PURSUING LEARNING AND ENDING UP WITH CONTROL. REFLECTIONS FROM THE FIELD OF PATIENT SAFETY

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Abstract

The paper discusses a case in which a new managerial approach was proposed to engender organizational learning from incidents, but became, in practice, a system oriented toward consensus, closure, and bureaucratic control -- three well known "enemies" of organisational learning (Weick and Westely, 1996; Sitkin et al., 1994; Gherardi, 1999). We suggest that this puzzle can be explained if we focus on the discourse that allowed the approach to successfully circulate and diffuse. In particular, we develop the idea that the approach travelled on the wings of a 'rhetorical package' which combined the discourses of 'anxiety' and 'reassurance'. While the package (and its related socio-technical network) was very successful at sustaining the journey of the innovation, it also ended up reconfiguring the approach shifting the emphasis from organizational learning to control.

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Research Context

A central discourse in the healthcare policy of several OECD countries is that safer medical practice and increased patient safety can be achieved by systematically learning from clinical incidents. Since the mid 1990s, a number of countries have adopted Root Cause Analysis (RCA) as a method for investigating adverse incidents in complex settings and enhancing organizational learning. RCA is a family of techniques stemming from the engineering and system tradition. It suggests that in order to prevent their occurrence, incidents must be investigated by an interdisciplinary team. The aim is to find out what happened, identify the underlying systemic causes, and formulate recommendations and an action plans (Carroll et al. 2002). Following the initial adoption in the healthcare system of the United States, RCA has spread in countries around the globe and is now mandatory in Australia and the UK.

Method

In the last 18 months we conducted an in depth study on how RCA has been translated into practice in two large hospitals in England. We followed twelve RCA processes from beginning to end, collected a substantial amount of documents, and observed the work of risk and patient safety officers for over 100 days. In addition to this ethnographic work and in order to chart the global travel of RCA, we conducted 20 semi-structured interviews with key policy makers for the introduction of RCA in the USA, Australia, and UK.

Findings

Our main finding is that while still being promoted on the basis of a discourse of organisational learning and the search for safer medical practice, when used in practice, RCA is oriented instead toward consensus, closure, and control. Not only is RCA not producing substantial improvements in safe practices across the organisation, in certain conditions, it demonstrably interferes with existing learning processes and practices (cp. Iedema et al., 2005; Percarpio et al. 2008; Rex et al., 2000). The new practice suffers from a puzzling form of goal displacement, whereby its well intended introduction generates a number of unintended consequences. In this paper, we address this apparent theoretical puzzle and ask how this dissonance between discourse and practice can be explained. We suggest that the response comes from observing the travel of RCA and how it was translated in practice (Czarniawska and Jorges, 1995).

Our field work indicates, in fact, that in all three countries we examined what travelled was not only a structured methodology for investigating incidents (RCA), but a more complex discursive package. This package concomitantly highlighted and amplified the uncertainty and dangers of the medical practice and offered a reassuring solution in the form of a set of techniques that could offer some form of control of uncertainty and produce safer healthcare services. The continent spanning circulation and translation of RCA was sustained and facilitated by the construction of an ‘anxiety-reassurance’ package and by the concomitant generation of a global patient safety movement fuelled by a number of “moral entrepreneurs” (Waring, in press) and organised interests (Power, 2007). The ‘rhetorical package’ supported the spread of the innovation through raising public and professional anxiety about the performance of pre-existing management practices around patient safety. The very anxiety created by the discourse around RCA finds its resolution in the methodology itself: RCA reassures that, if

correctly implemented, hospitals will learn from clinical incidents and healthcare services will become safer. To this ends, RCA mobilises the discourse of engineering and its "modernist" focus on controllability through rational deliberation and technique.

We find, in addition, that the discursive combination of anxiety and reassurance is far from constituting a mere marketing exercise, but that the discursive package significantly translated and modified the innovation itself. On the one hand, we note that those aspects of the RCA approach travelled, which can guarantee the biggest reassurance. These include claims of simplicity, the overt use of engineering terminology, and a number of tools that produced tangible outcomes such as reports and statistics. On the other hand, the focus on reassurance has a significant effect on the implicit goals of the method, which is used more often to produce reassurance and closure than learning. The discourse not only propagated the innovation, it also actively shaped it (Shenav 1999).

Implications

We use the case to comment on the potential for betrayal inherent in the process whereby innovations circulate globally and are translated locally. In particular, we note how the ambiguous status of the "learning discourse" (Contu, Grey and Örtenblad, 2003) makes itself particularly amenable to different and even contrasting interpretations. We also use the case to highlight how the current emphasis on governance - as a way to organise professional bureaucracies such as hospitals and schools (Hackett et al., 1999) - exacerbates the "oxymoron" inherent in the very idea of organisational learning (Weick and Westely, 1996) and may require its re-reaffirmation.

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