the epistemic gradient between doctor and patient by presenting treatment options as recommendations.

District hospitals are cultural entities with an abundantly rich oral history heritage where people can meet and 'old talk' not only for medical reasons, but also for community members to socialize in the village gossip and renew acquaintances. District Hospitals have undergone a radical metamorphosis which has changed the social dynamics of the people in society. They have moved from institutions that primarily provided social services for the poor to lucrative corporate business entities in the position of upper class on the socio-economic status continuum. They have evolved to become sites of steadily increasing technical sophistication that reflected the class, race, and religious conflicts taking place in society.

Hypothetically there is a need to change the existing ideological framework to one that focuses on reducing expenditure and maintaining accountability to a variety of clinical, consumer, and government stakeholders. The hidden curriculum of the medical training apparatus has been linked to important variations in the socialization of young doctors, clinical outcomes, and medical relationships to institutional factors such as profit status, teaching and research missions, and considerations of urban or rural location.

Despite a robust body of research outlining the forces shaping contemporary changes in healthcare institutions and the ways in which professional autonomy and medical hierarchies have been reshaped, research remains primarily focused on hospitals as sites for clinical care.

The paradigm is shifting to focus on the social determinants of health and their effect on health outcomes. The District Hospital is a public institution with a working-class clientele. The hidden curriculum and the socialization of young doctors who work in public hospitals and the increase in interaction between doctors and patients have been disrupted by 'new monetary considerations'.

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