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Labelling patients

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ABSTRACT

This article looks at how diagnostic radiographers label their patients.

An ethnographic study of the workplace culture in one diagnostic imaging department was undertaken using participant observation for four months and semi-structured interviews with ten key informants. One of the key themes; the way in which radiographers label their patients, is explored in this article.

It was found from the study that within the department studied the diagnostic radiographers labelled or categorised their patients based on the information that they had. This information is used to form judgements and these judgements were used to assist the radiographers in dealing with the many different people that they encountered in their work.

This categorisation and labelling of the patient appears to assist the radiographer in their decision-making processes about the examination to be carried out and the patient they are to image. This is an important aspect of the role of the diagnostic radiographer.

Introduction

The purpose of this paper is to discuss the ways in which diagnostic radiographers attribute labels to their patients whilst working. The example of one department is used as part of a doctoral study to inform these deliberations.[1]

Many different patients access the diagnostic imaging department for a variety of radiographic examinations. Within diagnostic radiography, as with other professions, the staff members tend to label or categorise their patients based on the information that they have about them. This could be based on the patient's age, gender, the examination they have attended for, the nature of the injury or pathology that they are being investigated for and the circumstances of the acquisition of the injury.[2] Many professionals form similar judgements about their service users, both in healthcare and other public services.[3] These judgements assist them in dealing with the many different people that they encounter in their work. Goffman[4] studied situations in which people meet and form judgements about one another. He argued that stigma and stereotype are linked and that these are related to people's unconscious expectations and norms. These can be seen in all social encounters. Symonds[5] takes this idea further arguing that moral norms are value-laden and that healthcare professionals categorise patients within an institutional social order.

The ethics of labelling and categorising patients are sensitive issues in current healthcare practice, particularly when the standard of care is under scrutiny.[6]

This paper presents some of the data from a doctoral study which was an ethnographic study of the culture in a diagnostic imaging department.[1] The study took place over six months with four months participant observation followed by semi-structured interviews with ten key informants. One of the key themes that emerged from the data was that of 'labelling patients'. This paper is a discussion about this theme and how it informs practice within diagnostic radiography.

Literature review

A search of the healthcare literature was carried out using the databases CINAHL and Medline. The search terms radiograph*, patient types, categorising patients and labelling patients were used. This search was carried out to identify any healthcare literature about labelling patients and also to look at the radiography literature more specifically. There were very few studies found, illustrating a gap in the literature.

Patient types

It is generally part of any culture or group to have 'types' of people and to be able to categorise people into groups.[7,8] When anyone meets another person for the first time they have a tendency to categorise that person. Once a person has been categorised in this was and decision is made about the type of person they are, then it appears to be easier to predict how they will

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behave and understand their actions. Madison [9] suggests that people use their expectations, images and impressions of people to label and categorise them. Labelling theories derive from the work of symbolic interactionists. These theories suggest that the world is not fixed and given, but depends upon how people define things around them. Becker et al.[10] in their seminal work about the culture in medicine use the term 'labelling' to describe how society defines different people. Goffman[4] linked stigma and stereotype and suggested that everyone has expectations and norms which are used in social encounters to label people.

Davis [11] in his paper entitled 'the cabdriver and his fare' says that cabdrivers develop their own typology of cab users based on their appearance, demeanour and conversation. In healthcare this also applies, Hollyoake[12] describes this in nursing.

Diagnostic radiographers encounter many different patients. The radiographer's role is both technical and caring, but tends to be characterised by less time spent with the patients when compared to other professions.[13] Therefore the diagnostic radiographer has to make quick decisions about their patients, and the patient may be in pain or have experienced an accident or illness. Categorising the patient into a typology assists the radiographer in their decision making and planning for the radiographic examination.[3]

Categorisation of patients in healthcare

Long et al.[14] carried out an ethnographic study of the culture in a hospital and talk about the identity of the patient, and how the patient loses their previous identity when they take on the patient role. They discuss how patients are labelled according to their medical condition, for example they could be labelled as 'a total hip replacement' or 'an appendix'.

This reductionist language, where patients can be referred to as body parts is endemic within the diagnostic radiography profession.[2] The diagnostic radiographer will scrutinise an X-ray examination request form, which normally begins with the examination being requested, a body part.[15] This reductionist language is also part of radiography education, so student radiographers are introduced to it early on in their training. Students begin by imaging different body parts.[2] Students become very quickly socialised into this way of referring to patients, and the culture where the patient is discussed in relation to the body part being imaged, e.g the next one is a chest.[1]

Various authors discuss how patients can be categorised as unpopular patients.[10,16,17] This in turn has a potential to affect the way in which they might be treated. For example the unpopular or difficult patient may be labelled as such and not receive a high standard of care. A student nurse reported an encounter where they felt that labelling a patient as challenging or difficult reinforced poor care standards.[18] She felt that the label influenced the way that other professionals viewed the patient and that it became detrimental to their care.

There were no research studies carried out about this issue in radiography, although Murphy[3,19] eludes to the fact the radiographers categorise their patients in order to decide how to image them.

Methodology

This study used a qualitative methodology; ethnography to study the culture in one diagnostic imaging department in the East of England.[1] Ethnography has its roots in both British social anthropology, where researchers went out to study foreign cultures and in American Sociology (from the Chicago school) which used observation to explore groups on the margins of urban industrial society. The task of these two distinct groups was the same, that of cultural description.[20] Since then ethnography has developed and moved into other spheres such as education, healthcare and social work. In many respects ethnography is really the most basic form of social research; it bears a close resemblance to the ways in which we make sense of the world around us.[21] Ethnography involves the study of a particular social group or culture in naturally occurring settings.[22,23] In order to document their findings the researcher needs to become part of the culture being studied to gain understanding and insight. In ethnography the researcher needs to have direct and sustained contact with those being researched within their cultural setting. This involves watching what happens, listening to what is said and asking questions.[24] Ethnography should also be carried out over a period of time in order to reduce the impact of the researcher's presence on the situation being studied. "People can sustain an act or maintain their best image only so long".[25 p49]

Ethnography employs several research methods, which link findings together[24] and allow for what Richardson and St. Pierre[26] call crystallisation. The methods used were participant observation for a four month period and semi-structured interviews with key informants from the department. The observation notes and interview transcripts were analysed using thematic analysis.

The purpose of this research was to investigate the culture in the imaging department amongst radiographers. Qualitative methods provide further insight and rich data about the complex issue of culture.[27]

Ethnography was selected as a methodology as it is the study of groups and cultures. It is carried out in natural settings, where people live and work in groups.[28]

Ethical approval was obtained from the University Ethics Committee, the local research ethics committee (LREC) and the research and development committee (R&D) at the NHS Trust where the study took place.

Observation

The observation started with an initial mapping of the department.[29] This involved observing the patient's journey through the department, recording where events occurred and creating a floor plan of the department in order to understand how the space was used. 43 members of staff were observed during the study.

The researcher is a diagnostic radiographer and was therefore observing her own profession. She took the role of 'observer as participant'.[30] Observation prompts the researcher to consider what it means to be a part of the group being studied.[31] It was useful to have some sense of shared cultural knowledge. Holland[32] believes that undertaking research in one's own field of practice reduces the 'culture shock' and makes the researcher more sensitive to the participant's behaviour. However, she also says that there is a danger of data being overlooked because of familiarity. During the whole period of observation the researcher was aware that her insider status could contribute to missing out on important information,[33] as she would not necessarily see something as strange or unfamiliar and record this. The researcher had to be aware of over familiarisation.[17,34,35] During the period of observation the way in which the department was run, the way in which radiographers worked and interacted with one another, and the way in which radiographers interacted with patients were noted. Field notes were recorded throughout the observation period by the researcher and these were used during data analysis to highlight events and to illustrate the findings about the workplace culture.

Observations were continued until data saturation had been reached, a point when no new information is generated.[36]