

LEARNING AT THE FRINGES. THE CASE OF ACCIDENT INVESTIGATION IN HEALTHCARE

In this paper, we present two ethnographic cases of acute hospitals in the UK who have adopted an approach - called Root Cause Analysis – through which clinical incidents and near misses are systematically investigated with the aim to engage in organizational learning and to increase the safety of medical treatment.

Following a number of high profile statements in trend setting countries such as United States, Australia, and the UK, safety has become an increasingly widespread concern in many Western healthcare sectors. The solution to what has been described as “an epidemic of underreported preventable injuries” (Bacharach & Small, 2000) has often been the establishment of large programmes based on three main components: the general introduction of systematic incident reporting procedures; the promotion of incident review and investigation practices; and the establishment of large repositories of incidents reports.

Underlying these initiatives is usually a rational and often simplistic view of organisational knowledge and learning (Currie, Waring, & Finn, 2008). The assumption is that by identifying the causes of accidents and issuing recommendations change and organisational learning will automatically ensue. Nowhere is this approach more visible than in the widespread adoption of Root Cause Analysis (RCA) as an approach to producing learning from accidents.

RCA is the name of family of structured methodologies for investigating the systemic causes of accidents in complex settings. Stemming from the engineering and system tradition, it suggests that in order to prevent accidents to recur an interdisciplinary team has to conduct interviews and hold meetings with the involved parties to inquire not only how the event happened, but what are its underlying systemic causes to formulate recommendations and action plans (Carroll, Rudolph, & Hatakenaka, 2002).

While RCA has some demonstrable benefits when used in an engineering context, it runs into several problems when translated into healthcare. These range from the difficulties of identifying ‘causes’ in a highly mutable ecology of different knowledges to the inherent difficulty in shifting work practices in such tightly coupled organisations. Moreover, when used in healthcare settings, RCA raises specific issues which derive from being fundamentally a tool for making work visible and accountable. As such, RCA is strongly resisted especially by healthcare professionals who associate the tool with the wider project of managerial control and the erosion of professional based control over practical knowledge (Iedema et al., 2006; Waring, 2007). After years of predictable scarce results, dissatisfaction with this approach is growing and there is a mounting sentiment that may lead, sooner or later, to the abandonment of this approach –and the adoption of some other quick fix.

In this paper we would like to argue that contrary to appearances, both the enthusiastic approach of ‘conducting investigations to learn’ *and* its rejection are based on a ‘problem-driven’ view of learning (Gherardi, 1999; Scarbrough & Swan, 2005). Both

approaches assume, in fact, a functionalistic perspective, which views tools like the RCA having (or not having) effects and learning as the homogeneous product of experience. They ignore the contingent and distributed forms which learning takes for the different groups involved.

Yet, precisely in contexts involving high risks, reliability is shown to be a result not foremost of installing control and centralized, rational planning, but also of learning in a space of decentralized improvisation, ambiguity, and flexibility (Carroll et al., 2002; Weick, 1987). We therefore argue that we have to resist the temptation of decreeing ex-ante that learning did or didn't take place and focus instead on the learning which happens at the *fringes* of the new practice of RCA. When we adopt a practice-based view (Brown & Duguid, 2001; Orlikowski, 2002) and explore how RCA tries to find its place in a wider net and what sort of 'learning' derives from this, a much more complex and articulated picture emerges. We thus investigate the 'organisational ripples' that the introduction of RCA produced on a micro level in the two large acute hospitals. Our focus will be, in particular, on the ways in which both the introduction of RCA and the resistance to it generated new patterns of relationship, new forms of discursivity (Iedema et al., 2006) and new opportunities and how these, in turn, became sites of learning. To do so, we analyse the discourses that take place both in the structured, formal interactions (i.e. documented responses to action plans and recommendations) and in more flexible encounters (i.e. talks and less formal meetings) between the patient safety group and the clinicians.

We will conclude that in healthcare as elsewhere, adopting a problem driven and determinist approach to learning makes us blind to the wide range of intended and unintended consequences of introducing new learning practices. This has the paradoxical result that not only large organisations waste large sum of money in scarcely effective initiatives, they also end up not recognising some of the less visible benefits that happen at the fringes of these initiatives and end up throwing away the baby with the dirty water when the wind changes direction.

Keywords: Evidence-based learning, practice-based learning, high reliability organizations

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