institute of Health Policy & Management

Sociological complexifications and safety improvement in Dutch elderly care; from studying factors to co-shaping agendas

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Leading Health Care

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The ‘problem’ of care for older adults

- Welfare *resource* of long-term care increasingly articulated as a *problem*;
  - Rising life expectancy
  - Reduced role elderly in society
  - Rising healthcare costs
  - Increasing quality and safety problems
- Attempts to restructure financing
  - Care-load packages and indications
  - Separating ‘basic’ and ‘special’ care
  - Choice instrument leading to less choice
- Focus on improvement quality and safety
- Meaningful connections research and policy?

From safety to sociology

- Sociology getting company from Q&S movement in problematizing healthcare
- double move conceptualizing health care as ‘risky’:
  - health care organizations are unsafe places
  - safety can be built in as system property
- Produces a legitimacy issue for sociology
  - And leads to utilitarian conception role social sciences:
    - find factors that facilitate or hamper improvement
    - facilitate spread of best practices
    - tackle implementation problems
- A rather narrow definition of ‘usefulness’

Serviceable social science in research policy

- The Netherlands organization for health research and development 4M€ patient safety research program to:
  - “acquire applicable knowledge, insights and experience of safety in the health care sector in various areas, including:
  - identifying tried and tested success factors to produce a reporting, registration and analysis system that can be applied in various sectors of health care”

- Is that ‘learning from social research’?

The usefulness question in sociology

- A soul-searching questions for social sciences
  - "The philosophers have only interpreted the world in various ways. The point, however, is to change it"

    » (Marx, 1845)
  - "Whoever lacks the capacity to put on blinders, so to speak, and to come up to the idea that the fate of his soul depends upon whether or not he makes the correct conjecture at this passage of this manuscript may as well stay away from science"

    » (Weber, 1918)
- Sociological dual fear of being
  - too detached or too involved

Whose Side Are We On?

- Study Chicago post war housing projects
- Value-neutrality unattainable
  - Large societal issues
  - And being ascribed partiality
- Sociologists need “to make sure that, whatever point of view we take, our research meets the standards of good scientific work, that our unavoidable sympathies do not render our results invalid”
  - To ensure this “avoid sentimentality”

» Becker 1967

Usefulness in Medical Sociology

- Distinction between sociology of medicine and sociology in medicine
  - first at a distance from medicine
  - second in collaboration (Straus 1957)
- Two seen as incompatible and second risky
  - “If the sociologist begins to talk like a physician, he may eventually come to act like a physician and even to think like a physician. If he sacrifices his identity as a sociologist, he loses the unique contribution he can make to medicine”

Usefulness and Patient Safety

- Should we come to devision of labour sociology of and in patient safety? Or way out of dual fear?
- Tension nicely caught in Leading Health Care:
  - Influence policy makers (not detached)
  - No ready-made answers (no sentimentality)
- With usefulness as ‘finding social factors’ we loose strongest assets of good social science research:
  - The articulation of new agendas based on complexifications of taken-for-granted conceptualizations of safety
- Turn to ontology: what does ‘doing patient safety’ actually entail? How does this enact ‘effective and affordable care’?

The ‘Care for Better’ QIC

- National Quality Improvement Collaborative
- Multidisciplinary teams from care organizations
- National conferences followed by local improvement work
- Following plan-do-study-act cycles
- Working on specific themes:
  - Decubitus ulcers
  - Fall-prevention
  - Sexual abuse
  - Medication safety
  - Aggression and behavioral problems
  - Eating and drinking
  - Patient autonomy

Research questions

- How is quality and safety improvement performed in the collaborative?
- How do teams translate these performances to care delivery in their organizations?
- What definitions of ‘patient safety’ does this enact?
- What do these enactments make (in)visible in quality and safety improvement?

Enacting medication safety

- Project focuses on setting ‘SMART’ targets and measuring these over time

- Project targets:
  - at least 70% of participating teams should realize a reduction of medication errors of 30% within one year
  - at least 80% of participating teams have formulated a written policy on medication safety
  - 80% of participating teams have an operating and organizationally secured registration system
  - 100% of reported near-misses or errors are actively discussed and if possible translated into improvement initiatives

Medication safety in action

- Much goal displacement going on:
  - some teams adopt target and aim at “90% reduction of medication errors”
  - others focussed on automatic drugs dispensers and developing and apply protocols because of their “village-like” and “too informal” way of working
  - still others want to increase error reporting because having all protocols in place, but having 70 reported errors a year: “There must be a lot more going on than that!”

From control to delegation

- ‘Best practice’ in care for physically disabled:
  - give medication responsibility to clients
  - classify clients according to self-dependence level
- Enormous change in professional role
  - Implies alertness and restraint professionals
  - Assess whether patients are still able to responsibly deal with medication
  - Unlearn to check medication before handing it out
- Engenders reflexive practice around medication
  - Reflect on classification of clients
  - Very different ‘business case’ control approach
  - Prevents jungle of rules and checks

Ontologies of medication safety

- ‘controlling medication behavior and reporting (near-) errors’
- ‘reflecting which errors are problematic and which to be allowed, plus helping clients realize when time has come to hand over their responsibilities’.
- Errors and safety as antonyms
- Errors as part of safe care
  - Jerak-Zuiderent, 2012

Safety as a System Property

- Both automatic drug dispensers and maximizing own responsibility are ‘systemic’
- But highly different systems
  - ‘Standardizing dispensing’ or ‘foster resilience’
  - Questions of ‘spread’ or ‘sustaining change’ bound to be hugely different
- Elucidating these different ways of doing patient safety: indicate possibly overlooked action repertoires
- Different ontologies render ambitions of ‘rigorous’ and scientistic evaluations meaningless or highly ambiguous

Differences as Intervention

- Strong diffusionist logic within collaborative
- Resulted in strong focus on ‘spread’ and measuring outcomes
- Multiple ontologies of medication safety or client involvement not against spread and performance management
  - But these need to be situated in specific and locally relevant definition of the issue
  - Otherwise good practices of goal displacement invisible and qualified as unsuccessful projects
  - Which precludes learning from safety improvement practices as they happen

Usefulness redefined

- Multiple ontologies a productive alternative to narrow definition of ‘usefulness’
  - Sociological expertise not about providing evidence within pre-defined safety improvement agendas
  - But about re-specifying other ways to enact agendas of patient safety and defining problem spaces of patient safety
- Unsentimental social science research
  - Not insensitive to problems of medication errors
  - But resists the ‘moral weight’ of such issues
  - To empirically unpack the difference within them
  - And allow for unexpected contributions to
    - Leading Health Care

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Sociological refigurations of patient safety; ontologies of improvement and 'acting with' quality collaboratives in healthcare☆

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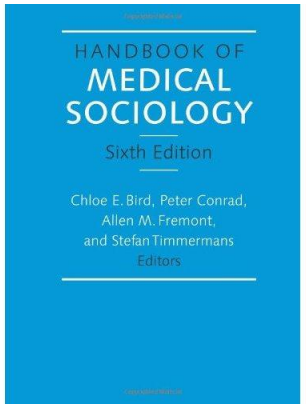

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The Sociology of Quality and Safety in Health Care

Studying a Movement and Moving Sociology

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References

- Becker, H. S. (1967). Whose Side Are We On? *Social Problems* **14**(3): 239-247.
- Jerak-Zuiderent, S. (2012). Certain Uncertainties; Modes of Patient Safety in Healthcare. *Social Studies of Science* **42**(5): 733 - 53.
- Marx, K. (1845). Theses on Feuerbach. *Marx and Engels; Basic Writings on Politics and Philosophy.* L. S. Feuder. Garden City, New York, Doubleday Anchor Books**:** 243-245.
- Weber, M. (1991 [1918-1919]). Science as a Vocation. *From Max Weber; Essays in sociology.* H. Gerth and C. W. Mills. Oxford and New York, Oxford University Press**:** 129-159.
- Straus, R. (1957). The nature and status of medical sociology. *American Sociological Review* **22**(2): 200-204.
- Zuiderent-Jerak, T., M. Strating, et al. (2009). Sociological refigurations of patient safety; ontologies of improvement and 'acting with' quality collaboratives in healthcare. *Social Science & Medicine* **69**(12): 1713-1721.
- Zuiderent-Jerak, T. and M. Berg (2010). The sociology of quality and safety in healthcare; Studying a movement and moving sociology. *The Handbook of Medical Sociology (sixth edition).* C. E. Bird, P. Conrad, A. M. Fremont and S. Timmermans. Nashville, Vanderbilt University Press**:** 324-337.