

Increased unintended patient harm in nursing practise as a consequence of the dominance of economic discourses

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Abstract

Caring is characterized by close and fragile relations between nurses and patients. At times, even with good intentions, nurses cause unintended harm of patients. We argue that the dominance of economic discourses in health care and their subsequent influence on service delivery and health care practices has the potential to increase unintended patient harm. Similar techniques and practices can result in either desired outcomes or harmful outcomes. We explore the notion of unintended harm and some of the ways it arises in nursing practice. We argue there is a clear link between the dominance of economic discourses and an increased risk of unintended harm. As a consequence of the dominance of economic rationalist discourses and the subsequent systems of control introduced, the practice of nursing has been significantly influenced. The challenge for nurses and the nursing profession is to develop strategies to refuse to give in to the dominance of economic interests over the need to prevent harm.

Keywords: Economics; Nurse-patient relations; Harm; Discourse; Economic discourse

1. Introduction

Caring is characterized by close and fragile relations between the nurse and the patient. Within these relationships dignity as well as violation can result from the same actions and behaviours of nurses. At times, even with good intentions, nurses cause unintended harm of patients. Patients may experience nurses' practice as intrusive of the boundaries of their personal space, as offensive or threatening of their self-trust. We argue that the dominance of economic discourses in health care and their subsequent influence on service delivery and health care practices has the potential to increase the risk of unintended patient harm. This paper is based on extensive reading of philosophical and sociological texts, combined with case-material from several qualitative studies of patients' encounters with healthcare services. We begin with a story that illustrates unintended harm in contemporary health care settings. This story provides the context for our analysis of the impact of economic discourses on nurses' practice and an exploration of the mechanisms that facilitate unintentional harm by nurses.

2. Story

This story is drawn from a rehabilitation unit in a Norwegian hospital (Heggen, 2002). An old man with hemiplegia following a stroke, had lost his ability to speak and had little appetite. The rehabilitation unit was a hectic and the work burden on nurses was high. One day the old man's son arrived to find his father half lying in a wheel chair. The nurses just passed by, seemingly too busy to "see" the old man. The spoon had fallen on the floor, and his dinner, mixed into porridge for a smoother and more efficient feeding, was leaking from the left part of his mouth. He started to cry as he saw his son. The despair and shame witnessed in his father's eyes, made words unnecessary.

The experience of this father and son is not unique and illustrates one form of unintended harm arising in health care settings.

3. Unintended harm

What do we mean by unintended harm? Let us start with the word 'evil', which is considered a taboo subject in Western culture. Harm, violation, as well as injury, are in some way or another related to evil. Usually evil can be distinguished as either natural or moral (Tranoy, 1998). Natural evil occurs without obvious human causes, for examples natural catastrophes such as earth-quakes, bushfires, or epidemics. In contrast, moral evil has to do with relations between human beings. Moral evil presupposes, and is uttered in, human relationship (Bauman, 1989; Vetlesen, 2001; Alford, 1997; Noddings, 1989).

Moral evil consists of different forms of evil that create harm and can be considered on a continuum of intended to unintended evil. At one extreme is intended evil where it is possible to identify obvious ill will and intention to impose harm and injury on other persons. One obvious example is to take life (for example, premeditated murder), or it might be denigration (for example, revealing delicate matters/secrets about other person's life). At the other extreme of this continuum is thoughtlessness and disregard where intent is not identifiable (for example, careless mistakes during surgery or anaesthesia). Positioned between the intended evil and disregard is egoism. Egoism is a form of evil where a person's own interests matter more than another person's suffering and dignity. An example of harm arising from egoism is where a nurse consciously neglects a patient who is not able to feed themselves, leaves the meal out of reach and takes her own lunch break. Possibly she reports that the patient has eaten the meal to cover her own 'laziness'. The continuum of moral evil contains various forms of evil action. Whilst taking a variety of forms, it is important to note that moral evil is created and experienced in human relationships. Given this definition, it is obvious in the context of healthcare that patients may experience situations as threatening to their integrity or as a violation, even if this was unintended by the nurses or doctors.

In determining whether or not care results in violation of the patient, it is not sufficient to consider the intentions and attitude of the nurse. One has to explore what is going on in the situation and the various individuals who are affected by that situation (Noddings, 1986). For example, in some aged care settings a time saving approach to showering involves grouping patients in a shower room and washing them collectively. This might be experienced as violation by a patient if they feel washed as if part of an assembly line. However, the nurse in this situation did not intend to violate the patient, nor does she realise the patient's perception of harm.

Therefore, we need to include patients' perceptions as well as nurses' perceptions when examining harm and whether it is intended or unintended. If a nurse claims that she offers care to a patient, and that patient experiences her care as violation, the situation in itself can not be characterized as caring and worthy. It is possible that the nurse, or the patient, or the situation and the context contributed to the experience of harm. Inquiry of any situation to determine moral guilt for unworthy care presupposes more than just judging the attitude of the person who violates. Care relations demand analysis of the situation and the relationship.

In summary, evil consequences are not dependent on evil will. Patients might experience situations as harmful even though the health professionals do not deliberately intend to harm. This paper will concentrate on unintended harmful actions undertaken by health personnel. This is not to say that we justify those kinds

of actions. On the contrary we will emphasize and argue why unintended harm is clearly unacceptable. We will explain and enrich the understanding of unintended patient harm and the “hidden” reasons and mechanisms behind it. How is it possible to harm and violate patients with use of words and behaviour? What are the harming effects?

4. How is it possible?

The central question in discussions about unintended patient harm is: How is it possible that health professionals, who are expected to act with the best of intentions and their actions should be based on knowledge and skills, cause harm to patients? Even more difficult to understand is how it is possible for humans to ignore and neglect injury.

The Holocaust literature (Bauman, 1989; Arendt, 1964) as well as Milgram's (1974) famous research about obedience, and Alford's (1997) research on the meaning of evil provides important insights. All of them point to one common factor, namely 'distance' from the victim, as a critical factor in making it possible to harm and violate others. This raises the next question of how it is possible to create distance in a close relationship, like that between nurses and patients.

Nurses can create distance from patients in the way they use their own body. A nurse can make sure she hardly reaches the patient's body or she might turn her head away from the patient or be far away in her thoughts. Furthermore, the use of technical equipment to increase distance, if the technique is allowed to come to the forefront, has been recognised by many (Olsvold, 1996). Expressions as: the ECG indicates, the X-ray reveals, are commonly used and show how health professionals tend to give technology status as the subject. This may result in a patient feeling remote.

Importantly, the practice of creating distance can also secure the necessary distance for maintaining patient dignity. The integrity of self is often challenged when experiencing illness and needing the support of others. The relationship between patients and carers is close and the maintenance of the patient's sense of self is vital (Lawler, 1997). Dignity as well as violation can be outcomes of caring relationships. It is the manner in which words, artefacts, a gaze, the body and comments are used in situations which are decisive for the outcome.

Laughter is a powerful social tool which might be used in both constructive and destructive ways. Lawler (1991) illustrates how nurses use humour in a skilful way to maintain the dignity of a patient. Humorous comments have a potential, when used appropriately, for relieving stress in a situation and make it acceptable for both nurse and patients. However, laughter has a strong potential for threatening as well as for stimulation of other person's self-reliance. A glance, a retort, biting or ironic remarks are tools to hurt others' feelings. Laughter can spoil self-confidence and deprive a person's ability for social mastery. Smile and laughter can be used in ways which make nurses more powerful and can increase patients' experience of social degradation (Møller, 2000).

The practices or techniques which create both positive and negative distancing from patients are supported by institutional culture. Research on institutional cultures has demonstrated that “natural” structures based on taken-for-granted routines, fixed rules, and habits can develop, and that these structures can make injuries possible (Goffman, 1961; Foucault, 1975a, 1985; Szacz, 1972). For example, the ‘natural’ structures’ in some aged care settings have facilitated the wide spread hidden use of tranquilizers to keep residents quiet (Waerness, 1999). This habit has probably

become a common way of handling an annoying situation because of staffing shortages. Common and habitual ways of practicing can create distance for nurses which prevent them from seeing the harm that might arise from the practice.

The division of labour, specialization, bureaucratic solutions, and delegation of authority in organizations, all contribute to the creation of favourable conditions for unintended harm (Weber, 1991; Habermas, 1979). The French philosopher Michel Foucault's (1975a) work extended our understanding of the processes used to discipline and control in contemporary institutions. For example, he described the use of surveillance and judging 'normal' behaviour as instrumental techniques for controlling modern society, including hospitals as a site where the ill are disciplined. Discourses were, Foucault argued, one of the ways that these practices are maintained.

5. Economic discourses

The work of Foucault (1972, 1975a,b) has also been useful in exploring economic discourses that are central to our current ways of practicing nursing. Discourses, in a Foucauldian sense, refer to more than the language we speak, they form the constraining grids that give rise to the ways in which we think and act.

...a discourse is a "system of statements which cohere around common meanings and values" (Hollway, 1983, p. 231). Discourses construct relationships we have in and with the world: the ways we speak about the world to some extent structure our 'realities' (Drewery, 1998, p. 103).

Our ways of knowing and being in the world are not simply governed by one discourse; we are influenced by many competing discourses.

Economic discourses are apparent in all aspects of our lives and, as Armour (1997) argues, have a tendency to subordinate other discourses and simultaneously influence the processes and events which explain or predict them. Economic discourses emerge out of the historical interpretation of production, distribution, and consumption of goods and services. These discourses become universal and normative (Peet, 2002). There are many economic discourses; our interest in this paper is in the contemporary economic discourses that influence nursing practice.

The centrality of economic discourses in health care delivery has become more visible internationally in recent decades as the demand for constantly increasing health care spending has been tempered with new models for constraining health care expenditure (Hunter, 1996). 'Neo liberal', 'neo-classical' or 'economic rationalist' discourses emerged during the 1970s (Alpin, 2000; Sheil, 2000). These discourses were founded on 'marginalist' economics which are based on an 'assumption that there are no objective values ... value can only be measured by the price an individual will pay (Sheil, 2000, p. 17)'. Consequently policies that reduced trade tariffs, introduced denationalised currency (for example: Euro) and privatised public services became dominant in Western economies.

Subsequently, a number of strategies have been introduced into health care to support the economic rationalist policies of contemporary governments. Managed competition has been one strategy for controlling costs, introducing the patient as a consumer and encouraging performance based results (Cabiedes and Guillen, 2001). Light (2001) identified a number of threats arising from managed competition suggesting 'it is much easier to make money by skimping on equity, quality and service than become more efficient (p. 1159)'. Further it upsets the professional control and medical hegemony of healthcare, therefore threatening existing practices.

Diagnostic related groups (DRG's) were also devised as a system for controlling the cost for treatment through a determination of standard length of stay for specific diagnostic categories of illness and an increase in home based delivery of service (Cartier, 2003). The DRG system created a number of problems including under treatment of patients to avoid the penalties of exceeding the standard length of stay; avoiding treating people whose DRG is not cost efficient; and cost shifting by moving patients into alternative institutions or the home (Andersen, et al., 2001).

The impact of neo-classic economic discourses on healthcare practices can in part be seen in the adoption of the new language that of the market place in the clinical environment. New terms and methods appear daily. Reinhart (1997) used the emergence of 'pharmacoeconomics' as an example of the focus on identifying the best amongst a range of rival approaches to care which entails complex technical process and data management. However, the definition of benefit and costs are 'arbitrary' creating debate about the translation of medical outcomes to monetary measurement. The dominance of these discourses has also led to the creation of internal markets, where wards and departments are in 'competition' with each other and there is an accompanying rationing of resources and a need for prioritization of services (Joyce, 2001).

As a consequence of the dominance of economic rationalist discourses and the systems of control introduced, the practice of nursing has been significantly influenced. There has been a restructuring of the workforce with an increase in part time and casual employees. This has contributed to a loss of social capital, trust and caring (Light, 2001) between the staff of health care services. Angus and Nay (2003) identified the dominance of economic discourses resulting in the marginalization of nursing discourses in aged care services. They described some instances where nursing has been managed out of a care environment by changing the client mix to avoid the legal requirements of registered nurse staff.

6. Practices influenced by economic discourses

Let us return to our initial story in the Norwegian rehabilitation setting. The son contacted the head-nurse and relayed his despair and anger. The nurse listened carefully and expressed regret that their focus of effectiveness has led to the son's perception of inadequate quality in their caring. She further conceded that quite a few users (patients) of the unit did not receive the level and quality of treatment and care they were entitled to expect.

Starting with the patient's situation, it is easy to understand that the old man felt powerless, desperate and unworthy. This experience is clearly one of harm caused through the neglect of staff. The head-nurse used economic discourses to justify the inadequate level of care in the language she employed to justify the situation to the son. She spoke with the new and correct language of economic rationalism, using terms as effectiveness, quality, user, and user's right. This language in this story was used to create distance for the nurse between herself, the complainant and the situation he was reporting.

Economic discourses arguably underpin the strategy of the head nurse in this story. In another research project (Waerness, 1999), patients related dissatisfaction with the care they received and clearly linked the new corporatization of hospitals to the physical, psychological and social harm they experienced as part of their hospitalization. In another study exploring issues in pressure ulcer management for people with spinal cord injury, patients were interviewed and identified a number of concerns about their experience in hospital (Wellard and Rushton, 2000, 2002).

Several patients described the time as an inpatient as like being in prison. One patient described his feeling of being distanced from the staff:

I was frightened to ring the buzzer if I wanted something, because there was no one in the ward, they were outside in the nurses' station in another room, chattering away with one another. And if you did ring the buzzer, the voice would come from the nurses' station—'who's that?'—'it's me, N'—'what do you want?'. Now instead of coming to see what you want, they are yelling out to you from the nurses' station—'what do you want?' And as much as to say, well what are you wasting my time for.

Participants also reported their perception of a reduction in the cleanliness of the hospital environment which generated fears of cross-infection for some and was given as a reason by several participants for a delay in presenting for admission to hospital.

Economic discourses clearly underpin these accounts. Participants were concerned about the potential risk of infection in an environment which is not maintained adequately. At the time of the study one cost cutting strategy used in the hospital setting was to restructure cleaning and subcontract to external cleaning services. The result was a reduction in cleanliness, which was also identified by staff in an earlier study (Wellard, 2001). The restructured workforce resulted in reduced numbers of skilled staff and frequently patients found it difficult to attract staff to pay attention to their specific problems. Distance between the patients and staff was created through restructuring.

7. Discussion

We have argued that the dominance of economic discourses and their influence on service delivery and health care practices have potential to increase the risk of unintended patient harm. We further argue that this situation, where the dominance of economic discourses is employed to justify, allow or accept harmful outcomes, is unacceptable. However, there are no easy solutions and no one individual is to blame, rather the dominance of economic discourses has become normalized and it is this that needs to be challenged. Three important considerations in developing a response to this situation are: the 'totalizing' effects of economic discourses in daily life; the way economic discourses tend to subordinate other interests; and the ineffective resistance to the dominance economic discourses in health care to date.

First, economic discourses influence all aspects of our lives, and this influence is seen in the appropriation of everyday language to support their dominance. This language is frequently taken for-granted and seemingly these discourses are invisible to those who speak from them. In the Norwegian case example the use of words like 'quality' and 'effectiveness' were used to filter inadequate care and harmful outcomes. The use of this language separated the nurse from the son's complaint and she unconsciously used economic discourse to justify the inadequate level of care available.

Second, together with their invisible influence, economic discourses are also effective in subordinating other discourses. Economic discourses, manifest in part with the new language have a potential to create 'reality' through their influence on the processes they describes and predict. For example, there is a tendency to equate an increase in outcome (output) to an increase in quality. There is a need to critically analyse situations in which we innocently use the new language of economic discourses. Caring, another example, has become shaped within economic discourses rather than in parallel with economic interests (Angus and Nay, 2003).

This subordination has increased the distance nurses create between themselves and patients. Consequently, the risk of harm is increased. However, it is important to remember that distance can also secure integrity and, therefore prevent harm. There no simple rule or cause-effect logic, our point is that economic discourses are not dangerous per se. The tendency of economic discourses to subordinate other discourses and lead identification of criteria for determining what is valuable, and appropriate in nursing practice, potentially increases the risk of unintended harm. In nursing, we have to assess situations using different criteria which ensure dignity and human rights for vulnerable patients are considered central.

Finally, there has been little effective resistance to the dominance of economic discourses and this effectively maintains their influential position in health care services. Resistance to the domination of any discourse shifts its power and provides opportunities for other discourses to become more prominent. Resistance is not about individuals operating alone to mediate the influence of dominant discourses. Whilst individuals need to consider their responsibility for ensuring safe practice which is inclusive of all patients, one key to shifting the unconditional dominance of economic discourses will be found in collective action. Collective action can occur through a number of mechanisms. There is an urgent need for collective critical and reflective examination of influences on, and consequences of, our practices. This needs to occur in wards and departments, at regional, national and international levels. There is a need for nurses to engage in debate about strategies that will assist in supporting current and future nurses to be more resistant to the dominance of economic discourses. There is also a need for nurses to be courageous and speak out about their concerns. Nurses need to support their peers who show this courage. It would be helpful if current nurse leaders who struggle and try to juggle the competing interests of different discourses would share the difficulties they face. It will be difficult, the strength of economic discourses can be seen in the potential threats of redundancy or the restructuring of services, and we will feel vulnerable. However, open debate and collective action will assist in making the invisible influences of economic discourses more visible and will therefore be an important strategy in reducing the acceptance of their dominance.

8. Conclusion

Sometimes harm is a consequence of nursing practice. This harm, in itself, is not necessarily evil. Frequently, harm is unintended and nurses are often unaware of patients' perceptions of being harmed. Nursing is a discipline in which practitioners need to be aware of the potential and actual destructive consequences of our actions. Economic discourses and their continued dominance in health care have the potential for increasing the distance between patients and nurses and hence make it 'easier' to unintentionally harm patients and sheltered behind words like quality, effectiveness, and outcome.

Unintended harm of patients is unacceptable. Whilst it is not possible or desirable to abandon economic discourses, they form part of our contemporary world, it is possible to resist the dominance of economic discourses at the expense of other discursive positions. Patients have a right to expect that health personnel are able to critically reflect on their practice and on the practice of those around them. All of us have the responsibility to be aware of the consequences of our behaviour and a role in developing organizational culture which may lead to unintended harm.

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