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Seeing risk and allocating responsibility: Talk of culture and its consequences on the work of patient safety

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ABSTRACT

To improve patient safety, hospitals have implemented interventions to change their culture. Although there is great enthusiasm for these interventions at policy and management levels, we know little about how clinicians talk about "culture" as they do the work of quality and safety improvement. This article investigates the way talk of culture arises *in situ*, showing how it is a trope that can frustrate, obscure, and prevent the collective social action necessary to change practice. The findings are based on a two-year ethnographic case study of a large hospital in the United States that undertook an organization-wide safety improvement initiative. They show that culture is frequently talked about as a behavioral trait of individuals, which makes the identification of social barriers and facilitators difficult. Culture talk can also obscure uncomfortable, yet crucial social phenomena, including history, politics and inequalities in power that may contribute to unsafe care delivery. The consequences of this obscurity are (1) practices that might make care safer are not considered, and (2) responsibility for enacting safe practice is allocated to those with the least authority and capacity to mitigate risk. The article closes by discussing how talk of culture obscures the role of social context and its contribution to risk in patient safety.

1. Introduction

As part of national efforts to improve patient safety and healthcare quality in the United States (US), scholars and accreditation bodies have increasingly emphasized the role that culture plays in reducing medical error (Pronovost and Sexton, 2005; Singer and Vogus, 2013a). Although interest in this approach at the "blunt end" of healthcare continues, evidence that intervening on culture definitively impacts patient outcomes has proven elusive (Parmelli et al., 2011), and the way that those at the "sharp end" use the vague but potent term "culture" remains poorly understood (Cook and Woods, 1994).

Sociologists have long conducted ethnographic studies of frontline clinicians involved in everyday care delivery to investigate how professional culture mediates error and threats to safety (Bosk, 2003; Light, 1972; Waring, 2009). This article focuses on culture as it relates to patient safety generally, and specifically to culture as a trope that has become an object of focus for those working at both the blunt end of healthcare, and clinicians at the sharp end "doing" the work of implementing patient safety interventions (Dixon-Woods and Bosk, 2010). There is great enthusiasm at the managerial level in healthcare, as there has been in other industries (Kunda, 1992), that an organization's culture can be intervened upon to improve outcomes.

This article presents an ethnographic case study of the word culture as it is defined and used in the context of a patient safety improvement program. How do people talk to each other about culture in the course of negotiating the problems that arise when doing patient safety work and what are the consequences of this talk? By analyzing the ways staff at one hospital talk about culture in relation to an organization-wide initiative to reduce healthcare-associated infections, I seek to improve our understanding of how culture as a managerial trope can occlude well-intentioned practitioners' views of the sources of risk to patient safety present in the social context.

1.1. What talk of culture does: how meaning structures action

The methodological approach taken in this paper — investigating how people in a setting *talk* about a particular topic in order to understand how it structures collective action — derives from work by sociologists who study the places where meaning is

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created, modified and circulated in the course of everyday life (Swidler, 1986, 2001). Ann Swidler's work in this area has been particularly influential in showing the analytic purchase that can be obtained by moving beyond the identification of symbols to examining how they are put to use. By studying how people actually use cultural materials *in situ* we can understand the influence that meaning making can have on behavior.

Swidler has empirically examined how middle-class Americans talk about love (Swidler, 2001) and rural Malawians talk about condoms (Tavory and Swidler, 2009) and the AIDS epidemic (Watkins and Swidler, 2009). In the case of condom use, Tavory and Swidler (2009) analyze conversational journals created by Malawians that capture everyday talk about condoms. They identify three semiotic axes that create possible meanings of condom use: the sensuality or "sweetness" of sex, the question of trust and love, and an assessment of AIDS risk as measured against the perceived dangers of condom use. These axes then "serve as pragmatic tools of knowledge and deliberation 'ready to hand' that Malawians use to perform the social navigation of everyday life" (Tavory and Swidler, 2009, p. 184). The meaning that a condom holds for a person in any one situation, what it symbolizes about their identity or the nature of the relationship with their sexual partner, influences action — whether they will use a condom.

This approach views "interaction as a key arena where semiotically charged objects and actions have powerful effects" (Tavory and Swidler, 2009, p. 185). This theoretical point informs the analysis in this paper. Investigating the way a particular cultural object (in this case the word culture as managerial discourse in the context of work to improve patient safety) is used in naturally occurring interactions between people can demonstrate its effects on action. I analyze the way groups of hospital staff involved in a formal patient safety improvement program use culture in the course of work to change practice to reduce a particular type of harm. What effect might culture as a polysemous trope in healthcare quality and safety have on the collective social action necessary to transform organizational practice?

1.2. Safety culture, risk perception and the attribution of responsibility

This paper examines the consequences of the use of the term culture on action. The outcome of interest is not an individual behavior like condom use, but is instead the collective social action of a group of people who are working together to identify threats to patient safety in organizational practice and intervene to mitigate them. The work of patient safety involves the constant classification of, communication about and management of risk (Dixon-Woods et al., 2009). However, not all risks can be known or attended to. The literature on the social construction of risk illustrates that risk perception depends less on the nature of a particular hazard than on the cultural context in which it arises (Douglas and Wildavsky, 1983). A constructionist approach to understanding how risks are identified encourages "counterfactual thinking; that is, paying attention to what could have happened but did not" (Clarke and Short, 1993, p. 382). Communication about risk directs attention in specific ways and selects, organizes and gives priority to particular features of phenomena while downplaying others.

Narratives about risk are infused with ideas about responsibility and blame (Douglas, 1992). The social processes that "select certain kinds of dangers for attention work through institutional procedures for allocating responsibility" (Douglas, 1985, p. 53). Conversations about what risks we should worry about and how to mitigate them are frequently accompanied by a discussion of who is responsible for managing them. Discourse about risk specifies what actions should be taken in response to vulnerability.

Susan Silbey, in a 2009 review of the increasing use of the term "safety culture" in management scholarship and media discourse about complex sociotechnical organizations, suggests that we can understand the endorsement of safety culture as a way of allocating responsibility for the risks of technological failure. Increasingly, she observes, the identification of a damaged safety culture has been used to explain technological catastrophes, such as Three Mile Island. Silbey is critical of the "distinctly instrumental and reductionist epistemologies" that management scholars deploy when they talk about culture (2009, p. 342). She suggests that "future research should explore just those features of complex systems that are elided in the talk of safety culture: normative heterogeneity and cultural conflict, competing sets of interests within the organization and inequalities in power and authority" (2009, p. 343). While hospitals are different than nuclear power plants, there are two general theoretical points Silbey makes that inform this analysis. Namely, that talk of safety culture is a way to allocate responsibility for risk and that talk of safety culture can occlude features of the social context rather than exposing them. This insight is used as a framework to examine what talk of culture *does*.

2. Methods

These data come from a larger ethnographic study investigating one hospital's experience implementing an organization-wide patient safety program to reduce healthcare-associated infections. I spent two years (2010–2012) continuously observing activities related to infection prevention at "Stonegate," a large pediatric hospital in the US. In total, I spent over 2000 h observing at Stonegate, which included 525 meetings related to infection prevention. I was primarily embedded in Stonegate's infection prevention department, whose staff gave me permission to observe them as they went about their daily work across the hospital, investigating infections, educating frontline clinical staff and attending meetings. Informed consent was obtained from all people observed and continually reestablished throughout fieldwork. I was completely transparent with all people observed of my purposes for being there and let them know they could ask me to cease observing at any point with no penalty to them. Jottings taken during observation periods were written into fieldnotes as soon as possible, typically at the conclusion of each day.

From 2011 to 2012, I conducted interviews with 103 hospital staff to elicit their perceptions of infection prevention and to reflect on the emerging themes I had identified after a year of fieldwork. I relied on purposive sampling to determine whom to recruit for interviews in order to maximize the range of responses (Weiss, 1994). My sample included staff that varied on three axes —

Table 1
Characteristics of interview sample $n = 103$.

	n
Occupational group	
Nurse	56
Physician	30
Respiratory therapist	5
Other	12
Organizational strata	
Top leader	18
Mid-level manager	10
Frontline clinical staff	75
Primary work location	
ICU	39
OR	18
General pediatrics ward	14
Other specialty	14
Patient safety department	18