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A qualitative study of speaking out about patient safety concerns in intensive care units

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ABSTRACT

Much policy focus has been afforded to the role of "whistleblowers" in raising concerns about quality and safety of patient care in healthcare settings. However, most opportunities for personnel to identify and act on these concerns are likely to occur much further upstream, in the day-to-day mundane interactions of everyday work. Using qualitative data from over 900 h of ethnographic observation and 98 interviews across 19 English intensive care units (ICUs), we studied how personnel gave voice to concerns about patient safety or poor practice. We observed much low-level social control occurring as part of day-to-day functioning on the wards, with challenges and sanctions routinely used in an effort to prevent or address mistakes and norm violations. Pre-emptions were used to intervene when patients were at immediate risk, and included strategies such as gentle reminders, use of humour, and sharp words. Corrective interventions included education and evidence-based arguments, while sanctions that were applied when it appeared that a breach of safety had occurred included "quiet words", bantering, public exposure or humiliation, scoldings and brutal reprimands. These forms of social control generally functioned effectively to maintain safe practice. But they were not consistently effective, and sometimes risked reinforcing norms and idiosyncratic behaviours that were not necessarily aligned with goals of patient safety and high-quality healthcare. Further, making challenges across professional boundaries or hierarchies was sometimes problematic. Our findings suggest that an emphasis on formal reporting or communication training as the solution to giving voice to safety concerns is simplistic; a more sophisticated understanding of social control is needed.

1. Introduction

Much policy focus has been afforded to the role of "whistleblowers" in raising concerns about quality and safety of patient care in healthcare settings (Francis 2015; NHS Improvement England, 2016). Whistleblowing is, however, only one type of behaviour for raising concerns. It is likely to be deployed reactively, after incidents have taken place or weaknesses have been detected, and only when other efforts to be heard or to take action have been frustrated. Many more opportunities for personnel to identify and intervene in concerns about the quality or safety of patient care are likely to occur much further upstream in the routine interactions of everyday work, though the exercise of "voice" (Morrison, 2011).

Defined as 'non-required behaviour that emphasises expression of constructive challenge with an intent to improve rather than merely criticise' (Dyne et al., 2003 p. 109), voice is directed towards others within the workplace, either to peers ('speaking out') or supervisors/managers ('speaking up') (Liu et al., 2010). Voice behaviour is a form of prosocial and constructive activity (Dyne et al., 2003), motivated by a desire to optimise performance and avoid error or harm. The ability of teams and individuals to speak out when they have concerns, and to accept challenges and input from others, is often seen as critical for promoting safety in high-risk settings (Lyndon, 2006; Orasanu and Fischer, 2008). Yet use of voice may be potentially risky: among other things, it involves challenging others or disrupting the status quo (Liu et al., 2010). People's willingness to speak out is thus highly dependent on their beliefs about perceived efficacy, and whether they think it will have

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any negative outcomes (Lyndon, 2008; Morrison, 2011). Attempts to address reluctance to use voice have tended to focus on training in more effective communication strategies (such as avoiding mitigated language and using graded assertiveness) (Okuyama et al., 2014), especially in communicating across hierarchies and boundaries (e.g. Brindley and Reynolds, 2011). However, interpreting challenges in exercise of voice as simply problems of communication is insufficient. In this paper, we propose that understanding how to support those who seek to intervene in potentially inappropriate or unsafe behaviour in healthcare requires an understanding of social control.

1.1. Social control in a 'company of equals'

Processes of social control – including the establishment and enforcement of social norms and informal conflict resolution mechanisms – play an important role in regulating behaviour in interdependent groups (Lazega, 2000). Social norms are 'standards of behaviour […] based on widely-shared beliefs about how individual group members ought to behave in a given situation' (Fehr and Fischbacher, 2004 p. 185). Group members are, in principle, incentivised to monitor and use informal social sanctions (such as exclusion) against individuals who violate these norms (Sripada, 2005). Sanctions function to re-enforce social norms and deter future violations; they tend to be graduated dependent on the severity and frequency of the violation (Ostrom, 1990). Social control, exercised through the "informal" use of voice and sanctions in response to norm violations, is thus a potentially effective means of identifying and resolving safety concerns without recourse to external parties and formal corrective systems, including whistleblowing.

In a healthcare context, early evidence of the importance of social control emerged from Freidson and Rhea's work, which examined a group of qualified physicians working together in a large US clinic (Freidson and Rhea, 1963). Describing how the physicians informally monitored each other's conformity to professional and social rules and norms, this work identified that "the elements involved in the process by which control may be exercised in this company of equals are fairly unbureaucratic in character", and included physicians' use of what Freidson and Rhea describe as "punishments", including the so-called "talking to". Similarly described in Rosenthal's later work on incompetent doctors in the UK (Rosenthal, 1995), sanctions such as the "terribly quiet chat" were often (though not always) effective.

This work was important in showing that social control may facilitate ongoing monitoring of colleagues' behaviours and practices and provide the ability to intervene in ways that may minimise burden and conflict. But it also showed that social control has its limitations. Professional and social norms may not always be aligned with goals of quality and safety; respect for professional autonomy may preclude clinicians from challenging others; and the system is reliant on individuals internalising professional and social norms and being responsive to social sanctions (Dixon-Woods et al., 2011).

This literature offers an intriguing hint that by the time healthcare personnel resort to whistleblowing, a failure of informal social control has already occurred. There is, however, little empirical evidence of what features of social control are used, and to what effect, in the context of the modern healthcare environment; Freidson and Rhea's work predates the era of multidisciplinary teams, and Rosenthal's work predates much of the patient safety and quality movement and major policy shifts.

In this paper, we focus on processes of social control in everyday clinical practice within multidisciplinary healthcare environments, outside the formal reporting processes for dealing with incidents and poor practice. We examine the types of challenges and sanctions used in these environments to prevent or correct behaviours or actions that may pose risks to patient safety, and we reflect on the role and limits of social control in promoting safe and high quality care.

2. Methods

This paper reports data from an ethnographic study of a national programme (Dixon-Woods et al., 2013) to reduce central venous catheter bloodstream infections (CVC-BSIs) in intensive care unit (Bion et al., 2013). The interventions introduced as part of the programme included a checklist designed to promote adherence to good practice and facilitate personnel in challenging poor practice in relation to catheter insertion, as well as a number of non-technical interventions targeting safety culture and multidisciplinary communication about safety.

Across 19 purposively sampled adult ICUs across nine different hospital trusts, authors CT and ML conducted ~910 h of ethnographic fieldwork. We observed day-to-day interactions around catheter maintenance and care, including how personnel responded when they had concerns about others' practices or aspects of patient safety. We recorded instances of individuals challenging or sanctioning others in response to behaviour or actions that could potentially risk patient safety. Face-to-face interviews were conducted with 98 'shop floor' personnel, including 34 consultants (equivalent to attendings in the US); 14 doctors in training, usually referred to as "junior doctors", including registrars (residents in the US) and physicians in their foundation years (similar to interns in the US); 28 senior nurses (e.g. nurse managers); 8 staff nurses (qualified registered nurses); and 14 infection prevention/microbiology personnel (specialised nurses and physicians). We questioned participants about their feelings and experiences of responding to concerns about poor practice, and of challenging and sanctioning others. Written informed consent was obtained prior to interview; for observations, people were informed and verbal permissions obtained where possible. Ethical approval for the study was obtained from Berkshire Research Ethics Committee [Ref: 10/H0505/2].

Interviews and fieldnotes were transcribed and anonymised. Analysis of data was based on the constant comparative approach (Charmaz, 2006). Initially, "open codes" were generated, representing the significance of sections of text. These were then incrementally grouped into organising categories or themes. Categories were modified and checked constantly in order to develop a coding frame, which was programmed into NVIVO software and used to process the dataset systematically.

3. Findings

We identified a range of informal processes of social control, including challenges – principally in the form of pre-emptions – and post-hoc informal corrective interventions and sanctions of various kinds that were routinely deployed as part of day-to-day work. Though mostly effective in promoting positive patient safety behaviours, some unwanted consequences of these processes were also evident.

3.1. Pre-emptions

The major form of prospective challenge that we identified was that of the *pre-emption*, which we defined through our analysis as challenges or corrective interventions that were used to prevent error or poor or risky practice in real-time. Pre-emptions were used by colleagues to alert others when they were at risk of violating