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Elective surgical patients' narratives of hospitalization: The co-construction of safety

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ABSTRACT

This research explores how elective surgical patients make sense of their hospitalization experiences. We explore sensemaking using longitudinal narrative interviews ($n = 72$) with 38 patients undergoing elective surgical procedures between June 2010 and February 2011. We consider patients' narratives, the stories they tell of their prior expectations, and subsequent post-surgery experiences of their care in a United Kingdom (UK) hospital. An emergent pre-surgery theme is that of a paradoxical position in which they choose to make themselves vulnerable by agreeing to surgery to enhance their health, this necessitating trust of clinicians (doctors and nurses). To make sense of their situation, patients draw on technical (doctors' expert knowledge and skills), bureaucratic (National Health Service as a revered institution) and ideological (hospitals as places of safety), discourses. Post-operatively, themes of 'chaos' and 'suffering' emerge from the narratives of patients whose pre-surgery expectations (and trust) have been violated. Their stories tell of unmet expectations and of inability to make shared sense of experiences with clinicians who are responsible for their care. We add to knowledge of how patients play a critical part in the co-construction of safety by demonstrating how patient–clinician intersubjectivity contributes to the type of harm that patients describe. Our results suggest that approaches to enhancing patients' safety will be limited if they fail to reflect patients' involvement in the negotiated process of healthcare. We also provide further evidence of the contribution narrative inquiry can make to patient safety.

Introduction

In this paper we explore how elective surgical patients make sense of their hospitalization experiences and how that sensemaking shapes and re-shapes their understanding of safety, through the stories they tell. Stories or narratives are accounts of events, 'verbal utterances occurring in space and time' (Chia, 2000: p. 513). They are the manner in which people make sense of the world and their part in it and can serve as moral tales, giving the listener insight as to how the narrator thinks the world should be (Frank, 2000; Riessman, 1993). In the healthcare context patients' stories are a means to obtain information about illness, and offer a method by which practitioners can gain a deeper, subjective understanding of patients' experiences (Fear, 2013). They can facilitate reflection on, and refinement of, professional roles and responsibilities (Greenhalgh, Russell, & Swinglehurst, 2005), and assist clinicians to learn from events which resulted in patient harm (Iedema, Jorm, & Lum, 2009).

Our paper begins by examining how sensemaking is a 'discursively constituted' (Iedema, 2011: p. 1168) process and examines how everyday discourses are shaped and informed by Paradigm-type Discourses (Alvesson & Karreman, 2011: p. 1129), which limit the frames of reference people use to make sense of events (Weick, 1995). Next, we consider patient safety and trust. Then we detail our method outlining the research setting and design. Following this, we consider how in the pre-operative period, patients make sense of their initial decision to have an operation, which places them in a paradoxical position, their narratives expressing a 'shifting dialectic of trust and doubt' (Williams & Calnan, 1996: p. 1613). We then explore patients' stories of their post-operative experiences when, having put their trust in clinicians, for many their expectations are violated. Finally, we consider the implications of our findings for patient safety.

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Sensemaking, storytelling and discourse

Humans think and interact in narrative (Fisher, 1984), developing shared meanings and corresponding forms of action by the use of language and the telling and retelling of stories (Weick, 1995). As abridged versions of events, narratives may or may not reflect actual experiences (Alvesson, 2003). Rather, they describe the narrator's interpretations of her/his experiences and the meanings s/he attributes to them. Meaning and coherence or sensemaking of the world occurs through people's telling and retelling of their particular versions of events. How people understand events comes to take the form of the stories they tell, these informing their understanding of their own beliefs and situation (Fisher, 1984; Weick, 1995).

In situations of uncertainty, sensemaking becomes a crucial process in the attempt to create order from disorder. Using cues to notice and bracket events, people place the unfamiliar into known categories pigeon-holing or labelling, to generate provisional, plausible, negotiated narratives (Weick, 1995). This process involves the co-construction of reality by intersubjective linguistic interaction, or 'small d' type discourse, where 'language is used to accomplish things in a highly localized setting' (Alvesson & Karreman, 2011: p. 1140). It occurs in a manner that predisposes people to notice, acknowledge and question some things, but bracket out others (Iedema, 2011; Weick, 1995). Such noticing and bracketing are guided by mental models. These include individuals' sense of identity and belonging to particular social or organizational groupings, their previous experience, knowledge and beliefs (Brown, Stackey, &Nandhakumar, 2008; Weick, 1995). Consequently, individuals tell their stories using language designed to preserve their self-esteem and social legitimacy, their narrative sensemaking tending to construct a version of events that is critical of others while placing themselves in a positive light (Brown, 1998; Brown & Humphreys, 2003).

Sensemaking frames of reference are also located in 'Paradigm-type Discourses' or 'meta-discourses' (Alvesson & Karreman, 2011; Iedema, Flabouris, Grant, & Jorm, 2006). Such Paradigm-type Discourses or 'big D', distinct from the 'small d' type discourses of everyday conversation (Alvesson & Karreman, 2011), are informed by bodies of knowledge and are particular to standardized sociocultural ideas of any given period. As such, Paradigm-type Discourses offer legitimization and authorization of dominant ideas, presenting them as truths (Syrjälä, Takala, & Sintonen, 2009). Discourse in this sense conveys the relationship between power and knowledge: in the intersubjective construction of knowledge, the frameworks that Paradigm-type Discourses provide for organizational actors' sensemaking reflexively privilege the position of some actors over others, producing 'the silencing effect of power discrepancies' (Edmonson, 2003: p. 1444). At the intersubjective level, 'small d' discourses used by those who are less powerful to mediate meanings and make sense of reality, are likely to be judged less plausible within the Paradigm-type Discourse of those in positions of power which may lead them to dismiss differences in other's accounts (Vickers, 2008). This suggests that the discourses patients use to make sense of their treatment, and in related patient–clinician interactions, may differ from those of clinicians (Pilnick & Coleman, 2003). Nonetheless, patients' sensemaking, and subsequent decision making, will be influenced by the clinicians' sensegiving that is located in, and arises from, the stories that clinicians tell patients about events and the socially constructed meanings they ascribe to them (Maitlis & Lawrence, 2007).

Within healthcare, intersubjective meanings are framed within the habituated and generic subjective meanings, embodied in rules and procedures of the organization and the knowledge and practice of the healthcare professions (Hales, 2007). In this context, the discursive power of modern medicine's scientific objectivity has repressed subjective, emotional and moral aspects of the patients' experience (Frank, 1997). Patients' discourses may be polyphonic but it is the medical Paradigm-type Discourse that is the dominant story or 'regime of truth' (Brown, 1990: p. 192) against which the others are judged (Frank, 1997). In their analysis of the paediatric heart surgery scandal at the UK's Bristol Royal Infirmary, Weick and Sutcliffe (2003) argued that the unwillingness of clinicians, such as nurses, to challenge unsafe practice arose from occupational and organizational cultural norms. These norms embedded surgeons at the top of the institutional hierarchy because of their assumed expert knowledge and the clinical autonomy which that warranted. Hence, we assume that there is a recursive dynamic between Paradigm-type Discourses ('big D') and everyday discourses ('small d') (Iedema, 2011) which may reduce an organization's capacity to function safely by legitimizing a dominant group's worldview, limiting people's understanding of the organization's complexity and their wariness for the myriad ways in which things can go wrong (Weick, 1988, 1993).

At an institutional level the UK National Health Service (NHS) has a unique historic combination of professional and managerial bureaucracy (Clarke & Newman, 2006). It has been mythologized as a theological institution, a national religion shaping, and symbolic of, shared values of human dignity, equality and trust (Neuberger, 1999). Since the 1980s, the NHS has been subjected to continuous government inspired change. The medical Paradigm-type Discourse has been challenged by another Paradigm-type Discourse; that of managerial efficiency, where clinicians are criticized as conservative, self-interested and profligate in their use of resources (DH, 2010). In this particular version of events, with economic constraints and an ever increasing demand, hospitals are exhorted to do 'much more for less' (Audit Commission, 2010: p. 3); efficiency prevailing over safety. With such pressure on front-line employees, often from senior managers, the violation of procedures appears to be endorsed as a means of increasing productivity and coping with competing demands. Overtime such violations become routinized, resulting in the 'normalization of deviance' (Almaberti, Vincent, Auroy, & de Saint Maurice, 2006: p. i69). It is within this context that some clinicians may behave carelessly and cause patient harm (Almaberti et al., 2006; Weick & Sutcliffe, 2003).

Patient safety and trust

Efforts to advance patient safety have attended to reducing risks from unsafe acts and hazardous systems, drawing lessons from aviation and the nuclear industry which are considered to have safe systems (Hudson, 2003). Consequently, the focus has been on rule-based approaches to improvement: checklists, utilizing protocols and implementing incident reporting systems (Ocloo, 2010; Waring, 2009). However, such industry based models do not reflect the patients' unique involvement in healthcare, safety research leaving the patients' perspectives relatively unexplored (Jorm, Dunbar, Sudano, & Travaglia, 2009). Rather, in accordance with theory of presumptive trust (Kramer, 1999), the current approach to patient safety and safe systems in healthcare, appears to consider trust as being created and sustained through 'managerial relationships, accountability, and credibility' rather than interactions between healthcare professionals and their patients (Brown, 2008: p. 352). Within this it is not the individual whom is trusted, but the system of expert knowledge that produces and maintains that person in the role (Meyerson, Weick, & Kramer, 1996). Indeed, clinicians' expertise is held in high esteem by patients (Lloyd, 2001), many of whom may believe that their role is one of passive recipient (Doherty & Stavropoulou, 2012). Patients'