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The tension between person centred and task focused care in an acute surgical setting: A critical ethnography

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ABSTRACT

Problem: Person centred care is a key indicator of quality care and a policy direction in many hospitals yet some patients experience care that falls short of this standard.
Background: Health services worldwide are prioritising the delivery of person centred in order to address historical concerns over patient safety and quality care and to improve workplace morale. Workplace culture is known to affect nurses' care giving.
Question: This research aimed to uncover the cultural factors that hindered or facilitated the delivery of person centred care in an acute setting and answer the question: How does workplace culture influence nurses' delivery of person centred care?
Methods: Critical ethnography provided the philosophical and methodological framework. Data were collected through participant observation, individual and focus group interviews, examination of care planning documents. Data were analysed hermeneutically and critically to make tacit cultural knowledge explicit and to suggest ways to reconstruct the culture of this specific nursing unit.
Findings: Nurses organised their work in response to the urgency of the task at hand and nursing routines. People who received that care were rarely included in planning care.
Discussion: Task focused ways of working can predominate in workplace cultures where an emphasis is placed on efficiency. Efficiency is part of the neoliberalist health care agenda and it stands in contrast to ideals of person-centred effectiveness because the latter may actually slow down procedures and require holistic approaches, rather than segmented care. Efficiency in this study appeared to be reinforced by an embedded and naturalised cultural practice amongst the nurses, which was to value fast-paced and completed tasks, because of the recognition it would receive from peers. Yet it also constituted a tension and bind for the nurses because the failure to be person-centred meant their professional values were unmet, and this led to moral distress and workplace dissatisfaction. If nurses were assisted to develop recognition of competing discourses in their work, and rationales to support a values-based practice, it is likely that they could be empowered to resist the status-quo and actually achieve the aspirations outlined in person-centred care rhetoric.
Conclusion: Organisations and individuals striving for person-centred care need to develop awareness of the social and political forces that shape and constrain practice, in order to approach their work more consciously and critically.

Summary of relevance

Issue

Person centred care is intrinsic to effective nursing practice and a key indicator of quality care.

What is Already Known

Nurses value person-centred care but are frustrated in their achievement of it. It remains unknown what specific factors occur in their working life and culture that act as barriers.

What this Paper Adds

Dominant, naturalised discourses that operate within health care, such as neoliberalism, value efficiency over effectiveness and are a potential barrier to the delivery of person centred care. Nurses unwittingly are co-opted into this discourse whenever they themselves reinforce a task-focus over person-centred effective-

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ness. Nurses lack the awareness and the language to articulate the sources of their distress in being unable to implement the values they aspire to.

1. Introduction

The nursing profession has a philosophical tradition where care and compassion are regarded as core. Indeed in Queensland, Australia, the Chief Nursing and Midwifery Officer, Dr Frances Hughes, stated in 2013 'Nurses in Queensland are renowned for their patient-centred care based on their intrinsic values' (Hughes, 2013). Equally, popular discourse depicts nurses as caring, altruistic and even angelic (Hallam, 2000; Summers & Summers, 2015). Yet not all patients experience this level of nursing care. A brief examination of some popular press reveals numerous reports where patients did not receive person centred care and even suffered neglect or abuse (Coward, 2013; Patterson, 2012; Smith, 2002). Commentators have since posed challenging questions to nursing, suggesting that the modern nurse is too soft, too posh, and not fit for the work required (Coward, 2013; Patterson, 2012; Smith, 2002). Some even accuse nurses of rejecting their professional and philosophical mandate to care (Coward, 2013; Patterson, 2012).

Although Hughes' comment is positive and motivating, her use of the word 'intrinsic' has an unfortunate implication that caring is natural or a simple matter for nurses, and, similarly that person centred care is dependent on personal values. Such a statement ignores the extra-personal factors that shape the context of care delivery; including organisational culture, a neoliberalist discourse that favours efficiency and outcomes, and rising patient acuity paired with short-staffed units (Goodman, 2014). Indeed, findings from several high profile health care scandals indicate that the manner in which nurses approach patient care is determined to a large extent by the shared philosophies and ways of doing things in the organisation and the particular setting in which they work (Davies, 2005; Garling, 2008; Francis, 2013; Walker, 2004). Furthermore workplace culture, rather than personal failings, profoundly impact on the quality of patient care (Francis, 2013). Thus, workplace culture can either facilitate or impede person centredness.

Cultural expectations and norms influence human behaviour without people being aware of this. Accordingly, as much as people believe they have the free will to behave as they choose, people's behaviour is usually predictable and conforms to societal or cultural expectations (Hardcastle, Usher, & Holmes, 2005). Similarly, culture not only directs people's behaviour but 'shapes and limits morality', indicating that what people value and place importance on is also culturally appropriated (Berghs, Dierckx de Casterlé, & Gastmans, 2006; p. 117.). As Nesbit (2012) reminds us our worldview derives from social interaction. In this regard social interaction and workplace culture appear to significantly affect nurses' individual and collective actions and beliefs. In turn culture itself is a product of social interactions and reinforced or reproduced in subtle ways (Forester, 1992). Thus, people are influenced by the culture they operate in and also perpetuate that culture, indicating why changing a culture is so difficult. It is therefore likely that a cultural inquiry, specifically critical ethnography, may illuminate and deepen understanding about this vexing problem.

1.1. Previous research

Previous research has noted an inconsistency between nurses' espoused values and practice and has highlighted that workplace culture can inhibit nurses from practicing in ways that are consistent with their value stance (Milton-Wildey & O'Brien, 2010; Dempsey, 2009). In these studies workload concerns and pressures led nurses to perceive that they had insufficient time to care for patients in the way they desired (Abdelhadi & Drach-Zahavy, 2012; Milton-Wildey & O'Brien, 2010; Dempsey, 2009). Furthermore nurses believed they were powerless to effect positive change in their workplace. It is known that feelings of powerlessness reduce the quality of patient care and can cause nurses to practice in ways to which they are opposed (Abdelhadi & Drach-Zahavy, 2011; Milton-Wildey & O'Brien, 2010; Dempsey, 2009). Examples might include taking risks with patient safety or failing to meet people's individual needs. However, what is not known about the dynamics that impact upon, and become barriers to care, are the specific mechanisms and structures inherent in workplace culture that influence nurses' beliefs, values and care giving behaviour. Therefore the research question underpinning this critical ethnography became: what assumptions and institutions of power impede autonomy and promote task focused ways of working?

2. Method

Carspecken's (1996) model of critical ethnography provided the framework for this research. Critical ethnographers emphasise the act of interpreting culture with the purpose of promoting cultural change (Greckhamer & Koro-Ljungberg, 2004). Examining a culture through the lens of power, privilege and authority uncovers unfair and unjust systems and reveals whose voice is heard and whose is silenced (Harrowing & Mill, 2010). The intent is to reveal the social and political forces that shape the culture and nurses' beliefs about themselves and their nursing practice (Batch & Windsor, 2015). In doing so critical research presents a broad understanding of what these nurses know, what they do and what they value.

Critical research acknowledges that power differentials and oppression operate at all levels of human interaction and that potentially oppressive organisational structures might hinder the delivery of person centred care (Hardcastle et al., 2005; Stewart, Holmes, & Usher, 2012). It may be that hierarchies of power in health care generally, and in this workplace specifically might constrain nurses' ability to plan and deliver nursing care according to their personal values and professional mandate and patient expectations.

A number of key concepts outline the ethnographic approach to social research. Firstly, the notion that all social life is meaningful and that social action can only make sense when contextualised; and secondly, that social actors know their own culture intimately and are therefore reliable informants (Goodson & Vassar, 2011). An understanding of these notions reveals why fieldwork is an important data collection tool. By engaging in fieldwork and becoming fully immersed in the culture being studied, the researcher gains access to privileged insider information (Sangasubana, 2011; Madison, 2012). Ordinary, everyday actions are more clearly understood within the cultural context. As a new insider, the researcher gains access to an intimate view of the society being studied that allows cultural phenomena to be understood from an insider's or emic perspective (Anderson, 1989).

In reporting ethnographically, the key is not merely to capture the voice of the informant but rather to illuminate for the reader the experience concerned (Denzin & Lincoln, 2011). However, critical ethnography differs from traditional ethnography in that it does not just speak *for* its participants, it speaks *on behalf of* its participants: the researcher thus becomes an advocate for participants (Thomas, 1993). The primary purpose of the researcher is to be sensitive to manifestations of power and to expose those tacit, unconscious elements that direct cultural thought and behaviour (Schein, 2004). This key differential describes how a critical approach 'aims to link social phenomena with wider socio-historical events to expose prevailing systems of power and dominion, hidden assumptions and ideologies' (Hardcastle et al., 2005, p.151).

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