‘They think that the poor old patient doesn’t know anything’: Sensemaking in the context of dominant and subordinate relationships

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Abstract
This article analyses the effect of dominant and subordinate relationships for patients’ sensemaking of their safety in hospital. Research on sensemaking has tended to focus on employee to employee relationships and post event analysis of dramatic incidents. Whilst recognising the role of hierarchy, accounts of sensemaking have tended nonetheless to emphasize agency and shared sensemaking or consensual adequacy, largely neglecting how people may be socialized into behaviour that complies with the norms dictated by more powerful actors. The contribution this article makes is therefore two fold. Firstly, it explores how people make sense of events involving service user to employee relationships, where there may be greater opportunity for discrepant sensemaking. Secondly, by focusing on the narratives of a subordinate group it enables an exploration of the processes by which power is enabled, maintained and resisted.

Keywords
Sensemaking, health care organizations, patients, safety, agency

Introduction
Sensemaking theory conceptualizes negotiated meanings as the product of interactions between equals, ignoring the way that meanings may be imposed by a dominant group upon a subordinate one (Brown & Jones, 2000; Brown et al., 2008; Weick, 1995). Research recognizes the differences in sensemaking between individuals in organizations. However, the focus has tended to be on how these differing interpretations translate into joint action despite our knowledge that power differentials, created for example by unequal access to expert knowledge, are likely to lead to discrepant meanings (Archer, 1989). There is a tendency for discussions of sensemaking to accentuate agency and neglect of evidence showing the socialization of individuals’ into compliance with accepted norms dictated by dominant actors and institutions, like government and the professions (Weick et al., 2005). Thus, the ‘sense’ that people make may not be their own but that imposed by more powerful actors. There is therefore a need to understand how people make sense of events in the context of dominant and subordinate relationships and involving non-employee to employee relationships, such as that of service user to employee, where there may be greater opportunity for discrepant sensemaking (Matilis & Sonenshein, 2010).

Health care offers a favourable context in which to examine this issue because patients’ collective identities are constructed as subordinate or inferior to clinicians’ identity as authoritative and knowledgeable. Further, the quality of processes and outcomes are complex and subject to competition and dispute by multiple stakeholders including patients who, despite their subordinate role, may feel responsible when things go wrong (Donabedian, 2003; Esmail, 2005; Mira et al., 2008; Reason, 2008; Watt, et al., 2009). In uncertain circumstances, such as those engendered by the need for and process of surgery, shared meaning is often obscure and sensemaking becomes a central and critical activity as people seek to ‘normalize the situation’ by ‘negotiated agreements’ (Weick, 1993: p636) thereby reducing confusion and uncertainty that disables action (Weick, 1993, 1995).

In addition to organizational change, the sensemaking literature has also focused on post event analysis of catastrophic incidents such as the shooting down in 1994 of two US Army helicopters by two US Air force F-15 fighters killing twenty-six peacekeepers over Northern Iraq. Research has demonstrated how the accumulation of small failures of understanding in interaction between individuals can result in catastrophic loss of lives (Weick, 1988, 1990, 1993, 2010; Snook, 2002). Extreme cases analyses have shown how hierarchical employee to employee relationships have played a part in the unfolding of disastrous events. Sometimes
this was because subordinates did not challenge the actions of their superordinate, their questioning of events went unheeded, or because the subordinate believed that if he or she were taking the wrong action the superordinate would recognize this and correct the decision (Snook, 2002; Weick, 1988, 1990, 1993). The imposition of dominant meanings, rather than negotiated agreements, can lead to highly consequential failures of understanding and inappropriate action. Moreover, how people enact sensemaking both during and after critical periods often serves to strengthen those same institutions that shaped the crisis in the first place (Maitlis & Sonenshein, 2010). Thankfuly such events are rare and are therefore unrepresentative of sensemaking (Weick, 2010). The conditions for tragedy lie in the social construction and accumulation of multiple small errors (Reason, 1998; Weick, 1990). ‘Small moments can have large consequences’ (Weick, et al., 2005) and cause psychological or physical harm to individuals and reputational damage to organizations. It follows from this that isolated failures have much to say about power, organizational practices and vulnerable populations, as the issue is not about safety it is instead about power (Perrow, 1999).

In this paper we focus on how micro level organizational processes are socially constructed to produce safety outcomes by investigating the narrative sensemaking of patients. Three interrelated questions guide this research. Firstly, how do individuals in subordinate positions (patients) create a situation that is sensible and can be responded to or ‘enacted’ by familiar behaviour? Secondly, is discrepant sensemaking resolved through the exercise of power relations where the meaning of the dominant actor (medical professionals) prevails? Thirdly, how does this impact on the organizational (hospital) context?

**Patient Safety in Hospitals**

Within the mythology of medicine ‘primum non nocere’, first, ‘do no harm’, although of uncertain origin has been a fundamental principle of practice. Nonetheless, there has been growing international concern about patient safety over the past decade (Berwick, 2002; Health Care Commission, 2009, 2007, 2006; Kohn et al., 1999). It is estimated that one in ten patients in the UK will suffer from preventable harm termed an ‘adverse event’ (Donaldson, 2004). Globally, the inpatient rate of adverse events has been documented to vary between 7.5 percent and 16.6 percent with half of the documented events considered to be preventable (Conklin et al., 2008). In the US medical error was thought to be the eighth leading cause of death (Kohn et al., 1999). In addition to causing human suffering, adverse events also have financial consequences, in the UK additional hospital stays cost at least £2000 million a year and paid litigation claims were estimated to be £400 million annually (DH, 2000).

Economic constraints and increasing demand for health care exert pressure on organizations to be more efficient, to do ‘much more for less’ (Audit Commission, 2010; Carroll & Quijada, 2004). As a consequence, considerations for safety in health care organizations have been dominated by concern for costs (Dermot Williams & Smart, 2009; Hood, 1991). Patient safety has been further compromised by the occupational authority, autonomy and individualism of the medical profession which can on occasions lead to wilful violation of safety standards (Carroll & Quijada, 2004; Collins et al., 2009; Dean, 2002; Leape & Berwick, 2005; Watcher, 2004, 2010) and a blame culture, where employees on the front line and therefore directly involved in the adverse event, are considered culpable even when wilful neglect is not the cause (Finn, 2008; Wagenaar, et al., 1990; Watcher, 2004). Such factors result in unsafe practices becoming ‘normalized’ as a way of coping with competing demands (Dixon-Woods et al., 2009; Weick & Sutcliffe, 2003).

Patients are the foci of small failures and are therefore in a good position to make observations, voice concerns about processes and stop their occurrence during the ‘critical period’, that is when an event that is likely to lead to trauma, physical injury or even death has begun to happen (Hudson, 2003; Koutantji, et al., 2005; Vincent & Coulter, 2002). On the other hand, patients have traditionally been deferential to the authority of medical professionals, in particular doctors. Medical paternalism has become enshrined in practice, it
being assumed that doctors are in the best position to make treatment decisions due to their expertise and experience. Further, status differences between clinicians and patients in terms of education, income and gender also contribute to power differentials in the medical encounter (Charles et al., 1999). More recently attempts have been made at policy level to promote patients’ active involvement in the process of ensuring safe, appropriate, effective and responsive health care (Coulter & Ellins, 2006; Donaldson, 2008). It has even been argued that patients are now being expected to drive change on behalf of the state (Greener, 2004; Peckham et al., 2008). In the following section we explore the nature of sensemaking in the context of dominant and subordinate relationships.

Theorising patients' sensemaking as a dominant and subordinate relationship

‘Enactment Theory’ (Figure 1), posits that sensemaking involves a reciprocal relationship between actors and their surroundings (Weick et al., 2005). Generally people take every day interactions for granted, thereby socially constructing their reality (Berger & Luckman, 1967). When unusual or puzzling situations occur people are obliged to render them sensible and sensible (Weick, 1995) and do so retrospectively and provisionally, particularly in linguistic interactions. Weick (1995) describes this as how can I know what I think until I hear what I say? Sensemaking involves using cues to notice and bracket events and thinking about what is going on by communication, actions and other forms of social behaviour. The aim is to make sense of the unfamiliar by placing it into known categories or narratives, that is pigeon-holing or labelling to generate provisionally, plausible negotiated narratives. Through this process disorder begins to be ordered, but there remain a number of possible meanings. At this stage individuals’ narratives remain provisional and joint action is impossible until there is some negotiated understanding between the actors involved. A narrative gains greater credence if it is consistent with the past experiences and significant identities which informed the process of selection and interpretation of cues and the construction of a plausible story. It is assumed that a story becomes plausible and is selected because it resonates with shared meaning held by organizational members, or if not entirely shared, there is consensual adequacy to produce organized actions (Brown et al., 2008; Louis, 1980, 1983; Pfeffer, 1981; Weick, 1995; Weick et al., 2005). Selected stories are retained, used and, if necessary modified by organizational actors adapting to changes in the environment; revised meanings become lessons learned (Weick et al., 2005); although ‘Only with ambivalent use of previous knowledge are systems able to benefit from lessons learned’ (Weick et al., 2005: 9).

Figure 1: The Relationship Among Enactment, Organizing, and Sensemaking

By investigating the narrative sensemaking of patients we aim to examine how individuals in subordinate positions make sense of their environment, how discrepant sensemaking is resolved and the effect of this on the organizational context. Figure 2 illustrates how we aim
to build on Enactment Theory, to explain how discrepant sensemaking can lead to organizational failures and the role of power in that process. As a context health care allows the testing of the effect of discrepant sensemaking on enactment theory: by consenting to surgery patients have made a public commitment to a particular course of action, underpinning this commitment is likely to be an expectation of safety and trust in clinicians to do them no harm.

Figure 2: The Relationship Among Enactment, Organizing, and Sensemaking in the context of dominant and subordinate relationships

In situations where relationships are typified by dominance and subordination, such as that of clinician to patient, discrepant sensemaking is more likely than shared sensemaking. Intersubjective meanings are framed within the habituated and generic subjective meanings, embodied in rules and procedures of the organization and the practice of the healthcare professions (Hales, 2007). Clinicians who are under time pressure either ignore or misinterpret events. A story becomes plausible and is selected because it resonates with the past experience of the dominant group and keeps their world manageable. Patients conform to clinicians’ interpretations, meanings are imposed rather than negotiated and it is the subordinate not the dominant group who is required to adapt to the environment. To explore how this is translated into organized action we examine what aspects of safety situations patients attend to, the conceptual frameworks that they use to enact their environment, how they resolve discrepant sensemaking and how this impacts on the organizational context.

**Research Setting and Methodology**

The study took place in a 432-bed hospital which, throughout the research period, was rated as ‘intermediate’ meaning it was the same as 60% of other English acute trusts (CQC, 2010). The rate of patient safety events occurring in the trust, which were submitted to the National Patient Safety Agency, was in line with expected (The Hospital Guide, 2010). Data were collected between July 2010 and February 2011 at a time when hospital horror stories had become prominent in the press following investigations into the poor quality of care at a number of English hospitals (Health Care Commission, 2006, 2007, 2009). The study involved 38 people undergoing elective surgical procedures for a range of chronic, acute and life threatening diseases. Patients preparing for elective surgery were recruited initially by
nursing staff when they attended their preoperative assessment visit. These patients were likely to be both prepared and informed about their treatment and therefore more able to make sense of events than people admitted for emergency care. A maximum variation purposive sample (Saunders, 2011) was selected to ensure the inclusion of patients undergoing a wide variety of surgical procedures a broad range of age groups and a length of stay greater than five days. Patients who are in hospital for longer periods are likely to become more familiar with and confident in their surroundings (Waterman, et al., 2004). Willing patients were subsequently contacted by the lead researcher; the sample consisting of thirteen men and twenty-five women aged from 24 to 89 years with a mean of 62 years was undergoing a variety of surgical procedures including hip and knee joint replacement, upper and lower gastro-intestinal surgery, gynaecological procedures, breast, urology and trauma surgery. For twenty patients the surgery followed from a history of chronic disease such as arthritis or for life threatening cancer, for eighteen patients the procedure was necessary to relieve symptoms arising from an acute short term problem.

Following ethical approval, data were collected using pre and post operation narrative interviews with patients supplemented by observation of clinic and ward processes, informal conversations with nurses, doctors and hospital managers and documents such as patient information leaflets. The research design was longitudinal, contextual and processual and involved being engrossed in the ‘flowing soup’ (Weick, 1995: 128) of organizational events in an inductive effort to construct ‘thick description’ (Geertz, 1973) about how patients make-sense of events with respect to the safety of their care. Interviews were undertaken at pre-admission, in hospital and post-discharge to explore patients’ experiences of the system and facilitate understanding of the processes by which power is enabled, maintained and resisted (Brown, 1998; Greenhalgh, 2005). Such illness narratives offer a means by which both academics and practitioners can gain a deeper, subjective understanding of the patients’ predicament, while simultaneously helping patients to make their own sense of events (Bruner, 1991; Czarniawska, 1997; Greenhalgh, 1999; Polkinghorne, 1988; Weick, 1995). Through making connections between old stories and new events, it was hoped their narratives could both represent and shape action (Bruner 1987), revealing the shared values and meanings that help to reinforce third-order controls (Lukes, 1972; Weick, 1995).

Initial pre surgery interviews were conducted in a private office in the hospital and audio recorded. The researcher explained to participants that she was not employed by the hospital but a university teacher for nurses, doctors and others who were in management positions. Participants received an information sheet along with oral assurances of anonymity and were asked to complete a consent form. Only two people declined to participate. During interviews a relaxed tone was set, loosely structured questions being used to allow lines of inquiry to be followed as they developed. Patients were asked to talk about their previous experience of health care and the expectations they held about their forthcoming surgery. These face-to-face interviews ranged from ten minutes to one hour. Six patients with lengths of stay greater than five days undertook a second post operation audio recorded interview in hospital and a further interview post discharge. The remaining patients (N= 22) undertook an audio recorded telephone interview, of between ten to fifty minutes duration, within three weeks of discharge. In the post discharge interview patients were asked to describe their experience of being in hospital, events in the immediate post discharge period and any concerns they had about their safety. These interviews included questions such as: What did you say or do? Why did you act in that way? What happened then? How do you feel now? Contemporaneous notes made during telephone interviews were transcribed immediately afterwards by the researcher. A total of seventy-two interviews were carried out. There was an attrition rate of ten patients (see Table 1) for reasons including, surgery cancelled (2), patient moved out of the area (1), had enough of hospitals and do not want to think about it again (1) and being unable to make contact within three weeks post discharge (N=6).
In analysing the data we recognize that stories are reconstructed firstly by the narrator then again by the researchers. Consequently as researchers we become the spokespeople for others, reconstructing their stories and in doing so imposing theoretical categories aimed at providing our particular audience with ‘an intuitively convincing account’ (Bruner, 1991; Boje, 1995). Important in this respect is the experiential knowledge of the researchers as this will influence their interpretation of the story. The lead researcher is a registered nurse with over twenty-five years experience working in the UK NHS and the co-researcher has considerable experience of researching social care. Invariably their understandings are reflected in the co-construction of these patients’ stories. Data analysis involved initial or ‘open’ coding of the data to identify concepts and group them into categories. Within each account we searched for conditions, interactions among actors, strategies, tactics, consequences and situations where tactics failed or participants had no chance to use them. Participants’ own words or ‘in vivo’ codes were used where possible. We then undertook axial coding by searching for relationships between and among the initial categories. This was an iterative process involving constantly comparing accounts to select and reduce the data to core categories by merger and delimitation and searching for confirming and disconfirming evidence as possible explanations emerged (Corbin & Strauss, 2008).

### Table 1 Reasons for Participant Attrition

<table>
<thead>
<tr>
<th>Reasons for attrition</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to make contact within 3 weeks post discharge</td>
<td>6</td>
</tr>
<tr>
<td>Surgery cancelled</td>
<td>2</td>
</tr>
<tr>
<td>Patient moved out of the area</td>
<td>1</td>
</tr>
<tr>
<td>Had enough of hospitals/do not want to think about it again</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total number</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

**Findings**

Patients made sense of their forthcoming surgery as an opportunity to enhance their health and well-being. It is a decision that has simultaneously negative cognitive consequences engendering fear over the prospect of being ‘vulnerable’ and dependent. To remain committed to their course of action patients have to convince themselves that it is worth the risks involved, which are made clear to them by the surgeons.

‘...bit apprehensive about the operation ...but after I hope the symptoms will reduce dramatically’.

63 year old man

I have been worried about this op...its nothing major but I suppose everything scares you.

Faith is instrumental to sensemaking (Weick, 1995) and patients expect that ‘they won't [go wrong] with us’. They trust the technical competence of the clinicians often basing this trust on knowledge of family or friends who are clinicians or on previous hospital
experience. They create a plausible story about the conduct of the ‘fantastic’ surgeons and the ‘brilliant’ nurses who are part of a shared referent: the institution of the British NHS in which they have faith and feel safe:

a cocoon from the outside world

the National Health …[has] certainly look after me well

I have total faith in them (doctors and nurses).

In general patients expect to be patient and to conform to treatment and other instructions toward their recovery:

I'm sure it'll all happen, and I'll be told what to do and I will probably do it and when they say 'You can go home' I will go home.

68 year old man

Those patients with previous experience of medical errors are more wary and they learn how to make their voice heard by using medical language:

So it's only from having advice from haematology, that's where my strength comes from…when I make myself sort of quite clear and explain the difference and you know, I'm not a medic but I'm explaining it as I have been told it by a medic so you know, eventually they will speak to haematology.

Daughter of a 73 year old woman

In the intra and post-operative periods when expectations are not met patients often find it difficult to reach an understanding with their clinicians. They experience a belief act discrepancy between their expectations and the actions of clinicians. Patients accept what they are told by doctors or nurses who, nonetheless, appear to patients to be ignoring or dismissing their concerns:

In the end I said I can’t argue with you as you are the experts.

84 year old woman

I was quite ill as well …I did tell them that I couldn't see properly… I kept saying about my eyes and um, they just sort of said things like 'Oh well it could be all the medication and everything' …I actually felt that they thought I was being a bit of a nuisance and I was quite upset about that. …That's why I accepted that and didn't ask until my visit to outpatients … they did an MRI scan and that was when it was confirmed that I had had a stroke.

58 year old woman

Patients conform despite unease with events. They attempt to make sense of their situation by being ‘good’ patients not being ‘a moaner’, ‘a complainer’ or ‘a nuisance’. The actions taken by clinicians, and often by patients themselves seem to reinforce patients’ subordinate role:
You researcher said to me would I question them but if the nurses won’t question the consultant then how can I?

46 year old man

You are very vulnerable in hospital it is like a weird prison, they take your drugs from you, even though you manage them all the rest of the time, yuck I hate it all. I feel like I have to be exceptionally nice to them.

53 year old woman

In part patients conform because clinicians are perceived on occasions to be short of staff, highlighted by comments such as: “There were not many nurses on, they were always busy” dealing with multiple demands from those people who are worse off, such as “One old boy [who] fell out of bed”. Institutional constraints are provided as acceptable justifications for events. On the other hand, patients struggle to make sense of their environment, they do not see their own narratives as plausible, rejecting them in favour of those provided by clinicians and they attempt to normalize the situation by self-blame.

codeine…[makes] me violently sick, frightened and dizzy. What really baffled me was that I had told the nurse that I couldn't take codeine but the same nurse, I could hear her saying she can take codeine. … maybe it was a good thing for me to be sick

69 year old woman

I just hope the staff don't think of me as when I come last time as being a moaner or anything! Because that's not usually the way I am.

58 year old woman

The effect is to reduce the value of the overall surgical outcome, to leave patients with a reduced sense of self-esteem and dread of further treatment.

I would have happily shot myself if there was a gun in the room.

67 year old man

I never want to go back into hospital again.

84 year old woman with cancer

Discussion

Becoming a ‘patient’ is a situation that people are forced, or force themselves, into. It is not a situation of choice and as such threatens both psychological and physical self-concept (Setterlund & Niedenthal, 1993). This results in negative cognitive evaluations of the forthcoming surgery and low pleasure emotions such as feeling scared and vulnerable. This places patients in a paradoxical situation of feeling vulnerable while claiming to feel safe. To make sense of their predicament patients emphasize rationality rather than consensus drawing on ‘ideological, bureaucratic and technical arguments’ (Fisher, 1984) to justify their trust in clinicians and construct a plausible story of a future in which they have better health. Patients presuppose hierarchical organisation in which their role is to follow the rules laid down by clinicians who are the people most qualified to make the decisions because they have the requisite technical knowledge (Weick & Browning, 1986).

Preliminary Conclusions

The research has already begun to suggest how in a dynamic and uncertain environment such as a hospital, differing interpretations translate into joint action not by negotiated agreement but through the exercise of power relations where the meaning of the dominant actor prevails.
This results in diminished intersubjective perceptions of what is going on, creating communication misunderstandings between patients and clinicians which have the potential to cause harm to patients. When patients experience dissonance between their expectations and the actions of clinicians they attempt to make sense of the situation by creating a plausible story to reduce dissonance between their beliefs and clinicians’ actions. Patients are in a vulnerable situation created by the need to submit to anaesthesia and surgery and they need to trust that clinicians will do them no harm. To reduce the threat that hospital treatment entails they feel obliged to develop a subordinate relationship with clinicians. They attempt to enact their environment in a way that avoids conflict with, and gives support to, clinicians. They construct an identity as obliging, conformist individuals. Thereby patients’ reflexive narratives socially construct the pre-existing organizational order even when events threaten their physical or psychological sense of self.

Firstly, it explores how people make sense of events involving service user to employee relationships, where there may be greater opportunity for discrepant sensemaking. Secondly, by focusing on the narratives of a subordinate group it enables an exploration of the processes by which power is enabled, maintained and resisted.

The research aims to develop an analytical account of how patients interpret, enact and experience the safety of their hospital healthcare, to enhance our understanding of the structural and cognitive constraints on action and cognition.

Firstly, how do individuals in subordinate positions (patients) create a situation that is sensible and can be responded to or ‘enacted’ by familiar behaviour? Secondly, is discrepant sensemaking resolved through the exercise of power relations where the meaning of the dominant actor (medical professionals) prevails? Thirdly, how does this impact on the organizational (hospital) context?

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