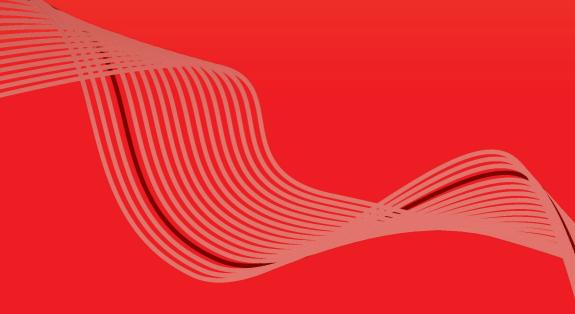# The Sociology of Healthcare Safety and Quality

Edited by
Davina Allen, Jeffrey Braithwaite,
Jane Sandall and Justin Waring

WILEY Blackwell

The Sociology of Healthcare Safety and Quality

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Towards a sociology of healthcare safety and quality
Davina Allen, Jeffrey Braithwaite, Jane Sandall and Justin Waring

Introduction

Improving the quality and safety of healthcare is a global priority (Braithwaite *et al.* 2015, WHO 2002). As healthcare organisations and systems across the developed and developing world face unprecedented financial constraints, growing demands for services (especially from ageing populations with long-term conditions and co-morbidities), and the challenge of keeping pace with technological progress, the case for a deeper understanding of these issues is particularly pressing. Hitherto, research and practice in quality and safety have been dominated by disciplines such as medical and safety science, social psychology, and human factors which have framed how quality and safety is understood, how it should be measured and studied, and the policies, interventions and practices through which it should be addressed. While quality and safety cuts across many traditional sociological concerns, and sociology has continued to progress understanding in this field, its insights and potential contribution have, until recently, been relatively neglected by mainstream policy and research. This might, in part, reflect a tension between the interventionist orientation of proponents of the dominant paradigm and the more critical detached stance of sociologists who, historically at least, have eschewed simplistic explanations or prescriptions for policy and practice. It may also arise from the complexities so often revealed by sociological research, rendering pressing clinical and organisational problems as less amenable to immediate solutions. After all sociologists have the reputation of Cassandra: when we make prophesies they are usually laden with doom and thus fated to be disregarded (Dingwall and Allen 2001). It is also the case that while sociologists have made, and continue to make, important contributions to the understanding of quality and safety, much of this work is fragmented across different sub-specialisms. As the introductory review chapter to this monograph shows (Waring *et al.* this volume), the insights of classic contributions by Strauss *et al.* (1985) on the social organisation of healthcare work, Illich (1976) on medical iatrogenesis, Bosk (1979) on managing medical mistakes, Timmermans and Berg (1997) on standardization, Fox (1999) on medical uncertainty and Rosenthal (1995) on the management of problematic doctors have largely been ignored within the prevailing orthodoxy. Within sociology itself, however, these earlier studies have provided the foundations for a new generation of sociological research oriented to this policy priority (for example, Dixon-Woods 2010, Jensen 2008, Mol 2008, Waring 2005). What has emerged from this growing corpus of work is a recognition that patient safety is not simply a matter of individual or group psychology or systems engineering,

but is shaped by wider socio-cultural and political structures. A sociological perspective also reveals the hidden influence of inequalities of power (between occupations, within occupations and between patients and professionals) on quality and safety, how these problems might be managed and by whom, as well as the everyday – and often invisible – situated practices through which quality and safety are accomplished (Allen 2014, Iedema *et al.* 2006, Mackintosh and Sandall 2010, Macrae 2014, Mesman 2011).

If healthcare safety and quality are to be more thoroughly understood, their textured nature and multi-dimensional properties drawn out, and a more integrated and programmatic approach provided, it is important that such sociological insights are brought to the fore. The aim of the *22nd Sociology of Health & Illness Monograph* is to further this aspiration by showcasing some exemplary studies. It offers a reflection on the contribution sociology can make and is making to the healthcare quality and safety agenda and raises some critical questions about the future of sociological engagement. How can we understand and explain the social, cultural and lived experiences of quality and safety? What theories, models and concepts are useful in progressing the quality and safety agenda? What is the appropriate balance between a sociology 'of' and a sociology 'for' quality and safety? What distinctly sociological research approaches might be applied to the study of quality and safety? What analytical perspectives might offer novel insights?

Parallel paths?

The first chapter in the collection reviews the emergence of this field and traces its evolution. Waring *et al.* argue that research and practice in quality and safety has progressed along two largely parallel paths. While an orthodox paradigm, dominated by those pursuing medical and safety science, has largely set the agenda in this field, the sociological paradigm has offered a more critical and nuanced understanding of these issues drawing on central disciplinary concerns such as: expertise and knowledge, the professions and healthcare division of labour, deviance and social control, risk, socio-technical innovation, governance and regulation, experiences of health and illness, organisational culture, help-seeking behaviour, professional-patient relationships, power and politics, and bureaucracies and institutions. There is now an accumulated body of sociological knowledge to provide the foundations for systematic engagement with dominant understandings of the problem of healthcare quality and safety and approaches to the management of risk and error and the chapters in this collection signal some fruitful directions of travel.

Organising for safety and quality

The first theme in the Monograph considers organising for quality and safety. Within the orthodox paradigm many see the solution to healthcare quality and safety in the restructuring and reorganisation of healthcare work (e.g. Chang *et al.* 2005, Donaldson 2009, Woloshynowych *et al.* 2005). This rationalist view is founded on the belief that organisational systems can be engineered and that revising formal structures and processes is the key to safer, more effective and efficient service delivery. From a sociological perspective, such assumptions are overly reductionist, and can often result in mechanistic interventions which have unintended negative consequences. For example, Braithwaite *et al.* (2006) found that restructuring large hospitals had deleterious effects – such as confusion and inefficiencies – rather than creating more streamlined systems, and Fulop *et al.* (2005) found that restructuring put

people back at least eighteen months in terms of managerial and planning progress. Oxman (2005) and Braithwaite *et al.* (2005) went even further, and questioned the preoccupation with restructuring health systems activities, parodying the efficacy, the relevance and even the sanity of continually applying the structural 'solution' with no obvious benefits. Infante (2006), coming from a different angle, eschewed managerialist-oriented optimism about the possibility of organising for quality and safety, arguing against the very idea that systems are able simply to respond to some form of 'rolled out' improvement activities. For Infante, a 'system' is an abstraction, even a kind of mirage, and progress is infeasible without adequate theorisation at the centre of which lie relationships, power, culture and complexity. As a rich body of sociological research has shown, healthcare work is complex and its organisation challenging. There will always be a human spirit which wants to see complex problems addressed through the application of clear answers and solutions. Unfortunately, it is rare for the world to yield to this kind of simplification. Focusing on 'the structure' or 'governance' or 'organisation' in order to address quality and safety while important, represents a partial view. Politics, culture and relationships – all important constructs in making care safe and improving quality – are overlooked when excessive attention is placed on structural factors.

The governance and coordination of patient safety is thus a significant organisational challenge which remains theoretically and methodologically under-developed. The chapters in this section attempt to address this problem. Freeman *et al.* draw on observational data from four hospital Foundation Trusts to offer insights into the operation of hospital boards in the English NHS. Boards are responsible for ensuring the quality of care and safety of patients under their jurisdiction. Following Hajer and Versteeg (2005), Freeman *et al.* combine elements from the conceptual frameworks of dramaturgy (Goffman 1974) and performativity (Austin 1962) to explore the enacted dimensions of patient safety governance. The chapter is underpinned by the idea that 'reality is mediated through the application of frames', and examines the socio-cultural nature of patient safety as administered by Executive Boards, focusing in particular on the processing and interpretation of performance data. Despite the distance between them, Freeman *et al.* found an unexpected influence from the Executive Board at the 'blunt end' of the hospital on the clinical frontline. Executive Boards can set the scene and through their activities establish a tone for patient safety and quality across the organisation. The Boards in Freeman *et al.*'s study focused attention differently and through this, established different standards and priorities.

Shifting focus, Mackintosh and Sandall drill down into the world of seriously ill patients and through observations and staff interviews examine the frontline organisation of how patients are identified, rescued and resuscitated in medical and maternity settings. Applying Strauss *et al.*'s (1985) classic patient trajectory concept they examine patients' journeys to show how 'rescue work' differed across the two contexts. In maternity services, patients were typically healthy and adverse events few, staff were alert to crises and they mobilised their capacity to be responsive when necessary. In contrast, in the medical wards where patients were older, more infirm and longer-term, it was accepted that rescue was necessary but that sometimes patients would die. The structures and organisational arrangements in these study sites were poorly designed to meet the needs of this patient population and as a consequence, deterioration was much harder to forecast and more difficult to manage. All in all, the complexity of rescue and resuscitation in the medical wards with patients with multiple conditions and co-morbidities was more demanding and difficult than it was in the corresponding maternity settings. In these chosen hospitals, younger maternal patients were effectively being prioritised over complex, older patients.

A central sociological concern is the interaction between the individual and the system of which they are part. This has been a deep preoccupation of sociologists and manifests in diverse ways in the work of many thinkers. Examples are Giddens's (1984) structuration theory, through the ethnomethodology of Garfinkel (1974), to Scott's (1995) work on institutional theory. Aveling *et al.*'s chapter goes to the heart of such debates about the relationship between structure and agency, and focuses on how hospitals address managing individual versus collective accountability for patient safety. They draw on a rich ethnographic database in five hospitals: three in a high income country (UK), and two from low income countries (both in Africa). They reach into the work of two key theorists to render a framework for their study. Following Thompson (1980), they conceptualise healthcare work as a 'problem of many hands' and combine this with Pellegrino's (2004) four principles for organising (there ought to be an organised system; accountability for each health professional; individual competence and character; and systems reinforcement of these) to frame their analysis. In clear echoes of Giddens's (1984) structuration theory, they show empirically that individuals influence the systems of care, while simultaneously being shaped by that system. The existing model of accountability within the orthodox paradigm, which implies that somehow the individual is accountable independently of the system in which he or she acts, is called into question. Systems and individuals are co-constitutive, interdependent, and their relationships are recursive. In other words, people are subject to social forces, and the impact of social forces is mediated by social action.

All of this is not to say that individuals are not responsible agents, and of course they need to be held to account for their actions. But for Aveling *et al.*, systems need to support both individual and communal professionalism and accountability. Simplistic patient safety models which blame individuals or make them individually responsible for group activities should thus be rejected. Aveling *et al.*'s analysis lays the foundation for more sophisticated models of accountability than allowed by the narrowly instrumental frameworks which dominate the orthodox paradigm.

Technologies and practices of quality and safety

The second theme in the collection centres on technologies and practices of quality and safety. Healthcare is a technologically intensive and dynamic environment, with new interventions emerging regularly. These range from the most sophisticated (and expensive) scanner or item of surgical equipment, through new medications and treatments, to everyday 'mundane' technologies such as the patient record and care-plan. All have a bearing on the social organisation of the work and hence healthcare quality and safety. In addition, a range of infrastructural technologies are used in healthcare to organise and support work activity, and many quality improvement initiatives and safety interventions hinge on the introduction of artefacts or tools to bring about behavioural change in the workplace. Examples include surgical checklists, patient status at a glance whiteboards (one of the foundation modules of the UK National Health Service Institute for Innovation and Improvement Productive Ward series) and early warning scores (see McIntosh and Sandall this volume). Yet while the orthodox approach to patient safety has developed and promoted numerous technological solutions to quality and safety problems, it has been rather less adept at theorising the operation of the technology itself and how it is anticipated to have its effects in different contexts. It is also the case that the implementation (or not) of such technologies often rests on a poor understanding of the fundamental nature of the work processes they propose to modify (Allen, in press). The effect of this double neglect is that all too often interventions

are routinely imported into healthcare from other fields – such as aviation or manufacturing – with little consideration of sector differences, and progress straight to implementation with scant attention to problem diagnosis as a precursor to intervention selection and/or development. This, as Dixon-Woods (2013) has observed, is equivalent to by-passing the laboratory and pre-clinical and pharmacokinetic stages of drug development.

There is considerable scope for sociologists to contribute to this technology-practice agenda. Under the influence of scholarship in Science and Technology Studies, the sociology of healthcare work (Hughes 1984, Strauss *et al.* 1985) has developed to generate a rich vein of empirical research on healthcare practices and, in particular, the effects of new technologies and their interaction with the social organisation of practice in the workplace. Insights from the sociology of healthcare work prompt critical questions about the intersection of new technologies with extant socio-technical arrangements. Marc Berg has been a leading contributor to this field offering insights into the impact of medical records (Berg 1996), protocols (Berg 1997c) and related health information technologies (Berg 1999) on healthcare work. A fundamental tenet of this scholarship is that formal tools can transform workplaces in important ways (Berg 1997a), but that their generative power can neither be attributed to the tool nor its users; rather it arises instead from their inter-relationship in action. Technologies embody diverse assumptions or scripts and are structured in different ways that are consequential for their impact on the organisation of work. Berg (1999) argues that there is a need to understand this relationship, not least because tools do not slip into some predefined space in the workplace; getting a tool to function as intended requires sensitivity to the work setting (see for example, Berg 1997b, Brown and Webster 2004, Webster 2002). All too often resistance to new technologies in healthcare is interpreted by quality and safety advocates as symptomatic of wider tensions between healthcare professionals or managers or seen as an implementation problem in need of culture management or better leadership. It may also be the case, however, that technologies are genuinely a poor fit with professional practice (Allen 2014, in press; Macintosh *et al.* 2014).

Szymczak's chapter speaks to these concerns. It focuses on the limitations of interventions drawn from aviation designed to encourage clinicians to come forward in the face of known threats to patient safety. These include reporting errors and near misses, blowing the whistle on the poor conduct of colleagues (Jones and Kelly 2014) and encouraging clinicians to raise concerns before harm reaches the patient (Lindsay *et al.* 2012). Szymczak examines an intervention designed to encourage clinicians to 'speak up' and argues that, despite the efforts of patient safety advocates, speaking up remains difficult. Orthodox approaches to this problem focus on individual-cognitive or organisational factors. Demonstrating the value of taking a distinctly sociological approach to a safety problem, Szymczak deploys Collins's (2004) theory of interaction ritual chains to explore clinicians' accounts of speaking up in the context of potential breaches to hospital acquired infections in a US hospital. Three mediating factors are identified that influence the decision to speak up. First, Collins (2004) suggests that successful interaction rituals require participants to have a shared focus of attention. Szymczak observes, however, that despite healthcare providers being co-present in their work, they are not all necessarily focused on the same thing and raising concerns in such a context could have a potentially inflammatory and disruptive effect on the ongoing flow of action. Second, speaking up is interactionally path dependent, that is, decisions to speak up or not are mediated by past experiences as well as those that are anticipated in the future. The data presented here reveal participants to be acutely sensitive to their relationships with other healthcare professionals. Third, speaking up is influenced by the presence of an audience. Collins argues that interaction rituals are facilitated when there is a barrier to outsiders. Much healthcare work takes place in the presence of an

audience – such as family members – and clinicians indicated that this was a further factor shaping their decision to speak up. What emerges from the chapter, then, is recognition that in a given moment, the decision to speak up or remain silent, is highly context dependent and embedded in the interaction rituals that shape everyday work. Szymczak argues that teaching scripted communication, as is the custom in aviation, can only have a limited impact on practice; it is not the words that clinicians struggle to find, it is the *place* and *way* to integrate them into the ongoing flow of action that is the issue.

A further insight offered by sociological studies of healthcare work is that many quality and safety interventions do not take into account the invisible daily practices through which healthcare quality is achieved (Allen 2014, Mesman 2011). Grant *et al.*'s chapter contributes further to these sociological insights. Applying Strauss *et al.*'s (1985) scholarship on 'articulation work' and drawing on extensive ethnographic research in NHS Scotland and NHS England they examine the invisible work of general practice team members in the achievement of repeat prescribing. Repeat prescriptions are medications for long-term use, typically for chronic conditions, and are issued without a consultation between the patient and prescriber. This is a high volume process in which risk and vulnerability are distributed across time and space, in a context in which medications management is a significant cause of adverse events. While clinicians are often the primary object of quality and safety interventions, Grant *et al.* illuminate the contribution of non-clinical staff – in this case GP receptionists – and make an important addition to the growing literature on this hitherto relatively neglected group (Arber and Sawyer 1985, Copeman and van Zwanenberg 1988, Swinglehurst *et al.* 2011). Viewed through the lens of articulation work, the study reveals the central role of the informal, invisible practices of receptionists, with informal cross-hierarchical communication often more effective than formal organisational structures. The chapter adds further weight to an emerging body of sociologically informed research which underscores the imperfect and contingent character of healthcare work and its attendant risks. Rules, guidelines and protocols have self-evident limitations in ensuring healthcare quality and safety in such circumstances, with quality and safety being dependent to a considerable extent on the informal resources of resilience and practical wisdom employed by local teams (Hollnagel *et al.* 2013, Wears *et al.* 2015).

Experiences, and contribution to quality and safety

The final theme focuses on experiences of quality and safety. It is concerned with the meaning of quality and safety for patients, professionals, managers and policymakers, and the implications this has for the relationships between different actors as they negotiate quality and safety in the clinical encounter or secure quality improvement across stakeholder boundaries. Prior work on patient safety has focused mainly on systems and professionals, but there is an emerging interest in patients' contributions to their own safety. Since 2004, Patients for Patient Safety (PFPS) has emphasised the role patients and consumers can play in efforts to improve the quality and safety of healthcare around the world. PFPS works with a global network of patients, consumers, caregivers, and consumer organisations to support patient involvement in patient safety programmes, both within countries and in the global programmes of the WHO Patient Safety. The ultimate purpose is to improve safety in all healthcare settings throughout the world by involving service users and patients as partners, and through the development of patient-focused empowerment tools to support help seeking. Patients and their families see things that busy healthcare workers often do not.

The voice of patients and families who have suffered preventable medical injury is a powerful motivational force for healthcare providers across the globe. However, patients have much more to offer than as the victims of tragic medical errors. Important as that perspective is, a victim orientation does not position service users as partners working with healthcare providers to prevent harm. Indeed, the perception that patients and their families are helpless or antagonistic victims has served to distance service users from playing meaningful roles in the development and implementation of patient safety work in the past and has generated fear among some clinicians who would have otherwise engaged with the process (Annandale 1996). At the service delivery level, patients who wish to contribute knowledge gained or lessons learned have often found few effective pathways for doing so (Snow *et al.* 2013). Particularly after healthcare accidents occur, a 'wall of silence' may descend and productive interaction may cease. When patients and families register concerns, their actions often are perceived as adversarial threats or unscientific anecdotes that lack evidence, rather than potential knowledge contributions. Although there are notable exceptions, at the policymaking level user participation tends to be marginalised too, often by well meaning leaders who assume patients and families are unable to appreciate the complexity of healthcare (Iedema *et al.* 2008, 2011). Such an approach fails to take into account that many users offer the richest resource of information related to medical errors as many have witnessed every detail of system failures from the beginning to end.

There is some evidence that patients report suspected adverse events earlier than professionals, suggesting that increased patient involvement has the potential to reduce delay in the identification and treatment of problems (Egberts *et al.* 1996, Coulter and Ellins 2006). However, strategies to improve patient safety have so far mainly focused on changing the organisation of delivery and provider behaviour and paid limited attention to the ways in which patients already contribute to their own safety (Vincent and Coulter 2002). A handful of initiatives, mainly from the USA, have been designed to empower patients and relatives to escalate care themselves. These include 'SBAR for patients' which develops the application of structured communication tools developed for use between health professionals (Denham 2008), 'family-activated paediatric Rapid Response Systems' (Ray *et al.* 2009, Entwistle *et al.* 2005) and the 'Speak up for patient safety' campaign in the USA.

While the scope for involvement is considerable, there is limited understanding of the potential for patients and relatives to contribute to their own safety, the contextual circumstances that moderate acceptability and the effectiveness of various interventions which might promote this, and potential unintended consequences (Davis *et al.* 2007). For example, patients in some settings were reluctant to challenge professionals, and were further discouraged from doing so if their concerns were not heard or attended to (Rainey *et al.* 2013), and even when service users did speak up, they found that staff did not take their concerns seriously (Rance *et al.* 2013). Furthermore, assertions about the benefit of patient involvement have been based on experiences of chronic disease management, rather than acute episodes of care which may involve life threatening events, and thus assume a level of agency that does not exist in all cases (Peat *et al.* 2010). There has been little research on understanding the organisational context and influences of staff responses to patient concerns (Dixon-Woods *et al.* 2014).

Two chapters in this Monograph explore these issues in the under researched settings of primary care and mental health. Sanders *et al.* draw on Weick's (1995) concept of sensemaking, and explore the ways in which patients make sense of their experiences of primary medical care and how that conditions their conceptualisation of safety. In qualitative interviews with primary care patients in England, patients reported being proactive in taking

action to protect themselves from potential harm within the context of the routinised and predictable nature of the primary medical care consultation. The authors argue that this contrasts with previous research that highlights the relative passivity of patients in acute hospital settings. Patients had to balance different dimensions of safety and weigh them against other concerns and social imperatives. Safety, for patients, was not necessarily always their top priority, and their preferences may not always have been considered 'safe' from the perspective of health professionals. Their accounts draw attention to a largely invisible and inaccessible (but taken for granted) safety infrastructure, the importance of trust and psycho-social as well as physical dimensions of safety and the interactions between them, informal strategies for negotiating safety, and the moral dimension of safety. The ability to take a proactive role was dependent on patients' expertise and knowledge accumulated over time, the social distance between doctor and patient, and patients' self-confidence. In consequence, some patients were more able to adopt a questioning, assertive and proactive role than others.

In the mental health context, Brown *et al.* report on findings from in-depth interviews with service-users, professionals, managers and other stakeholders across three mental healthcare (psychosis) teams in England, in what is described as a low trust service context. They note that trust has been seen as fundamental for quality healthcare provision and outcomes, enabling action, cooperation and knowledge sharing where these are otherwise problematic. They draw on theoretical understandings of the interlinking of different trust relationships across healthcare settings. They argue that analyses of micro-level mechanisms through which cultures of trust or distrust propagate are vital to sociological studies of quality and safety due to the ways in which trusting relations underpin patient's sharing of information, and the flow of knowledge within healthcare organisations. Describing chains of (dis)trust as a key element of organisational culture, they explain how (dis)trust within one intra-organisational relationship impacts upon other relationships. They explore how knowledge-sharing and care giving are interwoven within these chains of trust or distrust, enhancing and/or inhibiting the instrumental and communicative aspects of quality healthcare.

Both chapters highlight the importance of sensemaking as an analytic lens and of the value of looking at the creation or not of trust in two areas of healthcare where there is a paucity of research.

The sociology of quality and safety: future directions

The empirical chapters in this collection address technologies, practices, experiences and the organisation of quality and safety across a wide range of healthcare contexts. Spanning three continents, from hospital to community, maternity to mental health, they shine a light into the boardrooms, back offices and front-lines of healthcare, offering sociological insights from the perspectives of managers, clinicians and patients. In their review of the field, Waring *et al.* argue that hitherto the sociology of quality and safety has evolved in parallel with the orthodox paradigm with relatively little cross-fertilisation beyond critique. As the sociological corpus matures and critical questions about the prevailing orthodoxy gain wider currency (Swinglehurst 2015), the conditions exist for more constructive engagement. In their chapter, Waring *et al.* identify three dilemmas within the current orthodoxy – concretisation, culture and politics – which they argue would benefit from a sociological perspective. In the second part of this chapter we consider how the chapters in this collection contribute to these concerns and outline potential lines of inquiry.