MAKING SENSE OF ORGANIZATIONAL INTERVENTION BY FOLLOWING WORK ACTIVITIES

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Abstract

In this paper I'm making sense of hospital work by interconnecting narratives about knowing and learning and practical work activity. My paper explores the gap between normative description of care and how it actually happens. I use concept of care trajectory in bridging narratives and activity. The research site is Surgical Operating Unit which had fallen into a crisis like situation and the patients care was endangered. Many change efforts had been carried out in order to improve the crisis like situation but they had not provided the support needed. New type of intervention was started in 2006. However patients were not represented in the intervention meetings and therefore I followed care process of six patients. Here I explore a multilayered care trajctory of a knee surgery patient in depth.

Keywords: narratives, evaluation, activity, care trajectory

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1 Description of the reseach site and intervention

The research site of the empirical case in this article is Surgical Operating Unit and its interfaces at University hospital in Finland. The Surgical Operating Unit consists of approximately 200 nurses and 100 medical practitioners representing surgical specialties and anaesthesia. Interfaces of the unit are the regular wards from where the patients come to the Surgical Operating Unit for operations and there is a recovery room located inside the Surgical Operating Unit which I also see as interface. Activities of the professions taking part to the care of a sugical patient differ historically, surgery being divided into specialities and anaesthesia being spread out in the hospital serving different units.

Normative descriptions form a picture of a clear-cut care process in hospitals with predetermined phases. However the object of hospital work has expanded, the patients are more demanding, there are demands for provision of good care and on the other hand there was constant demand for cost effectiveness. In my case example the different parties taking part to operation of a patient have difficulties in constructing a shared object of work. Recent studies indicate that care processes are complex, not so easy to manage, include process failures and are not necessarily conducted in patient centred way. Public awareness has recently increased and the medical community has started to receive customer reclamations e.g. in relation to patient's safety (Tucker and Edmondson, 2003). Patient's role in medical work has been discovered in some studies. An interesting result is that patients influence their own care process by shaping it (e.g. Strauss & al., 1997). Edvardsson, Rasmussen and Riessman (2003) on their half perceive the hospital environment as a forcing space which forces the patients to act in a certain 'normative' manner that is considered suitable for the patient. They conducted a comparative analysis of two narratives a single person by examining her two separate hospital experiences.

An activity theoretical intervention, based on Change Laboratory method (Engeström & al., 1996), was facilitated at Surgical Operating Unit by our research team including Y. Engeström, H. Kerosuo and me, funded by the Finnish Work Environment Fund. It was carried out in autumn 2006. Working group involved participants from surgery and anaesthesia that had previously developed their practices separately. Intervention provided a shared platform for reflexivity for the first time. Single members brought up experiences to collective discussion and individual and collective reflection intertwined. Reflections started to emerge within and most importantly between the professions and dynamic process of knowledge and innovation creation began. Ideas and suggestions for new organizational model were shared during the sessions. Many polyvocal narratives of the organization and its activities were told. In the end of the process a new organization and leadership model was created.

I report the care process as narrated care trajectory of a knee surgery patient. I followed, in situ, the patient who was being moved from regular ward to operation, to recovery room and back to ward. During the care process patients are first being placed to one of the regular wards of the hospital. When an operating theatre is available they were usually pre-medicated and soon after moved from the ward to the Surgical Operating Unit to the operation. After the operation they are transferred to the recovery room located inside the Surgical Operating Unit. From the recovery room all patients are usually moved back to the regular ward within two days, according to their condition. In some acute case the patients are moved to the intensive care unit. In this paper I present care trajectory of a knee surgery patient who I followed in the regular ward, in Surgical Operating Unit in operating theatre and in recovery room inside the Surgical Operating Unit.

2 Methodology of the study

How to make sense, evaluate and develop hospital work towards patient centred care? My hypothesis is that there is 'gray area' or gap between illness and hospital experience of the patients and provision of medical care. The attempt in my paper is to evaluate the care process and to find out which factors in the care process create the gap and inhibit development.

I listened to her experiences and also the speech actions of medical professionals. When meeting with the patient for the first time I conducted a narrative interview (Mishler, 1986) with the patient. I asked the patient to tell about her life and the medical history and experiences about the hospital in her own words. During the observation I wrote a lot of field notes and photographs during my stay at the hospital which I used as data and also as memory aids. I also recorded talk in work situations and in interviewing the patient. By carefully observing physical actions and spaces I enriched my narration and was able to contextualize the speech actions of medical professionals and the patient in my analysis. I will present some excerpts in this paper that are marked with the status of the person whose narratives I constructed and whose activity I observed (e.g. patient, anaesthetist).

In this study the concept of trajectory is central analytical concept which brings together narratives of the organization and the patient as well as the activities taking place during the patient's care process. The concept of care trajectory is used as a mediating tool in bridging narratives with activity. As result an activity theoretically interpreted, multivoiced narrative of a care trajectory is constructed. Care trajectory is identified in this paper as a systemic, dynamic process with several elements that constitute and shape it. My aim is in this paper is to analyse the relationship between complex activities and narratives of the different professions providing care of a patient. The aim is to widen understanding of the trajectory and problems in the trajectory from different perspectives.

Strauss and others (1997) have studied social organization of medical work by following patient's illness trajectories. Their interest is especially in chronic illness trajectories. Trajectory term expands the term course of illness and refers to not only the 'physiological unfolding of a patient's disease but to the total *organization of work* done over that course, plus the *impact* on those involved with that work and its organization'. By physiological unfolding the authors refer to medical, nursing and technical tasks. The quality of illness determines the different kinds of skills, actions and resources required in certain illness trajectory of a patient. Authors propose that the concept of trajectory is necessary for sociological understanding of illness management. (Strauss, Fagerhaugh, Suczek & Wiener, 1997: 8-9, 38.)

Illness trajectories have temporal phases and they usually include different kinds of work and work relationships and they are complex to manage. In hospital organization the physician and other various persons organize countless number of tasks and simultaneously the evolution of trajectories gets shaped by professionals taking care of the patient and also by the patient. (Strauss, & al., 1997: 29-39.) However Strauss and others (1997) complain that the patients are not usually considered as shapers neither of their own illness trajectories nor as a part of the division of labour.

Strauss & al. illustrate how patients influence the process by shaping their illness trajectory. Patients shaping of the illness trajectory may have significant consequences to the course of their own illness trajectory. The patients may for example elect to tell important issues about him or her or may not follow regiments. The patient may have awareness of dying which may cause ways of behaving 'correctly while dying' in order to 'die properly' or breaking the rules of dying which

causes problems for the staff. Yet much of this and various other kinds of shaping work such as sentimental work conducted by the patients remain invisible to the hospital employees. The staff-patient work should be seen as interplay in which both parties may explicitly learn, teach and also negotiate in decision making. (Strauss, & al., 1997:191-208.)

Activities and narratives are seen as 'building blocks' of a care trajectory. It includes various narratives and activities performed by the patient, physicians and the nursing staff. Care trajectory of a single patient is therefore a systemic, dynamic process consisting of different elements and voices. This means that the trajectory is never the same in different patient cases, even when the diagnosis is the same the care trajectory always differs. Activities of the different professionals, the patient and material conditions shape it in each case and each time differently.

My attendance differentiates my study from narrative studies that are typically retrospective in nature. For me narratives told in intervention meetings are not enough, empirical evidence on organization of the care processes was needed in order to make sense of hospital work. However narrative methods can interestingly be used in linking program evaluation and organization development (McClintock, 2003/2004). For example by Costantino and Greene (2003) enriched program evaluation to include narrative aspects such as participants' experiences about the program and its outcomes. Dart & Davies (2003) have studied story-based evaluation tool in agricultural extension program and came to a conclusion that storytelling process itself is a very significant change technique.

Narrative evaluation captures temporality aspects of organizational change. People create narratives to structure their past experiences (for narrative evaluation see Abma, 1999). However narrative evaluation namely focuses on changes in individual level, analysing static texts or experiences occurring in individuals minds. Narrative research has been criticised for being intuitive in nature and not having theoretical framework behind the analysis (Redwood 1999, 674). Therefore I extend narrative evaluation apprach with activity theory in my study (Engeström 1987).

Buchanan and Davson (2007) combine elements of narrative approach with process or contextual analysis. From their view organizational change is 'a multi-story process, in which theoretical accounts and guides to practice are authored consistent with pre-selected narrative styles'. According to the authors narratives are both about change process and become the change process. I physically followed the patients care trajectories, the whole process of patient's care, while she or he is in the hospital. As Buchanan & Davson I also take a process perspective and suggest that narratives are processes; in the context of this paper these processes are conceptualized as narrated care trajectories that are filled with activities.

Narrative research is always concerned in temporality. I organized the narratives and my observations of activities into sequences with beginnings, middles and ends, which is the emplotment of the narratives (Ricoeur, 1984; Czarniawska, 2000). Narration enables the inclusion of the patients own biography, medical history of the past and current thoughts as well as the thoughts and fears about the future when going to the surgical operation. Use of narrative approach enables the exploration of various paths and interconnections between actions (Griffin, 1992; Stevenson and Greenberg, 1998). Narrative study tries to explain "why something happened in a change process and how individuals understood these events" (Stevenson and Greenberg, 1998: 743).

Contributions of Boje (2000), Czarniawska (2004; 1997) and Gabriel (2000), in the study of organizational narratives, emphasize the importance of context and presence of cultural aspects in

stories. I agree with them. Institutions have specific history in which work practices and other collective events have taken place in the past, currently take place and will take place in the future (Hodgson & Cicmil 2006).

Narrative methodology usually emphasizes individual aspects; here I extend it by using activity theoretical framework in my interpretation of the narrated care trajectory in order to widen the understanding of the complex care activity. I examine and narrate activities and collect narratives of the different professions and the patient. My focus is on exploring collective, cultural historical aspects and dynamics of the trajectory and discovering how does narrative construct the object?

Activity theoretical studies of health care have taken the perspective of history into account (e.g. Engeström, Engeström & Kerosuo, 2003). From an activity theoretical perspective the concept of object includes the sense and meaning attached to an object of an activity (Vygotsky, 1978). The object carries the motive of the activity. Collective human activity has collective motive and it is oriented towards the purposeful object. Human activity is historically and culturally evolved, and materially mediated by artefacts. (Leont'ev, 1978; Engeström, Miettinen & Punamäki, 1999.)

I activity theoretically construct the course of the care trajectory as object oriented. The object of the activity in the work of surgeons is the patient (in the cue of patients) to be operated, for anaesthetists it is providing anaesthesia to patients. The overall object of the different parties is the provision of patient care. However the object has different meaning to the physicians and the nursing staff due to historical differences of their activities. I followed activities and material surroundings related to the patient's care trajectory and by so doing extended traditional data collection methods in the field of narrative research.

3 Care trajectory of a knee operation patient

In October the tenth in 2006 and I arrive to the Surgical Operating Unit in the morning. I meet the head nurse who was responsible for constructing the rotas for the day. She browses through her computer and chooses a patient that I could follow through her care trajectory. The patient I was to follow had arrived to the regular ward number 37 which was a rheumatic ward in the profit unit of internal diseases. Her knee operation was on the list for elective operations which means that her operation was planned to be conducted during daytime. The operation was estimated to last about an hour. The patient is a 56 year old female. The head nurse speculates whether I need someone to guide me to the internal diseases ward because it is across the hospital. I happened to conduct my pervious research work in the same unit so I replied that I can manage to get there on my own.

3.1 With the patient in the regular ward

At 10:30 AM. I arrive at the ward. It is a nice co-incidence that the patient happened to be in the internal diseases ward because I already know the head-nurse of the ward and she warmly welcomes me there. She indicates the room for me where the patient is and I enter the room to meet the patient who is in the room waiting for her operation. She had been to a local health centre for pre-examination. She has come to the hospital the day before approximately 24 hours before I meet her. She had been to laboratory for some tests and EKG, x-rays of feet and lungs and her stomach has been emptied. She is in the room by herself and I greet her friendly. I then explain that I am a

student from the university and interested in researching her care in the hospital. I ask for her permission to follow her care process and she agrees. Then I ask her about her situation.

She tells that she has been a home aid but because of the physically demanding job and her health related problems she retired from the working life. She had rheumatoid arthritis, fibromyalgia, osteoporosis, one operated knee, other knee with constant problems osteoarthrosis and psoriasis. She starts a story about the problems her knee has caused her. Her other knee has been operated 12 years earlier. She has been on painkillers for years. She was in physiotherapy for three months because of her knee causing pain.

The patient is at the university hospital for knee operation in which an artificial knee joint will be created for her. She has been pre-examined before arriving to the hospital. She tells how she has been to surgical policlinic six months before now, in April 2006, to meet an orthopedist. The orthopedist then prescribed her to be operated. She has not been able to walk properly or ride a bicycle and tells how she drags her leg behind her while walking. I feel empathetic towards her difficult situation and we reflect together on the operation. I tell her about my mother and how well she is now after the same operation.

Then she tells about her future and plans for rehabilitation and she tells about a machine and uses her hands in describing the functions of the machine. It will be used during her stay in the hospital. She speculates then about the time she will need to stay in the hospital and about breathing and other instructions she has been given in order to prevent blood clot. She tells about her living conditions how she lives in an apartment with no elevator and tells that she is able to go to her daughter's home. The she starts to talk about her 32-year old daughter who will come and help her. She tells about her three other children also and luckily for her three of them live near by. She has seven granddaughters of which she is very proud of and happy about. The one who lives further will also come and see her after the operation which she happily tells about. Then she starts to cough and says. Quatations have been translated from Finnish.

Patient: "It's horrible how dry my throat is.."
Researcher: "Don't they (nurses) give you any water?"
Patient: "I don't think they will..they will give me some medicine..they will poison me soon" (laughs a littele bit)
Researcher: "I would've given you some but..I'm afraid I cannot otherwise..
Patient: "I was given something to drink in the morning two cans of water..but now I have been without food and drinks (…) the nursing staff is really nice here though."

One of the nurses has told her that the estimated time for start of the operation is at 12:00. She was anxiously waiting for the operation. Another patient from the room has been taken to the operation at 7:00 in the same morning. She starts to talk about the operation. The patient now for the first time starts to complain about the waiting. She also tells a horror story of how her daughter almost died in the same hospital while giving birth. Her daughter's pancreas was damaged in the operation. She was in intensive care and was lucky to survive. I try to support her and am empathetic towards her.

Patient: "It's horrible how long I must wait, have you been watching an operation like this, how long will it take"
Researcher: "I'm afraid I have not been following an operation like this..I was told by the nurse that it might take just couple of hours.."
Patient: "She (her daughter) was critically bleeding..so one fears for these hospitals always a bit (..) and I know three cases and one of the mums died..(…) hopefully something will happen soon.."

Patient: (half an hour later while anxiously waiting) “Seems like they are not taking **us** to the operation.. (…) in the operation they take drills out and start drilling..”

The patient has told me a lot of details about her personal life and children and I feel that I can support her in waiting for the operation. She has had bad experiences of anaesthesia from the past. She tells me that it has been very difficult to put her into anaesthesia. The anaesthetists could not find the right spot in her spine to conduct local anesthesia and she was finally put into sleep. We have similar sense of humour and she is able to reflect on her fears with me. She even uses the term “us” when talking about her operation. Finally after an hour a nurse entered the room and gave relaxant pre-medicine for the patient at 11:40 and is instructed to use the toilet. She goes to the toilet and despite the medicine she is very anxiously waiting for the departure to the Surgical Operating Unit. At 12:04 she starts to become tired. The patient waited for the regular ward for one hour over the estimated operating time the nurse gave her.

Patient: “Please, please come and get me (…) they could finally come and get me there (to the operation)!!”

3.2 Anaesthesia shaping the care trajectory in the operations theatre

I walk beside the patient’s bed with a nurse from regular ward. The nurse from regular ward reports the papers of the patient to anaesthetic nurse. In the Surgical Operating Unit I learn that the reason for the patient’s long waiting time was that the previous operation had lasted over time in the operating theatre were she was supposed to be operated at 12:00. According to anaesthetic nurse a new surgical prosthesis technique, with less metal, was introduced then for the first time and caused the delay. At 12:30 the patient and I arrive to the Surgical Operating Unit. The patient was to be operated in anaesthesia. She gets moved from the bed by nurses and porter and is placed to the operating table.

I then meet anaesthetist who is a senior and has worked as an anaesthetist for 25 years. I have already met in the hospital before and talked with. She friendly welcomes me to the operating theatre and while working describes her work to me. Before the anesthesia she goes through the patients experiences about anaesthesia with the nursing staff. Then she starts the anaesthesia with a new nurse of anesthesia and porter at 12:35. Nurse of anaesthesia tells me that she is doing a 12 hour shift today. I sit close to the anaesthetist and hear her talk. She gives me the permission to tape some of her talk.

Anaesthetist: “This lady has had both good and also bad experiences..ones the anesthetist had said that she will no longer continue the local anesthesia but put her to sleep (…) be we agreed with the patient that we try anyway local anesthesia..(..) I am a very annoying person in a sense that I just prick and prick (..) you can say auths and you can swear but please try to keep your back in position for me (..) please do not be so nervous it will be all right, I know you have stressful experiences but try to relax now (…) what is it that you are afraid of, seriously (…) it will be ok.”

The anaesthetist tells me that it is always stressful for her that the patient has had bad experiences. She manages to place one string to the spinal cord and the needle is in the spinal fluid. The needle is not placed from the place where she originally planned but from a different place. She puts some of the local anesthetic into the spinal fluid and starts questioning the patient together with the porter

who is assisting her. They use cotton plugs in testing if the leg is going numb. The patient searches for anesthetist with her eyes and moves her head a bit.

Anaesthetist: "Does anything happen in your left foot, does it prickle, does it itch, do you feel warm, and does it go numb, put your head down now (..) we will put more if needed (…) do you feel anything in your toes?

Patient: (weak voice) "Toes start to feel warm.."

Anaesthetist: "..but lady now you realize it started to go numb.. does the pain disappear from your knee, now we should think about how we ease your pain (..) do you feel ok (..) do you feel sick?"

Patient: (weak voice) "Yes (…) I don't have legs.."

Anaesthetic nurse: (to me) "The patient is in that condition totally naked and defenceless and feels unsecure..but calms normally down when hears that there is one person who listens to them and holds their hand if needed (…) in this busy hospital life we (anaesthetic nurses) are fortunate to be able to concentrate on one patient at a time.

The operational nurse then enters the operating theatre. Nurse of anesthesia measures the blood pressure of the patient it is measured after every five minutes. Anesthetist pricks another needle to patient's spinal cord to take care of the pain after the operation. Two nurses of anesthesia consult each other and realize there is still little movement in the patient's feet but it is going numb all right. At 12:57 the operational nurse places the anesthetic curve below the patients head. A nurse of anesthesia places thermal blanket on the patient. At 12:50 anaesthesia is ready. From anaesthetist perspective the patient was "a difficult case".

Anaesthetist: It really was a challenging back!! It took longer time than normally.

Anaesthetist reflects on the historical difference of the professions of surgery and anaesthesia and debated that the surgeons do not quite understand the nature of anaesthetic work and situations that may require time. It seems to be a delicate issue and even though she has been very open she does not want me to record her comments about it. According to anaesthetist there is a lack of anaesthetist in the hospital and also in Finland in general. Nurses try to hurry up the preparation of the patient. Anaesthetist leaves the operating theatre. She might meet the patient in the recovery room but is not sure if she has time. Usually she only goes when the patient has some complications.

Operational nurse: (to the patient) ..now we are placing you to the posture to be operated..quite fast actually so that the surgeons will be able to operate"

3.3 Surgeon's contribution to the care trajectory

According to the surgeon who operates the patient the activity of orthopedists is multifaceted including different kinds of operations for example wrists, hips and knees, traumas coming from emergency. He is specialized in orthopedics and traumatology.

The surgeon had seen the patient the day before the operation in the morning. According to the surgeon there are spikes in the knee of the patient that need to be removed I the operation. Because of the rheumatism skin of the patient is very fragile and must be handled carefully. The patient sleeps most of the time when the actual operation takes place. A young surgeon and senior supervisor start operating the knee at 13:20. A consultant is present as technical assistant supervising the surgeons because a new technique is introduced in this operation for the second time. Same surgeons had conducted the same operation before this. The operation is conducted in stage where blood is vacuumed and the patient does not bleed. The new I am not able to record the surgeons talk while they are operating the patient so I concentrate on following their work. Nurse describes that even though the patient refused her fair towards the anaesthesia she was from nurse's point on view totally terrified. The patient is quite small and cannot take a lot of local anesthetic.

Operational nurses hand instruments to surgeons and also carefully count the instruments used for safety reasons. Nurses mark everything down to the computer, e.g.instruments and medication used during the operation. A strong smell of burned bone starts to appear. This is the first orthopedic operation I am following and I think the smell it is sickening. The surgeons talk to each other almost during the whole operation. The patient has falls a sleep and snores a little. The operating theatre is very noisy; the surgeons are banging, tapping and hammering the knee with different kinds of metal tools. In the middle of the operation the surgeon is needed on the phone but he refuses to take the call. I observe an incident where anesthetic nurse gives measurements to the senior nurse. Young surgeon who is in charge gives a friendly remark to the nurse that he is actually in charge of the operation. Some nurses came in to the operating theaters to release nurses for coffee brake. At 14.08 anesthetists comes back to the operating theatre. During the operation anesthetist and nurses plan post-operative care for the patient.

The patient suddenly starts waking up during the operation and swings her hand; anaesthetic nurse tries to calm her down.

Anaesthetic nurse: "There's nothing to worry about you are still in the operation, everything has went well, I place your hand here again"

The operation ends at 15:20 and took two hours as a whole. I interview the surgeon and he describes that operation was routine like.

Surgeon: " It was a routine like operation, everything went in order but I had to do more work than usually because of the patients had so many bone spikes there because of the rheumatoid arthritis took extra time it was more than the patients with the rheumatoid arthritis usually have (…) a lot of bone spikes had to be removed before I could place the prosthesis..and also the malposition of the knee effected.. "

Anaesthetist wakes the patient up and she is little confused. According to anesthetic nurse cleaning of the operations theaters after an operation usually takes 15 to 30 minutes depending on the operation. In infection cases it takes longer.

3.4 With the patient in the recovery room

Surgical patients are placed to recovery room or to the intensive care unit after the operation. The regular wards do not take patients before their local anesthetic is over. The recovery room has same

quality monitoring equipment as in the operating theaters. It is also important to see that their pain is controlled well, that they do not bleed and have steady blood pressure, their EKG is measured, oxygen given. Patients with local anesthetic usually stay at the recovery room for couple of hours. In case of an emergency nurses in the recovery room get help from the operating theaters by calling them up.

Anaesthetist: "And naturally if there is a need for bunk beds (in the full recovery room) we have to consider the situation who is ready to leave (to the regular ward)..if someone is even more in need for monitoring and even more in need."

Researcher: Ok, and then the patient goes quicker to the regular ward?

Anaesthetist: "It is a must.. but then again the regular wards might be filled with patients and do not have any beds left, which is in my opinion a upsetting situation (…) for the millionth time there is no space and we cannot put everybody in the corridors".

Anesthetist nurses work in the recovery room and describe it as demanding task. There are lot of night sifts and the patients need to be monitored constantly.

There is a free place for the patient in the recovery room straight after the operation at 15:20 hours. Nurses place her to the regular bed from the operating table and take her to the recovery room which is situated in the same corridor. At 15:45 the patient arrived to the recovery room. She rests at the recovery room. I am there and she is very tired and does not talk much to me. Some new patient arrives to the recovery room, phone rings ones in a while and there are still couple of empty places for patients coming from operations later on. The nurses in the recovery room start to examine the patient and realize that she is ready to be transferred to the regular ward.

At 19:05 nurses of the recovery room start to prepare patient for regular ward. After that the patient is anxiously waiting for the nurses from the ward to collect her. It is very cold in the recovery room and at 19:40 the patient tells me she feels very cold and complains to me about pain she is having. She literally writhes in pain. Her voice is very weak when she talks to me. She sighs constantly and wondering whether her relatives have tried to call her. There were no nurses available to transfer her to the regular rheumatic ward where she came from. There is nothing I can help her with except talking to her and trying to calm her down. She starts to become extremely dissatisfied and angry.

Researcher: "I'm sure they will come in a while (nurses from the ward) and then you will get a proper thick blanket (..) this waiting requires a lot of patients (…) so you are wishing I could take you there, of course I would like to only if I had the authority".

A nurse comes to the bed and provides the patient with a blanket, I ask her whether the ward has rang yet the recovery room but they have not. The nurse from her part has ringed the ward many times. I stayed with her in the recovery room altogether 4 hours 15 minutes. At 19:59 a nurse arrives from the rheumatic ward and collects the patient. Nurse from the recovery room goes through the patient's documents with the nurse that just arrived from the ward. I then follow her and her bed back to the regular ward with the nurse.

Patient: "I thought you had all forgotten about me (…) it has taken you over an hour (to come to pick her up).."

A nurse gives the patient something to drink and a piece of bread shortly after we came back to the regular ward. She is tired and tries to eat some bread. I left the ward at 20:20.

4 Discussion and Conclusions

I bridged narratives and activities of different professionals involved in care of a surgical knee operation patient. I studied narratives of different parties, observed their activities and narrated finally the care trajectory as 'a whole' or as complete as I could from an otsiders view with certain limitations. In activity theoretical terms the care trajectory was constructed as object oriented, I focused on how each participant understood or made sense of the object of his or her work. The parties involved had different objects of work and they performed their ‘parts’ and encountered the object from their own historically laden knowledge. Results of the study indicate that the surgeons and anaesthetist did not address their talk directly to the patient when providing care. The objects of their work were the patient’s back and removal of epiphytes which are spikes in the knee. The nursing staff however took close contact to the patient and spontaneously tried to mediate e.g. instructions and questions expressed by anaesthetist.

This paper illustrates that there is a gap or 'gray area' between normative description of care and reality, at least from the focus of patient centredness. Care trajectory presented was multilayered, complex and hard to manage. Narrated care trajectory was a unique constellation with unexpected features and directions, shaped by interpretations and object oriented actions of the actors involved. I as a researcher mediated the collective construction of the care process along with medical professionals and the patient. The narrated care trajectory is multivoiced and reveals brakes in the care process which compartmentalized the care process from the patient’s point of view. The patient had to wait unexpectedly in two phases of the trajectory. The patient feared the knee operation and, interpreting her narrative, this fear was grounded in her past hospital experiences. The unexpected waiting evoked her fear.

The patient actively shaped her own care trajectory. She had had bad experiences of anesthesia from her past and she was terrified when taken into the operating theater. Her anxiety and fear were experienced by senior anesthetist and from her perspective the process of local anesthesia took longer than normally because the patient’s back was challenging and the patient herself was ‘a difficult case’. I argue that fear interfered the medical work from the position of the anaesthetist and created a gap to the normative description of care.

From surgeons point of view the operation was ‘routine like’ even though it was twice as long as similar operations normally and new technology was in use for the second time. However he later in his narrative reflected that the operation was in a way complex because the patient was rheumatic and had so many bone spikes to be removed. The knee operation before the one I followed also took one hour more that usual because then the new technology was introduces for the first time. This meant one hour waiting time from her scheduled operation time (told by a ward nurse) for the patient in the regular ward. This break clearly compartmentalized the care process from the patient’s perspective.

The patient reflected very different things than the professionals in her story. She narrated e.g. scary hospital experiences of her daughter, talked about her personal life and illness in detail. She invited me to listen and I felt empathetic towards her story. She had also told about her previous experiences to the anaesthetist. Still the patient tried to perform as if she was calm and did not

complain in the operating board. She only complained and was angry in my presence. Even strongly medicated with relaxants, while lying on the operating board she could not relax at all and her body was stiff and her eyes were full of anxiety and fear.

The study indicates that the existing double bind, constructed by us researchers in the intervention process; provision of good care and constant demand for cost effectiveness, still remains unresolved in the context of the Surgical Operating Unit and its interfaces. Different parties performed their own actions but did not perceive the process as a whole, their object was not *provision of good care* in patient centred manner but it was limited to objects of their own profession e.g. operation of patients or anaesthesia to patients.

The care trajectory can be used as a tool in follow up meeting of the change project conducted in Surgical Operating Unit. It can be presented by the researchers and used as tool for reflection in order to facilitate change. Whether a new understanding of a shared object take place in long-term will take time and require supportive efforts in implementation phase of a new organization and leadership model created in the intervention. It is yet too early to say whether the new model will function as a supportive structure and enable more flexible co-operation relationships and co-operation skills of the different professions. However this paper calls for deliberate remediation, arrangements and new kinds of division of labor and actions where mediation, which was here conducted by the nursing staff, could be expanded.

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