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Narrative and deliberative instauration: The use of narrative as process and artefact in the social construction of institutions

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ABSTRACT

Patient Safety is a global institution in the field largely assumed to have emerged following the publication of *To Err Is Human* by the *Institute of Medicine* in 1999. In this paper we demonstrate that Patient Safety has been constructed as an institution separately in the practice of anaesthesia since 1954 and in hospitalised care since 1964. The publication of *To Err* was, in fact, only one of a number of later field configuring events. We use Bruner's (1991) theory of narrative to frame the institution building process which we term deliberative instauration in recognition of the historic literature on the subject. We further link the process of institution building to Vygotsky's theory of social mediation and the use of artefacts in relation to the object of intended action. We conclude that a narrative can be understood as both an artefact and a process used in the social construction of institutions by professional psychological collectives (in this case physicians).

1. Introduction

Collective, homogenous patterns of behaviour of individuals are the product of stable networks of relations. These stable and homogenous patterns of behaviour become sanctioned by the members of the psychological collective to form institutions (e.g., see, Daniels, 2010, 2012, Undated; DiMaggio & Powell, 1991; Scott, 2007). Institutions are complex modifications of original mediated responses between individuals and objects and one of the resulting behaviours is the development, maintenance, and transformation of those same institutions. However, institutions are also complex social constructions in a state of constant flux that both enable and constrain the behaviours of the members. The institutions are subject to change and transformation through the actions of their members. The assumption that institutions have a normative effect on behaviour is contradicted by changes made to the institution/s by the members; this is the paradox of institutions. In keeping with this the generation of alternatives to existing routine practices, the transformation of existing institutions, and the building of new institutions, are generally considered phenomena that are worthy of study as special forms of action.

Theories of objectification of norms of action and cognitions into artefacts that decisively influence the course of action can be found in philosophy (e.g., Dewey, 1938/1991), the social sciences (e.g., Latour, 1991, 1992), and psychology (e.g., Vygotsky, 1979). The interaction between the human agent and its object is mediated by tools and signs; artefacts. The meanings associated with artefacts are internalized through participating in common activities with other humans. Equally, the shared creation of artefacts is a means, by default and/or by design, of reflecting and of transforming activity, and as such is a key to changing practices (Vygotsky, 1934/1986). The same basic mediational means, cultural artefacts, are used on the individual and social planes (Vygotsky, 1987), calling into question the boundary between social and individual. Simply put, the creation and use of artefacts

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is an institutional process that not only institutionalizes the web of behaviours, cognitions, beliefs, meanings and so on in which the artefact is embedded but also one that builds and transforms institutions.

In this paper we address the question of the complex social process of changing, or transforming, the routine practice of a psychological collective over a long period of time on a global scale. That is, we are concerned with the knowing transformation, or construction, of a social institution (deliberative instauration; Kantor, 1929). The social institution in question is Patient Safety and we take account of the developments between circa 1954 and circa 1994. We consider two cases: Anaesthesia (1954–1985); and hospitalised care (1964–1994). In both cases the pattern of activity is the same and takes place on a global scale. Taking a social constructionist approach we analyse the discourses of the relevant profession, as they are themselves constitutive of cultural life. They make distinctions, furnish rationales for action, and implicitly, and explicitly, evaluate forms of conduct (Gergen, 1996). Discourse is a form of participating in common activities with other humans and the inscription of discourse (in text) is the shared creation of artefacts, especially within a profession. We expand the understanding of the role of artefacts and the process of engaging with artefacts using Bruner's (1991) theory of narrative.

In taking a social constructionist perspective we consider that traditional empirical research – the observation of objects and events – is most effectively deployed in illustrating interesting or challenging ideas, tracing patterns of conduct of major significance to the society, and generating debate and dialogue (Gergen, 1985, 1996). This is to say we are neither setting out to test theory nor, necessarily, to develop theory per se. We are using theory to frame our observations. The contribution made by this paper is to trace a pattern of conduct of major significance to society and to show how the observed process can generate substantial lasting changes in individual and collective routine behaviour.

The rest of this paper is structured as follows. First we provide some brief context for Patient Safety since 1999. We do this because this context is the most often referred to understanding of the institution and industry. We then discuss the relevant theory of narrative and text followed by an overview of the method. Next we present the case studies of anaesthesia and hospitalised care separately, focussing on the breach of the canonical script and the reconstitution of the canonical script. We then provide a discussion of the process of deliberative instauration, the role of narrative and the use of texts. We end with a short summary conclusion.

With regard to reflexivity we have little to say that has not already been said and articulated in the literature relating to social constructionism. Clearly we are aware that the production of an academic paper is a shared process during which an artefact (the article) is produced in keeping with the institutional and cultural norms of the psychological collective and according to the conventions of the selected genre. The concern that the observation of a narrative process at work in wider society may be a practice of sensemaking on the part of the observer applies equally to any observation, and, indeed, we would argue that this is inevitably the case.

1.1. The context of Patient Safety

Patient Safety is a global institution in the healthcare industry. Typically Patient Safety is considered post-1999 following the publication of *To Err is Human* (*To Err* hereafter; Kohn, Corrigan, & Donaldson, 1999/2000) by *The Institute of Medicine* (IOM). The publication of *To Err* had a substantive impact on the American public, policy makers, and medical establishment which went on to ripple around the world. Following its publication there was an increase in available funding to support Patient Safety research, with a matching increase in subject-related publications, a growth in the number of organizations, changes in policy, regulation, legislation and accreditation world-wide, and a general change and growth in related practices, beliefs, and rules, and the network of related organizations within healthcare.

However, at the time of publication of *To Err*, Patient Safety was already well established globally not only in Anaesthesia but at the level of the hospitalised care also, and a number of voluntary error reporting systems and organizations were already in place, and had been for substantial periods of time. This paper considers the events leading up to the apparent impact of *To Err* rather than supporting the assumption that the publication of *To Err* was the key event (while recognising that it was a key event). The publication of *To Err* is best conceptualised as one of a series of field configuring events (Anand & Watson, 2004; Hardy & Maguire, 2010; Lampel & Meyer, 2008) in a sequence of field configuring events spanning roughly seven years (see below).

While there is no doubt about the level of institutional development following the series of field configuring events and the publication of *To Err*, there is equally no evidence of a substantive change in either safety or quality in hospitalised care at either an equivalent level or scale. Indeed, some of the principal actors in the process of institution building, Luciane Leape and Don Berwick among them, openly recognise that Patient Safety has not led to improvements in either safety or quality of care (e.g. Jha, Prasopa-Plaizier, Larizgoitia, & Bates, 2010; Leape et al., 2009; Woodward et al., 2010).

Of equal importance is the recognition, in the case of anaesthesia, that reported mortality rates may have decreased but this is due to the adoption of improved technology, or technological artefacts, not as a consequence of changes at the institutional level (Gaba, 2000). Similarly, technical changes in interventions used in hospitalised care that lead to improved outcomes linked directly to that technical change are often adopted as outcomes of institutional change. This is acknowledged as coherence by contemporaneity: the belief that things happening at the same time must be connected (Bruner, 1991). What we see in a recent report (*Making Health Care Safer II*, 2013), 14 years after the publication of *To Err*, is that of 100 Patient Safety interventions reviewed only 10 had sufficient evidence of effectiveness and implementation to be "strongly encouraged" for adoption. And, again, these were discrete technical processes relating to modifications and changes in equally discrete and already existing practices.

While there is a point of interest here with regard to the development of artefacts within the institution, and the subsequent role of those artefacts within the institution, this is a different level of detail to that with which we are concerned in this paper. Equally, the point is made that one of the outcomes of the reification of the institution is the institutionalization of the attendant behavioural norms associated with the institution. These behavioural norms include meanings, beliefs, cognitions, and behaviours such as the