

Knowledge, Culture & Power: critical perspectives for patient safety

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Patient Safety: past & present

- Since the early 1990s, Patient Safety has risen to the fore of health services research, policy & practice
- Research:
 - Patient Safety Research Portfolio
 - Patient Safety and Service Quality Centres
 - ESRC/MRC & NIHR funding priorities
- Policy & Regulation
 - National Patient Safety Agency
 - Healthcare - Care Quality Commission
 - World Health Organization's 'Alliance for Patient Safety'
- Practice
 - National Reporting and Learning System
 - Training & development - Safe Surgery Saves Lives
 - Innovations in workforce configuration and technology

Patient Safety Research

- Patient Safety Research continues to make enormous contributions to policy and practice
- Theory & Conceptualisation
 - The elaboration & application of HF/systems approaches to healthcare
- Methods & Approaches
 - The development of innovative & mixed methods
- Formative & Summative findings
 - Identifying the sources of risk in clinical domains & evaluating the contribution of service innovations

A 'measure & manage' orthodoxy

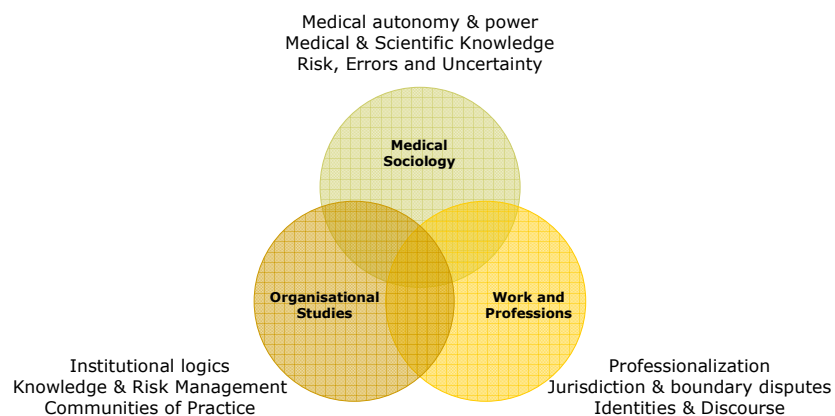
- Human Factors type approaches make enormous contribution to patient safety: a new 'safety orthodoxy'
 - Re-focus attention from 'active' to 'latent factors'
 - Shift culture from blaming to learning
 - Emphasises the importance of safety management
- Exemplifies techno-managerial approach to risk and risk management: a 'measure & manage' orthodoxy
- Reification & reductionism – treats knowledge & culture as abstract variables that can be easily measured and managed
 - Taxonomies of error, risk stratification, root cause analysis, safe/unsafe culture
 - Risk Management, Culture Management, Knowledge Management
- Downplays the complexity of knowledge & culture as it relates to professional practice, teamwork, identities, jurisdiction and organisational complexity

Critical perspectives?

- Critical in two senses:
 1. Critical of the taken-for-granted assumptions & neglect issues with mainstream thinking
 2. Critical to address these issues if we are serious in making safety improvements

- Beyond the 'measure & manage' orthodoxy –
 - rethinking the relationships between knowledge, culture & power
 - Focus on the pursuit for Organisational Learning

Making Connections



Rethinking patient safety research

A new menu for patient safety?

- Sense-making & knowledge construction (Weick)
- Community & practice (Becker, Lave & Wenger)
- Identity & belonging (Becker)
- Rituals & responsibility (Douglas, Power)
- Jurisdiction & legitimacy (Abbott, Freidson)
- Knowledge & Power (Foucault)

Organisational Learning

- Learning is at the heart of the patient safety reforms – “memory”
 - Globally, various risk & knowledge management systems have been developed towards patient safety
- Drawn from the recommendations of ‘safety science’ & the experience of ‘high-risk’ High-Reliability Organisations
- Common features of RM/KM systems:
 - Capture knowledge of risk
 - Codify, analyse and collate knowledge of risk
 - Leverage and utilise knowledge to control potential future risks

National Reporting and Learning System

- Capture knowledge:
 - Incident reporting from frontline staff (e-systems)
- Codification & analysis:
 - Risk stratification to prioritise threats
 - Root Cause Analysis to determine underlying risks
- Engender learning & change
 - Share knowledge upwards & outwards via NPSA, SHAs, service leaders
 - New guidelines, policies or procedures (e.g. safety checks)
- Cultural change as a precursor:
 - Promote systems thinking
 - Promote staff participation via reporting
 - Promote willingness to change

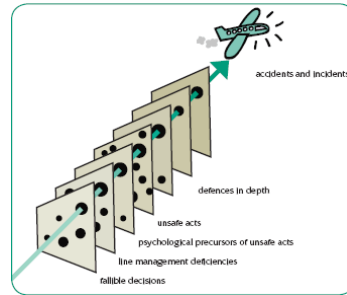
The risk matrix

Severity - Frequency	<u>Low</u>	<u>Medium</u>	<u>High</u>
<u>Low</u>	Low risk	Low risk	Medium risk
<u>Medium</u>	Low risk	Medium risk	High risk
<u>High</u>	Medium risk	High risk	High risk

Understanding the sources of risk

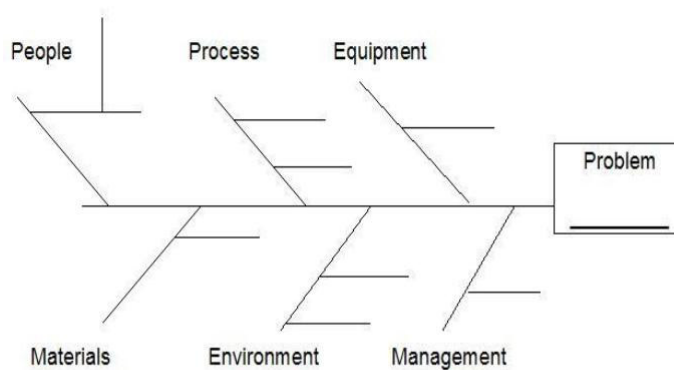
- Active risks
 - Individual behaviour
 - Sharp-end mistakes

- Latent Factors
 - Organisational complexity
 - Management & resources
 - Poor defences
 - Over-reliance on tech.
 - Poor teamwork & communication



(Reason, 1997)

The fishbone approach



Knowledge in question

- Knowledge as an organisational 'resource'
 - It is a 'thing' to be managed & utilised
 - It is explicit and amenable to codification & management

Or

- Knowledge linked to practice and identity
 - Professions represent strong cognitive-cultural (epistemic) cultures
 - Knowledge/knowing is embedded in practice and cannot be independent or detached from agency
- Knowledge can be 'sticky' & difficult to mobilise
 - Knowledge & experience are often tacit - difficult to articulate, codify or share

Culture in question

- Culture something an organisation 'has'
 - Cultures can be measured as variables of shared values and beliefs
 - Cultures can be changed towards organisational goals

Or

- Culture is something an organisation 'is'
 - Cultures are complex systems of shared beliefs, norms and values integrated into organisational life
 - Cultures reflect and re-construct both structure & agency
 - Cultures can be resistant to or difficult change
- Cultural norms can support particular forms of knowing and sharing of information
 - Difficult to establish a single or common culture around issues of risk

Implications for Power

- Knowledge, Culture & Power are inseparable
 - Institutionalised knowledge offers a basis for social power - professions
 - Ways of knowing are shared & reflect collective values and beliefs systems
 - Knowing and knowledge shape the way actors see themselves in relation to other & act upon the world
- Social discourses represent complex expression of power
 - Disciplinary forces that articulate particular ways of acting
 - Discourses can be mobilised by particular groups – as expressions of legitimate expertise or authority
 - Discourses can be embodied and internalised – as expressions of self-surveillance or governmentality
- Issues of power – whether formal institutionalised power or discursive & cultural forms of power – are central to healthcare organisation and delivery
 - Professional claims for autonomy and control
 - Inter-professional working
 - Management change

Critical perspectives on the NRLS

1. Challenge to clinician power?
 - New 'expert' discourse derived from Human Factors
 - New actors acquire responsibility & legitimacy for managing risk based upon expertise
 - New discourses reinforces need for procedures to collect and analyse knowledge scrutinise clinical performance and systems
 - A challenge to clinicians?
2. Challenge to knowledge management?
 - Knowledge not easy to articulate or utilise outside experience and context
 - Knowledge is sticky and can be hoarded by expert groups
 - Cultures difficult to manage & resistant to change
 - NRLS offers only partial answer to learning needs?

Study 1: Introducing Incident Reporting

- Ethnographic study of the introduction of incident reporting & safety management (2000-03)
- One NHS hospital, with follow-up in second hospital (2004)
- Areas of focus:
 - How reporting systems devised & introduced
 - How systems managed and operationalised
 - How incident data utilised by managers
 - How clinicians perceived, received and reacted to systems
- Located within the debates around medical/managerial relations and emerging challenges to medical autonomy and self-regulation

Study 2: Risk management in practice

- Ethnographic study of risk management activities in relation to risk investigation (2007-09)
- Two NHS hospitals
- Areas of focus:
 - How reporting systems have evolved
 - How incidents are escalated and communicated to stakeholders
 - How incidents are investigated and analysed
 - How action plans are developed and implemented
- Located within the debates around organisational learning and the contribution of different approaches to learning – especially between professional and managerial approaches

Study 3: Knowledge sharing

- Mixed-methods study of knowledge sharing across occupational boundaries within new care settings (ISTCs)
- 4 Day Surgery Units (2 NHS; 2 ISTC)
- Areas of focus:
 - What are the patterns of communication & KS around patient safety and risk
 - What influence do occupational cliques & collegial groupings have on KS across boundaries
 - What are the drivers of KS within communities of practice
 - How are new organisational forms transforming patterns of 'situated learning'
- Located within debates, simultaneously, on the importance of knowledge sharing and learning within communities of practice, and the introduction of new organisational forms in healthcare

Drawing the studies together

- The interpretation of, reaction to and control of risk is a situated social activity that is imbued with shared - also conflicting - values, norms & expectations, where sense-making and action is as much about the control of professional boundaries, identity and 'others' as well as patient safety
- Three inter-related dimensions:
 - **Knowledge** – how risks are constructed – epistemic cultures
 - **Culture** – what are the values and norms around risk
 - **Power** – what are the implications for social control for both 'in' and 'out' groups
- Explore this looking at three :
 - How risk knowledge is constructed
 - How risk knowledge is communicated
 - How risk knowledge is managed
 - How risk knowledge is shared in other settings

Constructing risk & ambiguity

- The interpretation of incidents is complex & situated
 - Extreme incidents often stand-out – but open to interpretations & debate
 - Some incidents are taken-for-granted and seen as 'part of the job'

- Sense-making & construction:
 - Embedded in practice
 - Complex & fragmented
 - Interactive & co-constructed
 - Emotive
 - Issues of responsibility & acceptability
 - Linked to issues of competence

Talking about the missing swab

- Reporter [scrub nurse]: I still don't know what happened to it [surgical swab]. It doesn't make sense.
- Sister: Well we've checked the theatre, twice.
- Reporter: The count was correct before we started. Suzie made the count with me. I just don't now what happened. I really don't.
- Sister: Don't worry these things happen. You still need to complete an incident report.
- Reporter: I know. That's why I'm here. But I just don't know what to put. I can't put it just disappeared can I.
- Sister: Just give as much detail as possible. And put down all the steps that we took to find it.
- Reporter: Ok.

Reporting incidents

- Reporting remains uneven – some groups appear more willing to report than others
- Common barriers to reporting:
 - Time & resources
 - Difficulty in accessing/using forms
 - Blame & taboos
 - Risk is inevitable – what's the point
 - Too bureaucratic – form-filling not a part of culture
 - Lack of feedback or change – what's the point
 - Management surveillance of practice
- Lack of sharing reflects a number of cultural issues and fears
 - Hoarding of knowledge at the local level
 - Marginalising management involvement in practice
 - Limiting the capacity for learning

Re-constructing knowledge

- The process of reporting transforms narrative & knowledge
 - Difficult to 'fit' uncertainty and experience into report
 - Hollowed-out of depth and meaning
 - Abstracted into bullet points & statements
- Re-construction of knowledge
 - Becomes dis-embedded from practice
 - Linear and stripped of complexity
 - Issues of emotions and responsibility often removed or held back
- Staff seem to feel disconnected from these narratives
 - learning stops being a part of practice rather something for managers
 - Concerns over how it will be interpreted

The 'reported' missing swab

- Report: #1139
- Severity 2:
- Type: [not entered]
- Clinical Type: Operation/invasive procedure
- Description:
 - (4x4) small swab was missing during the operation. The swab count was correct when I checked first (open) count, while closing Aorta Proximal stitch. When I check before closing the chest one swab was missing.
- Action taken:
 - X ray taken. Reopen and checked in again. I personally and all other members of the team checked everywhere to no avail.

Re-constructing risk & responsibility

- Reports are re-constructed as particular set of variables or factors
 - Location, staff group, time
 - Incident type
 - Codification of incidents as severity and frequency leading to 'risk score'
- Re-authoring of risk by management:
 - Disembedded from practice
 - Metric trends that lack meaning for staff
 - De-authored statistics
 - No emotional content
 - Reflects managerial assumptions
 - Reinforces managerial utilisation of information

Data 'entry' for the missing swab

- **Report: #1139**
- Type: Clinical incident
- Classification: no adverse outcome
- Description: Swab was missing during operation. X-ray taken and staff checked theatre – swab not found.

Managing risks?

- Risk managers pre-occupied with process
 - The pressure is about 'closing cases' & finishing 'paperwork'
- Risk analysis and investigation often de-coupled from practice, learning & change
 - Codification & classification made by 'guess work' or reviews of 'past cases'
 - RCA often superficial and lacking staff participation
- Ritualistic forms of compliance – going through the motions
 - Not about looking for opportunities for learning, but producing reports for the Trust Board or SHA

Analysing risk – myopic & constrained

- Root cause analysis often led by managers with input from relevant clinical leads
 - Inclusion & participation variable - not all groups involved
 - Rarely involves staff except in the form of written statements (extended incident forms)
- Processes can be dominated by different groups at different times:
 - Managers exert influence in terms of structuring the investigation
 - Clinical leads exert influence related to clinical working & systems
- Analysis often constrained by what they can 'find' but also what they can 'change'
 - wider factors, such as finance, staffing or organisational complexity, often ignored or downplayed
 - Pushes analysis & causality 'back-down' to the local level
- Often a sense of trying to find somebody to blame in a non-blaming or impartial way

Responding to management

- Patient safety identified & valued as integral to medical work
- Apprehension of management leadership
 - Lack of expertise of clinical work
 - Inability to interpret information
 - Fears about surveillance & control
- Corruption:
 - Doctors modify procedures so they no longer function as desired, such as refusing to report certain events or use new IT systems
- Co-option:
 - Doctors assume control of the procedures and re-embed them within pre-existing systems, e.g. audit or M&M
- Circumvention:
 - Doctors decline participation in systems because they have superior or more tailored procedures for risk analysis and learning

Reform 'from above'?

- Does the NRLS work?
 - It gather 'information', provides a basis for learning and generates local & national data
 - It fails to really engage staff in the processes of learning, learning often detached from practice and struggles to tackle the big 'upstream' issues

- Only by rethinking the issues of knowledge, culture & power can we explore why

Or 'from within'?

- Knowing and knowledge is embedded in practice & difficult to articulate explicitly

- Learning is experiential & situated in practice involving interaction, trial & error and socialisation with other members

- Knowledge & learning are integral to notions of self, community and profession

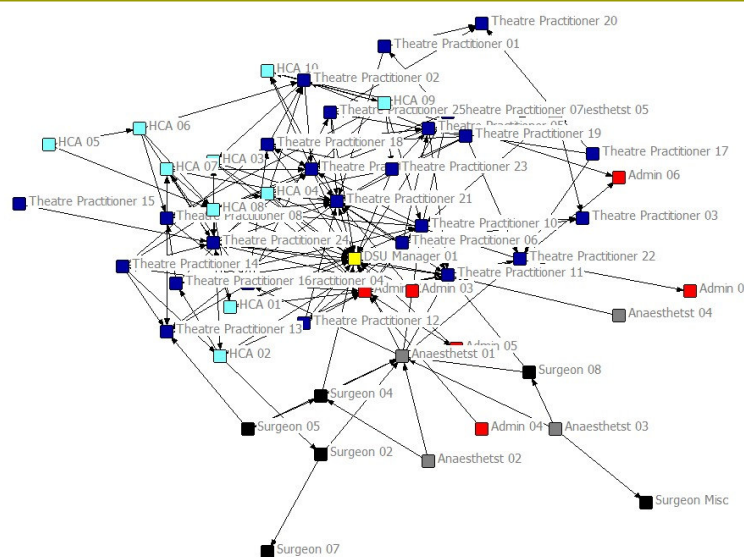
- Learning within Communities
 - Learning might be better stimulated at the local level
 - Devolve responsibility for systems
 - Encourage clinicians to modify procedures
 - Ensure some standardisation of outputs (fact-sheets)

- So how do clinicians share knowledge at the local level?

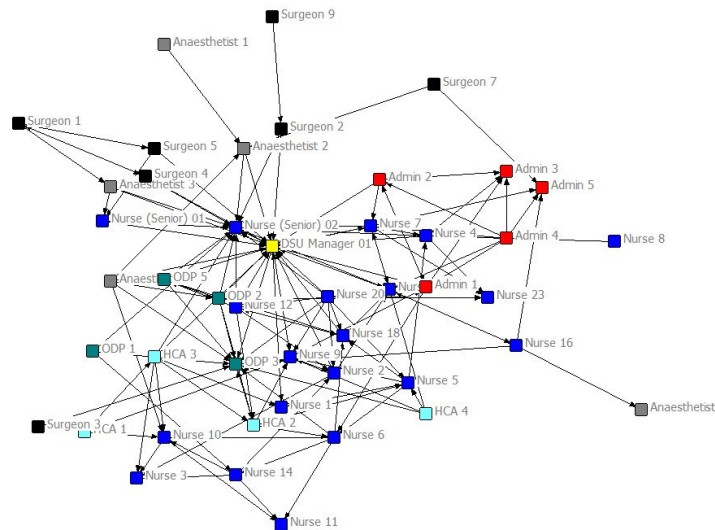
Social Networks of knowledge sharing

- Ask staff to identify the individuals they share knowledge in the normal routines of their work
 - essential knowledge (can't work within it)
 - knowledge related to service quality & safety
- Produces a messy picture of social interaction –
 - the building blocks onto which shared values, beliefs and experiences are 'mapped'
- Identified the patterns of 'strong knowledge sharing'
 - validated items of knowledge sharing, frequency & 'tie strength'

Knowledge sharing...



Knowledge sharing...



The dynamics of knowledge sharing

- Network position of managers
 - Typically central to networks for planning & communication
 - Knowledge brokers to other 'outside' & peripheral groups
 - Inward facing or outward facing?
- Core & peripheral staff
 - Core staff more likely to share information
 - Greater level of daily contacts and relative stability of routine
- Between groups
 - Clinicians more likely to share knowledge with those from similar background
 - 'functional proximity' and time-served can increase sharing across boundaries
- Knowledge sharing often based upon numerous small interactions:
 - 'Watercooler' learning – often at the backstage where staff feel more comfortable and secure

Contributions of backstage talk

Critical reflection	Assists experiential learning and the identification of potential and actual sources of risk
Collective sense-making	Contributes to the formation of a shared and less ambiguous understanding of work events
Functional contribution	Contributes to problem-solving and dealing with change in context
Communication & follow-up	Assisted colleagues in decided upon future action and reporting
Supportive & emotional	Provides a cathartic outlet and emotional support to anxious colleagues
Cultural and professional	Reinforces the expectations, norms and values of professional socialisation, practice and identity

Concluding thoughts

- Knowledge, culture & power are central, if sometimes overlooked, issues for patient safety research
 - Knowledge is constructed through often complex social interactions reflected shared values & beliefs
 - Knowledge is tacit, impartial, imbued with emotion and embedded/embodyed in practice
 - Cultures are complex, fragmented and often in conflict
 - Aspects of culture, vis a vis safety can easily be overlooked or prescribed
 - Power is integral to healthcare organisation & delivery – if we wonder why service reform is difficult we need to consider the institutionalised lines of power that shape the service
- Need to look beyond the orthodox thinking and re-engage with wider theories within the social sciences
 - Systems thinking can only take us so far
 - Not just about identification root cause factors or changing culture
 - Need to understand how 'knowledge' is collected, who is analysing events, what risks are escalated and which are ignored, what are the implications for patients and staff
- These alternate perspectives might raise difficult questions, and more difficult answers, but they are critical if we are really serious about learning

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