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Exploring the situational complexities associated practice change in health

Introduction

Globally, evidence based practice is being embraced as the gold standard for healthcare (Brown et al., 2009). However, there is a gap between the desired 'best practice' and actual clinical care (Grol & Wensing, 2004; Bultz & Johansen, 2011). As such, there are calls for research designs that aim to critically examine service delivery processes and the contextual factors that impact effectiveness and efficiency in healthcare (Fixen et al., 2005). Over time there has been a shift in theorizing about how to bring about innovation or change in health practices from the traditional focus on the individual (Greenhalgh et al., 2004; Grol et al., 2007). This shift in theorizing recognizes a range of factors interact at different levels impacting on innovation and change in healthcare. These interactions occur between patients, professionals, and teams; and the organisational, economic and political contexts (Grol et al., 2007).

The aim of this paper is to describe discourse analysis as a method for understanding the situational complexities associated with bringing about practice change with particular reference to the introduction of changes in the psychosocial care of distressed adults with cancer. In the following discourse analysis was used to analyse the audio recordings from clinical supervision sessions that were integral to an intervention in a cluster randomised control trial. The aims of the intervention in the trial are to reduce the levels of psychosocial distress of adults diagnosed with cancer and to reduce stress and burn out of those Health Professionals providing care to distressed patients (Turner et al., 2011). The patients' who are recruited to the trial are offered up to 4 individualised sessions. Each session is up to 30 minutes in length delivered by a nurse, occupational therapist, speech pathologist, dietician, physiotherapist or radiation therapist. Clinical supervision is provided to these Health Professionals once a week. The sessions are multidisciplinary group sessions facilitated by a consultations liaison psychiatrist.

The purpose of using discourse analysis in this study was to critically examine the discourses during the clinical supervision sessions. The researchers' were interested in what and how discourse shapes the actions of health professionals to change practice or not. A critical approach to the analysis of discourses within the context of clinical supervision appreciates

the socially constructed reality of healthcare and adult learning. This will help to understand barriers to implementation of changed practice so that these barriers can be addressed and change facilitated (Lather, 1991; Mezirow, 1991; Freire, 1972). Discourses from selected clinical supervision sessions are presented. The result illustrates how discourse analysis can be applied for the purpose of elucidating change. The analysis illustrates the complexity of the issues faced by Health Professionals when embracing practice change within healthcare. Discourse analysis presents a way of generating a deeper understanding of the situational complexities which are associated with changes in Health Professionals practice.

Discourse analysis applied to practice change

The language that health professionals use within clinical supervision constructs their experiences of providing psychosocial care. The use of conceptual metaphors, euphemisms, binaries, analogies and subject positions are used to represent dominant ideologies or hegemonies that have been largely unchallenged (Wood & Kroger, 2000). Highlighting aspects of language used by these Health Professionals' during clinical supervision makes visible the interconnectedness of current psychosocial care practices and possible ways to facilitate changes or innovate practice. This knowledge may then be used to create awareness of the needs of clinicians who are delivering psychosocial care to people with cancer. It may also lead to their emancipation through the exploration. Relationships of dominance, social inequality, power and control that may be creating or perpetuating the barriers to providing psychosocial care can be explored through discourse analysis so that the barriers can be addressed. As the desired outcome is change in practice a critical approach is indicated.

The existing literature recommends clinical supervision as a means to improve psychosocial care (Botti et al., 2006; Watts, Botti & Hunter, 2010). Clinical supervision is primarily a verbal interaction. As such, an approach that focuses on language and specifically language as a social action is appropriate. If we consider the discourse analytic perspective that talk is action (Wood & Kroger, 2000) then the change is change in talk and change is achieved through talk. The audio recording of clinical supervision represents a data set that captures the kind of talk that will enable that change. The barriers and / or enablers that are encountered when delivering the intervention will illustrate how health professionals transition between what they know they should be doing to what they are actually doing within their practice. Critical examination of positionality or subject positions, representation,

i.e. whose interests are being represented and subjectivities, dilemmas or tensions within the data reveals individual versus organisational tensions; exposes power and its effects along with ways of resisting or constructing alternatives to the current situation.

The need for change in the care of people with cancer

Whilst there are a range of evidence based guidelines for the psychosocial care of people with cancer (National Breast Cancer Centre and National Cancer Control, 2003; National Breast Cancer Centre and National Cancer Control Initiative, 2003; National Comprehensive Cancer Network, 2003; National Institute for Clinical Excellence, 2004; Canadian Association of Psychosocial Oncology, 2010) long term distress anxiety and depression are high (National Breast Cancer Centre and National Cancer Control Initiative, 2003). Of concern is that despite the availability of guidelines for psychosocial care this evidence has yet to be translated into routine care (Bultz & Johansen, 2011). In the context of cancer care there are a number of factors preventing the uptake of guidelines into routine care including: cultural, organisational and individual factors (Dilworth et al., 2011).

The Project

The research presented here is a qualitative “sub” study of a large, multisite, randomised control trial (RCT) (Turner et al., 2011). The RCT measures the effectiveness of a brief psychosocial intervention to reduce distress levels of adults with cancer. The intervention involves health professionals who have otherwise not received specialised training in psychological support skills, being trained to provide a brief intervention to moderately distressed adults with cancer. During the intervention phase of the trial, when the Health Professionals are delivering the psychosocial support, clinical supervision is used to provide safety and support facilitated by experienced consultation liaison psychiatrists. During the sessions the progress of the intervention and details of each ‘case’ are discussed. Health Professionals and supervisors discuss any issues and concerns that may have arisen as part of the intervention, reflections on the experience and the plans for continuing the intervention. Whilst many aspects of the practice innovation are being evaluated the researchers are seeking to understand the change process and the factors that may facilitate and / or inhibit the process.

Analysis of the discourse data generated through audio recordings of the clinical supervision explores the barriers and / or enablers encountered by health professionals who are delivering the intervention. Another aim is to explore if clinical supervision be used as a mechanism to translate knowledge into practice.

Data is being collected from four sites across Australia. Ethical approval has been given by all local Health Service and University human ethics boards. For the purposes of this analysis data from 8 clinical supervision sessions is included. The number of health professionals in the session's ranges between 3 and 6. There is a broader data set of 56 sessions that is not specifically considered in this analysis but inevitably will have influenced the analysis. The analysis and discussion presented here focuses on the situational complexities.

Application of discourse analysis to the data

The example presented here is a small part of the larger data analysis process that is taking its course as part of the first authors PhD research. This example was chosen for the clarity it provides around the situational complexities of this context. The example also sheds light on the complexities of practice change and innovation.

Following familiarisation with the data set I recognised a discourse around the barriers to psychosocial care. These barriers are complex and multifaceted. The data reflects the literature. Iterating between the literature, the data, policy and practice guidelines reveals complex systems of care and interactions that work against the Health Professionals' delivering this psychosocial intervention. The systemic constraints including: limited time, practicalities of space or transport is clearly articulated in the supervision sessions. Health professionals describe not having had a chance to call their allocated patients; patients not being able to or not attending sessions, not having an appropriate place to talk with their patients, difficulties contacting the patient via the telephone. Where we see an extension on the previous literature in the data is the presence of positive resistance against these barriers. In terms of time pressures there are examples of HPs delivering this intervention on their days off, after hours, as a priority to other work (asking other staff to cover for ½ hour). To address transport difficulties support is offered and delivered over the phone. If the patient is difficult to contact on the phone accounts of up to 15 phone messages, varying the time of

day that calls are made, and “detective work” to find out appointment times. The difficulties of the environment are discussed in more detail below.

In the excerpt below Mary describes how she used her new skills in the course of her everyday practice. This interaction takes place between Mary and her clinical supervisor in the context of a group supervision session. Mary has described that she is using her new communication skills in her day-to-day practice. She is reporting an example of:

“a patient who you know we couldn’t sort of [] from the outside see just a grumpy old man but... tried to break through, like, down a few walls today which was sort of semi successful.

Supervisor

But you stopped, reflected or listened did you?

Mary

Yes, well as much as I could he was very difficult to, but we established you know that he was the kind of person that has always been in control and how this was lack of control, a complete lack of control now and you know that that was his way of sort of saying I am going to regain control but. In the end established that he did want to see out the treatment, he wasn’t just going to top himself. (loud exhale)

Supervisor

So stopping to have that conversation in the middle of your normal, what you normally do, is that possible or is it disruptive?

Mary

(small reluctant laugh) Sort of umm listening to pumps going off and thinking I want to get that, I want to get this or do this or do that but I am going to try and focus here for five minutes. I think it feels a lot longer than it actually is when you notice, when you are aware of other things you have got to do umm ...

Initially my thoughts about this exemplar were that it highlighted organisation and environmental barriers to psychosocial care. It demonstrates the lack of an appropriate environment and the busy workload of the Health Professional as factors impacting on the Health Professionals ability to provide the psychological support for this person. Through critical questioning I extended this analysis to explore knowledge, power and subjectivity (Foucault, 1976). For the purposes of this paper problematisation of the data focuses

specifically on how the organisational demands described as a barrier to psychosocial care play out when examined from a critical perspective.

Positionality: The busy nurse the helpless patient

Mary positions herself as a busy but concerned Health Professionals. She describes a heightened awareness of the environment both as a busy environment with “pumps going off” but also as an open, not private environment. There is a sense of being preoccupied or distracted by the tasks she has ‘got to do’ as opposed to this ‘listening’ which she is choosing to do. The exemplar implies a tacit knowledge of the ward environment. Mary uses this implicit recognition of alarms ringing equals tasks to construct herself as a nurse. This dictates a particular position, a busy nurse. Mary’s position as a nurse then has implications for the expected behaviour in this situation.

In relation to her patient Mary constructs this man in contrasting lights. There is a facade to his character which Mary tries to “break through”. What initially was a “grumpy old man” gives way to reveal vulnerability. His previous life experiences have meant he has “always been in control”. The changes in health status and related treatment leave him feeling hopeless. Mary reports him saying “*if this doesn’t end soon then I will end it*”. This man’s distress at his “complete lack of control” positions him in an unfamiliar role which is distressing. The nurse patient relationship positions both Mary and the patient. Mary is in a position of power, with a duty to care for this “grumpy man”. The patient is positioned as powerless in this environment and in respect to his illness.

Representation: Prioritising psychosocial care

Mary as the supervisee describes her choice to take the time to listen and explore this person’s motivations and intentions to establish his safety. This exchange represents a heightened awareness of her patient’s mood, also a willingness to prioritise his distress. This excerpt is an example of how the Health Professionals are able to transfer the skills from the trial they are participating in to their everyday practice. This is where conceptions of knowledge come into the discussion. This new knowledge has enabled the Health Professional to exercise power against the status quo. In the example above the Health Professional takes the time to establish a relationship in which she is able to determine the extent of this persons’ distress and the potential for harm to come to this person. Having the confidence to “probe”, being able to tolerate the distress of the patient. In addition to this

point, the analysis reveals the fragility of the current situation. The barriers, systemic limitations can be seen as hurdles that can be overcome.

Mary uses the subject/ object property of language to construct two selves. Mary says “*but I am going to try and [make myself] focus*”. This implies a “recalcitrant, unwilling self and a powerful controlling self”(Potter & Wetherell, 1987, p. 107). This is an example of the multiplicity of self. The conceptualisation and construction of self, in this case multiple selves, is not viewed as neutral (Potter & Wetherell, 1987). It produces a changed sense of self. The powerful self claims credit for her effort to establish a supportive, therapeutic relationship with this man. The earlier claim of being “somewhat successful” implies that perhaps this change is not a lineal process. This iteration between changed and not, fixed or successful and failed is common. “Credibility and the power to persuade others of what one wants them to accept only come through the use of some routes of self expression... the pressure to be accountable and intelligible to others sustains and gives power to certain communal organisation of self experience.” (Potter & Wetherell, 1987, p. 106).

Subjectivity: How busy is too busy?

The tensions here lie around the task versus care argument often described in particular in relation to nursing work. That is the pressure to get tasks completed or ‘focus for five minutes’. How busy is too busy to listen? Mary recognises that despite feeling torn the time taken ‘feels a lot longer than it actually is.’ This is not just an issue for nurses’, within the healthcare system there remains a focus on physical aspects of care that marginalises emotional, psychological aspects of care (Chibnall et al., 2004; Schulman-Green, 2003; Scott & Pollock, 2008; Kenny et al., 2007). Traditional work practices have tended to value task-focused interventions, with psychosocial interventions being seen as “soft” or less valuable (Schulman-Green, 2003). Again Mary’s choice here is to prioritise her ability to support this man.

Discussion

Organisational demands on the Health Professional

For Health Professionals a lack of time and the burden of a heavy workload are frequently cited barriers to the provision of psychosocial care (Watts et al., 2010; Botti et al., 2006; Kenny et al., 2007; Beckstrand et al., 2009; Frost, Brueggen & Mangan, 1997; Absolom et

al., 2011). The cultural tradition of nursing, in particular, described as task versus care is reported as a source tension when nurses recognise a need for psychosocial support (Botti et al., 2006; Kenny et al., 2007; Turner et al., 2007). This analysis adds depth to the “too busy” argument put forward in the literature. Some of the arguments strength is lost. Sharing of her story in the context of a group clinical supervision session recognises the tensions. This story also allowed Mary reposition herself as someone who despite being busy is able to listen to these concerns as a priority to particular tasks.

The literature reports that nurses’ ability to form meaningful relationships with patients is limited due organisational factors such as shorter length of stay and part-time nature of work force (Turner et al., 2007; Botti et al., 2006; Frost et al., 1997). Experienced nurses have reported working only part time and therefore not being allocated as primary nurses removing their ability to form a meaningful relationship with their patients (Botti et al., 2006). In this exemplar Mary describes a brief encounter with a person. Neither his length of stay nor the hours she works are relevant to this kind of support.

Generating new meanings

Some have argued that the evidence based practice (EBP) discourse is exclusionary. Despite the premise of improving patient outcomes there is an established hierarchy of evidence within EBP that privileges the randomized controlled trial (RCT) and excludes other ‘ways of knowing’ (Holmes et al., 2006). A socially constructed view of cancer care means that sharing stories generates shared meaning (Mezirow, 1991). The newly generated meanings allow the health professionals to reconstruct the meaning of psychosocial care from something that is not achievable to something that is. If we consider that discourses are not just groups of linked utterances, but that there are also internal rules and may also be regulated by their relationship to other discourses (Foucault, 1972). Mary’s self discourse can be seen to be challenged by and in turn challenge the organisational discourse, that is, busy and time poor. The difficult patient discourse personified or represented by the “grumpy old man” description has also been influenced by Mary’s repositioning of herself within a changed discourse. This brief example of data analysis demonstrates a method by which a complex intervention might be mapped to a broader context. Critical questioning of the data highlights the links between what is known and what is happening. Also how through the generation of new and shared meanings change could be achieved.

Conclusion

An important finding from the healthcare quality improvement research is that change is hard to achieve (Grol et al., 2007). All the same, there is a need to improve the psychosocial care of adults with cancer. This requires change in practice by individuals, systems and cultural aspects. This excerpt of a broader exploration of how discourse maps the current state of psychosocial care for adults with cancer illustrates the fragility and potential for change in this area. This change will be driven by sharing and creation of shared meaning of Health Professionals. This new meaning making has potential to transform practices and outcomes for people with cancer.

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