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The Patient as a construction and a non-participant member of a change-process.

An interpretative study of an information management project and the core in a practice.

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Abstract

The contribution of this paper is a discussion about how the patient as a phenomenon is constructed and used by employees for different purposes, enabling and inhibiting change. The employees belong to a special thinking collective that have a special thought style. How they talk about the patient is part of a unique language and an identity which allows group members to learn who knows what, what is accepted behaviour, and coordinate their activities. The thoughts presented in this paper are based on a three year interpretative case study of how a patient record is reconstructed. Data has been collected with interviews and observations. They have then been analyzed within a framework consisting of theories about social interactionism, interpretative schemes and cultural knowledge. This paper directs itself towards people working with change-projects in health care, and elsewhere. The findings indicate that the core in a practice such as “the patient comes first” has implications for how management of projects is conducted and a patient record reconstructed at the anesthesia and intensive care unit of a hospital.

Key words: The patient, anesthesia information management, social interactionism, interpretative schemes, cultural knowledge, constructionism.

Introduction

The purpose of this paper is to contribute insight into how the patient as a construction is used in connection with reconstructing a patient record, at the anesthesia and intensive care unit of a hospital. Medical work is often described as a complex, information-intensive and time-critical activity (Lundberg, 2000). To facilitate communication, cooperation and coordination it is regulated by extensive legislation, and supported by tools like patient records and X-ray pictures, that are used by a large number of actors for many different purposes (Berg, 1998, 1997; Kay and Purves, 1998). The value of the patient record is that it is the place where the critical data of the medical care, the patient history, lab results, x-ray results and so on are gathered. A physician bases decisions about care on this data and information. Patient records are tools for decision-making, but also a sort of glue that keeps the medical world together (Berg, 1998, 1997). They regulate relations between the doctor and the patient, between the doctor and the nurse as well as on many other levels in both organization and society. Today patient records on paper can be illegible or unobtainable and aggregating information from them is both labor-intensive and costly. But computerizing the patient record is expected to change all that. General practitioners and small health care units have used computerized patient records for a long time without any specific problems while computerized patient records in clinical settings are harder to find (Berg, 1998). It is supposed to be lack of leadership, costs, standards and cultural issues of secrecy and patient care that pose barriers to integrating and taking advantage of medical information in a more efficient way.

This paper directs itself towards people, both inside and outside health care, who are involved in different kinds of change projects, related to implementing new information and communication technology and improving work processes in health care settings. The section that follows will present the theoretical framework that guides this study. How work has been conducted is then described, followed by a description of the empirical site, the patient record and the patient as a construction. Then this paper ends with a discussion about implications and contributions of this research.

Social interactionism, interpretative schemes and cultural knowledge

According to symbolic interactionism, founded by the social psychologist George Mead and his student Herbert Blumer in Chicago, reality is socially constructed and defined (Blumer, 1969/1998). We participate in a social world by playing roles. By internalizing these roles, the same world becomes subjectively real to us (Berger and Luckmann, 1966/1991). We also belong to several thinking collectives (*denk-kollektiv*) each characterized by a special thought style (Fleck, 1934/1997). A thinking collective (Fleck, 1934/1997) is a group of people exchanging thoughts and ideas. They carry the history of an area of thinking, a certain amount of knowledge and a certain culture among themselves. A thinking collective can be a professional, a national or a political group of people that act within a certain framework. Normally human beings belong to several thinking collectives and sometimes they overlap.

The common features of social constructionism as well as symbolic interactionism are a rejection of a dualistic ontology, of an objectivist epistemology, of the individual as the foundation of knowledge and of language as a mirror of objective reality. Instead social constructionism and

symbolic interactionism regards subject and object as an inseparable relation. In the social construction of reality there is an ongoing dialectical process between subjective and objective reality. It can be described as externalization, objectivation and internalization. During primary socialization we internalize language, greetings and gender, things that regulate the most common activities and interactions among people. Later secondary socialization includes processes in which individuals internalize aspects of reality such as professions. As we increasingly become part of reality through primary and secondary socialization, we begin to reproduce it ourselves. So what is going on in our everyday world is an ongoing reproduction rather than an ongoing production of reality. Reality is mediated through our lived experiences. Our descriptions of phenomenon are always colored by our specific historical, cultural and linguistic understanding of reality. Social interactions between people are the primary vehicle for developing this knowledge. And language does not achieve its meaning primarily through a correspondence with objective reality, but rather through the way we socially define and use it. Mead (1934) looks at language as a principle of social organization that has made the human society possible as it presents itself today.

According to social interactionism we act towards artifacts and phenomenon on the basis of the meanings these have for us. And the meaning is derived from, or arises out of, the social interactions we have with other people. We learn how to label phenomenon and artefacts from viewing how other people in the group we belong to label these. To understand why certain things happen in an organizational setting we must therefore study how people in this setting construct and define their everyday world.

Social interactions create interpretative schemes for how to view the world and perform certain tasks and interpretative schemes influence how interactions take place. Interpretative schemes act as a kind of modalities between structures and interactions. Social structures are at the same time results of human action and the means for it-both medium and outcome. Shared understanding of the function of an artifact or a phenomenon by a group of people (structures of signification), the kind of distribution of power this artifact represents (structures of domination), and how the artifact is to be used (structures of legitimation) would all qualify as examples of social structures. Then interactions are represented by communication, exercise of power and sanctions. (Giddens, 1984, 1979)

Interpretative schemes or mental schemas is a way of organizing information about the world relevant to a particular task and can be described as a filtering mechanism. A schema can also be conceptualized as a cognitive structure that represents knowledge about a concept or type of stimulus, including its attributes and the relations among those attributes. It facilitates top-down, conceptually driven, or theory-driven processes, which means processes that are influenced by prior knowledge (Fiske and Taylor, 1991). When interpreting the information before taking a decision on how to act, a professional draws on a frame and /or a particular abstract knowledge system that he or she has acquired through studying and working (Abbott, 1988). To make sense of a phenomenon means that a human being, such as a physician, can place it in a framework that is known to him or her and construct a meaning out of it. The individual recognizes what is happening because he or she may have seen it before. A schema influences the encoding of new information, memory of old information and inferences drawn from this. A mental schema makes it easier for a person to make sense of a situation and decide how to act. Individual cognitive

schemes can combine to form an overall interpretative schema mapping relevant aspects of how an organization's experience of the world is to be understood (Ranson et al 1980), and assumptions about why events happen as they do and how people are to act (Bartunek 1984). Interpretative schemes build on shared mental models or organized bodies of knowledge that team members have in common (Kim 1997).

Categories and mental schemas allow us some sense of prediction and control, which is essential to our wellbeing. They save energy. And they make us believe that we understand the world. Stable mental schemas lend a sense of order, structure and coherence to social stimuli that otherwise might be too complex and overwhelming to make sense of. Mental schemas are difficult to change. People ignore exceptions to a schema, they even interpret the exception as proving the schema. Many of the information processing advantages of schemas would also be lost if they changed at each encounter with slightly discrepant information. But having an incorrect schema is also costly since it can make people inadequate problem solvers. The wrong schema can lead one to be inaccurate, biasing encoding, memory, and inference. But nevertheless schemas are believed to be cognitively more efficient than understanding each instance afresh (Fiske and Taylor, 1991).

Knowledge management, language, identity

Theories about knowledge management have grown out of earlier research about information management and organizational learning. Information management can be described as the management of information resources, the information of management tools and technologies, or the management of information policies and standards (Choo, 1998). Organizational learning used to focus on people and human resource management while knowledge management is supposed to be something more. It is supposed to improve "factors that lead to superior performance: organizational creativity, operational effectiveness, and quality of products and services" (Wiig, 1993). Knowledge management can also be defined as a phenomenon that "turns an unreflective practice into a reflective one by elucidating the rules guiding the activities" (Tsoukas and Vladimirou, 2001).

The practice of managing knowledge may consist of intra-organizational and /or inter-organizational activities. When mobilizing internal knowledge, information processes are managed to promote the sharing of information, conversion of tacit knowledge, experimenting and prototyping and the migration of knowledge to other parts of the organization. The transfer of knowledge from an individual to a group level might for example occur through the development of a unique language or a code which allows group members to learn who knows what, what to do and to coordinate their activities. There are three critical factors that concern knowledge integration: shared experiences, shared symbolism captured in metaphors and logos and shared artifacts. Then the effectiveness of integration mechanisms depends on the existence of a common knowledge and other forms of symbolic communication, the commonality of specialized knowledge, shared meaning and the recognition of individual knowledge domains.

The creation of new knowledge is often stimulated by a situation that identifies gaps in the existing knowledge of the organization. Such gaps stand in the way of solving a technical or task-related problem, designing a new product or service, or taking advantage of an opportunity. Choo

(1998) uses a general metaphor for knowledge creation that is “looking across many levels”. It means that new knowledge is created by sharing and shifting knowledge across many organizational levels, including individuals, groups and other organizations. Knowledge creation can be achieved through recognizing the synergistic relationship between tacit and explicit knowledge and through the design of social processes that create new knowledge by converting tacit knowledge into explicit knowledge.

As an example, Leonard Barton (1995) suggest following knowledge building activities: shared problem solving, experimenting and prototyping, implementing and integrating new processes and tools and importing knowledge from outside. When it comes to the last activity he distinguishes between external knowledge that is technical in nature and knowledge about the market. The key to importing technological knowledge is for the organization to expand its absorptive capacity by scanning broadly and continuously for technical opportunity and by identifying employees who can act as technological gatekeepers. Knowledge about the market might generate new products. This might be a challenge when the technological potential outstrips the users ability to understand it. During the activity of shared problem solving employees with different specializations and problem-solving approaches are brought together so that the diversity of their knowledge and back-ground can be channelled toward creative problem solving. As people become highly skilled they develop individual “signature skill”, which are formed from their specialization, cognitive style preferences, and preferences for particular tools or methods. Bringing people with diverse signature skills together to work on a problem generates a situation that can be fertile for innovations. When integrating and implementing new methods and tools is proprietary knowledge introduced into process tools and methods that improve internal operation. To ensure successful implementation user involvement is essential since the future users of the tool will have critical information that must be integrated during design. Through the activity of experimenting and prototyping the organization extends its existing capabilities as well as build new capabilities for the future. In situations like this ”intelligent failures” provide valuable lessons.

Choo (1995) uses two concepts for knowledge: rule-based knowledge and back-ground knowledge. Rule-based knowledge guides action by answering three questions: What kind of situation is this? What kind of person am I or What kind of organization is this? What does a person such as I, or an organization such as this, do in a situation such as this? Back-ground knowledge is knowledge that is part of the organizational culture and communicated through stories, metaphors, analogies, visions, and mission statements. Back-ground knowledge supplies the world-view by which people in the organization understand and makes sense of events, actions, objects, utterances or situations. Then cultural knowledge is a filter that helps us place a value on certain parts of knowledge and also keeps out knowledge that is deemed unimportant by the dominant group in a culture or organization. Choo (1998) describes cultural knowledge as knowledge that: *“Includes the assumptions and beliefs that are used to describe and explain reality, as well as the conventions and expectations that are used to assign value and significance to new information. These shared beliefs, norms and values form the framework in which organizational members construct reality, recognize the saliency of new information and evaluate alternative interpretations and actions”*.

Back-ground knowledge or cultural knowledge can be used intertwined and the difference between them is blurred.

The strategic knowledge of any organization lies in its long-term, knowledge-generating capabilities which it has built up over time. These capabilities are the result of the quality of its internal network of people, skills, communications, information resources, and cultural norms and the quality of its external network of relationships with customers, suppliers, distributors, information sources, and other associates.

Interpretative case study research and systematic reflection

This is an interpretative case study with the aim of exploring, describing and interpreting a phenomenon in a real-life situation (Garfinkel, 1972, Denzin, 1983). This research can also be viewed as a knowledge management project in which the meaning has been to explore and describe the core in a practice. From the beginning was the purpose to investigate how a group of people in a hospital constructed their everyday-work life in connection with reconstructing a patient record. This research wanted to find out how they talked about the project and what they perceived as important. The patient soon appeared as a core category in the interviews, relating to all other categories. (Strauss and Corbin, 1998) I therefore continued to study how the patient, as a construction was used by the employees when trying to reach certain goals.

This research takes place at the anesthesia and intensive care unit of a big university hospital. The hospital opened 1940 and has more than 9000 employees. A computerized patient record is going to be implemented at the clinic. But before that the patient record on paper must be reconstructed and adjusted according to new legislation and new demands from employees. The project leader is the head-nurse at the clinic. She says: "*We will start sketching on a new anesthesia record, for the best of the patient of course, we must be able to follow up on our work...*" The questions that the group is going to answer are: What is it that we do? What is it that we would like to document, that is not done today? How are we going to document so that it is possible to follow the course of an anesthesia? The project started during the fall of 1999 and continued until 2002. Then the management at the clinic decided to try out the reconstructed patient record for a more substantial period.

Interpretative researchers normally conduct research using ethnographic or thick descriptions of the world. In ethnographic research the researcher spends at least a year at the research site, close to what he or she studies. Thick description gives the context of an act, states the intentions and meanings that organize the action, traces the evolution and development of the act and presents the action as a text that can be interpreted (Geertz, 1973). A thin description simply reports facts, independent of the circumstances that surround the action while a thick description goes beyond fact to detail, context, emotion, and web of affiliation and micro-power (Denzin, 1983). My goal has been to give a descriptive account that is so well grounded in observational and interview data that it is possible to understand "what is going on here" and analyse "how things work" (Wolcott, 1994). I believe that a description that is "good enough" can be a diagnosis and also an explanation of what is taking place. My goal as an interpretative researcher has been to investigate, make visible and interpret how others make sense of and interpret what happens to them in their every-day world.

A problem in interpretative research is the temptation to reach far beyond the case itself in speculating about its meaning or implications. Wolcott advises new researchers that it is better to err on the side of too much description than too little interpretation. The anthropologist Clifford Geertz thinks that a good interpretation of anything—a poem, a person, a history, a ritual, an institution or a society—takes us into the heart of that of which is the interpretation. "What we call our data is really our own constructions of other peoples constructions of what they and their compatriots are up to" (Geertz, 1973).

Interviews have been both unstructured and semi-structured and done over a period of three years. This research took place during three phases. The purpose during the first phase was to achieve a general knowledge about health care, anesthesia and the patient record. During this period 2 interviews were done with the head of the clinic, 5 interviews with the chief physicians, 3 interviews with the chief nurses, 5 interviews with physicians, 5 interviews with nurses, one interview with the engineer, one interview with the secretary and three interviews with the project leader, altogether 25 interviews. The first interviews were conducted more like informal conversations discussing health care and problems related to information use and information management, with many different people. The goal was to establish a "community of interpretation" (Sandberg, 1994). Then interviews became semi-structured and oriented towards answering the purpose of this study.

I look at the outcome of interviews as something that is constructed jointly by the interviewee and myself. The interviews have a purpose but at the same time I'm open their leading in a direction I didn't expect from the beginning. My role as a researcher has been influenced by my perspective that information and knowledge is important, but at the same time I have been aware of that a reconstructed patient record is just one of many urgent projects for the employees at the clinic. When I came to the interviews I had a few questions on a paper but never a complete interview protocol. The interviews have rarely taken more than one hour.

During the second phase of the research project I went through the interviews identifying categories, as suggested by Corbin and Strauss (1998). Following six categories were generated: the patient, performing anesthesia work, using the anesthesia patient record, reconstructing the anesthesia patient record, reactions to the reconstructed patient record and health care. I then singled out all sentences in each category in which the word the patient appeared. The findings have then been analysed, interpreted and discussed using the theoretical framework reported above. In an interpretative study truth depends on the perspective taken. One final truth does not exist. Sandberg (1995) writes that achieving truth within the interpretative research tradition is an ongoing and open process of knowledge claims correcting each other. Inspired by Sandberg (1994) I have tried to apply "communicative and pragmatic validity" and "reliability as interpretative awareness" to the results in this study. Communicative validity involves establishing an ongoing dialogue in which conflicting knowledge claims are debated throughout the research process. Oral descriptions of what is important in anesthesia work have been generated and transformed into text. Then when analyzing the descriptions generated, the researcher must communicate with the text in order to achieve descriptions of any value. A third way of validating my interpretations has been through dialogue with other researchers and professionals in the practice being investigated. Pragmatic validity involves testing the knowledge produced in action. According to Sandberg (2000) striving for pragmatic validity

increases the likelihood of capturing knowledge in action rather than “espoused theories” about what is going on. Pragmatic validity has been achieved by observing the people at work and comparing what I have observed with what they have said in the interviews, and then observing their reactions to my interpretations of some of their statements. The concept, “reliability as interpretative awareness”, means that a researcher cannot escape from his or her interpretation but must deal with them throughout the research process.

During the **third and last phase** I have used systematic reflection to achieve interpretative awareness. For me that has meant giving myself time to go through all my interviews from the beginning, reflecting over what people have said and letting ideas I have had about the material mature. To address questions of validity and reliability audio and videorecording have been used. I have tried to give a detailed description of the phenomenon studied and extracts in the text from interviews. To assess the relevance of results stakeholder checks have been used. They involve opportunities for people with a specific interest in the research to comment on categories or the interpretations that have been made. A thesis about what is valuable for the people researched has been constructed. If they recognize what has been perceived as important, I believe that my research has substance and is of value.

Anesthesia work and the patient record

An anesthetist evaluates the patient before surgery to see if the patient can go through with surgery or not. He or she then puts the patient to sleep in the OR, the operation room, manages breathing during and pain after the surgery. In the OR an anesthetist is required to rapidly interpret and respond to a large number of clinical parameters, selecting appropriate treatment for the patient among many different options. An anesthetist records something called *vital signs*. That is the degree of oxygen in the blood, heart frequency, medication, degree of awareness and pain. About 90% of an anesthetist's time is used for registering pulse and blood-pressure. This is done every fifth minute during surgery in normal situations and every minute in stressful situations. The degree of oxygen is registered once every fifteen minutes. The substance anaesthetica is injected by the anesthetist and then monitored by the nurse. It is a general saying that the anesthetist is the one that “sees the human being” in the patient. He or she uses the patient record for information but it is also important for an anesthetist to be able to keep her eyes on the patient during surgery.

A patient record is an artifact, a tool used in connection with decision-support both for the physician and the nurse and it contains high quality information. “*It is a diagnostic instrument and also a therapeutic instrument*”. “*To write a good record means to describe a problem in such a way that a diagnosis or several can be presented on how to solve this problem*”. (Excerpt from interview with a physician) Different specialists use and write patient records differently. Psychiatric and medical records can be described as a sort of extensive narratives about the patients while an anesthesia record is highly technical and only shows a curve and what has happened with certain parameters during surgery. Practical knowledge, like writing a patient record, has to do with rule-following, judging and interpretation. A patient record can be compared with a sort of glue that keeps the medical world together and writing a patient record is part of certain rituals that creates and constructs the day of a medical doctor. What is recorded in a patient record is characterized by a special thought style, a style that has developed among a

medical collective. The anesthesia patient record consists of three parts: the perioperative record, the anesthesia curve and the anesthesia report. The first one is produced during evaluation/risk assessment before operation and gives advice about what anaesthetics to use. The anesthesia curve is produced during surgery and characterized as a technical record that shows what happens with the vital signs. *“The first my eyes focus on in the record are pulse and bloodpressure”* (excerpt from interview with a physician). After surgery a report is produced about the course of the anesthesia. This is a process that traditionally has required manual documentation but now new measurement technology has increased the demand for improved information management.

The patient as a phenomenon and a construction

Health care as well as anesthesia can be described as a thinking collective characterized by a certain culture and rule-based knowledge. Members of a thinking collective have a special thought style and use certain words when relating to everyday life. In private business “profit” can be looked at as a goal, a reason for existing. But in health care profit is not a goal. To make the patient healthy is instead the goal for health care employees. The first thing one notices when going through the research data connected to the project of reconstructing a patient record is how often the word “the patient” is used in conversations and texts. It represents a main theme and fits the criteria of being a central category (Strauss and Corbin, 1998). It is central; all other major categories can be related to it and it appears frequently in the data. The patient is constructed as kind, deserving better, as having a lot of patience. And it is disgusting to call the patient a customer or client, since the patient does not have a choice. The patient is described by health care employees as being “owned” by the health care system.

1. “We will start sketching on a new anesthesia record, for the best of the patient of course, we must be able to go back and do follow ups...”
2. “Optimal information-level that is optimal for the patient and that you self can read the next time without having to guess what happened.”
3. “The patient comes first...”
4. “The clinical eye weakens-you forget the patient.”
5. “ To have to write all those search-words is difficult-I have not time to see the patient.”
6. “I used to know every millimetre of the patient”
7. “The core business is to put the patient to sleep”.
8. “I manages the breathing for the patient”.
9. “We takes care of and protects the patient...”
10. “The patient comes first, then you document what you have kept in your head:”
11. “The patient comes first, we do not want to take of the patients time, it’s been ok before, what’s the use?”
12. “...and then they say, let’s call the patient a customer...then you go crazy. A customer can actually go out on the streets and order what he want’s with his money...”
13. “...most people, myself included likes the patient...it is almost a bit strange how well the general health car employees wishes his patient, and if they don’t do that from the beginning...they are trained into wishing the patient the best...”
14. “...most patients are very kind and have a lot of patience, they deserves better...”
15. “...a customer is a disgusting expression for a patient...”
16. “...the problem is that health care as a collective owns the patient...”
17. “It is everybody’s anesthesia record and most of all the patients and it is important that the right things are noted there that is of use, most of all for the patient.”

Figure 1 Excerpts from interviews

Figure 1 gives examples of how the word the patient is used in interviews and in figure 2 the word is related to categories developed during open coding.

When performing anesthesia work “the patient comes first”. “The patient comes first” is a norm that is supposed to guide action. In this case it is a norm for explanation but not always use. How the patient as a construction is used is part of the back-ground knowledge or cultural knowledge in this organizational setting. An interpretative scheme for how to talk about the patient influences the discourse and how communication and interaction take place. The core business in anesthesia is to put the patient to sleep. An anesthesiologist manages breathing for the patient during surgery. The anesthesiologist and the anesthesia nurse also take care of and protect the patient during surgery. And attending to the patient is supposed to come before documenting. That is how the profession of performing anesthesia work is constructed.

Emergencies always have to do with patients and since the patient comes first everything else have to wait. Other important properties of anesthesia work are to care for and protect the patient. “*Patient safety*” is also used for not implementing an information system and for not doing many needed changes. One of the informants describes how the employees within health care are socialized into thinking that the patient comes first... “*...most people, my self included like the patient, it is almost a bit strange how well the general health care employee wishes his patient, and if they don't do that from the beginning...they are trained into wishing the patient the best...*” A reorganization, that takes place at the clinic at the same time as the project I explore is also described as a “*patient-oriented*” change. It is done so that the anesthesiologist should be able to remember the name of her patients. The reorganization is described like this: “*One should work one self into the patient group and the diagnosis, and stream-line the information flow. One should not have to run around and “save” situations. One should feel that one has taken good care of the patient*”. (Excerpt from interview with the head of the clinic).

There is a value in documenting for the anesthesiologist. He or she is forced to document according to legislation and forced to reconstruct the patient record according to new legislation. The value of computerizing the patient record is that the anesthesiologist should not document to optimistic numbers as happens when he or she has to do it later, be able to read what is written in the patient record and search for trends in the history of the patient's condition. It is also sometimes useful for the anesthesiologist to go back and see how the patient was anesthetized the last time he or she was going through surgery. Documenting is done in intervals during surgery. What is written in the patient record is sometimes also used during education when the employees goes back and discuss cases. How to write a patient record is learned when a physician or nurse is socialized into his or her profession. Changing the document is not that easy since it requires parallel processes during surgery. That is a risky situation according to most employees involved. What is documented in the anesthesia patient record is what is called vital signs. Among them are bloodpressure and pulse and level of oxygen.

Performing Anesthesia Work	Using the Anesthesia Patient Record	Reconstructing the Anesthesia Patient Record	Reactions to the reconstructed Patient Record	Health Care
“The patient comes first...”	“The patient comes first, then you document what you have in your head”.	“We will start sketching on a new Anesthesia Patient Record, for the best of the patient of course, we must be able to go back and do follow ups...”	“The clinical eye weakens-you forget about the patient”	“...and then they say, lets call the patient a customer...then you go crazy. A customer can actually go out on the street and order what he wants with his money...”
“The core business is to put the patient to sleep”		“Optimal information level, that is optimal for the patient and that you yourself can read the next time, without having to guess what happened...”	“To have to write all those search-words is difficult-I have no time to see the patient.”	“...most people, my self included like the patient, it is almost a bit strange how well the general health care employee wishes his patient, and if they don't do that from the beginning...they are trained into wishing the patient the best...”
“I manages breathing for the patient”		“The patient comes first, we do not want to take of the patients time, it's been OK before, what's the use?”	“I used to know every millimeter of the patient”.	“...most patients are very kind and have a lot of patience, they deserve better...”
“We takes care of and protects the patient...”		“It's everybody's Anesthesia Record, and most of all the patients and it is important that the right things are noted there that is of use, most of all for the patient...”		“ a customer is a disgusting expression for a patient...”
				“...the problem is that health care as a collective owns the patient...”

Figure 2 Excerpts from interviews related to categories

When it comes to reconstructing the anesthesia patient record the project-group searches for the optimal information level, of course for the best of the patient. But now the first contradictory statement appears. At the same time they do not want to take time away from the patient working in a change-project such as the project of upgrading a patient record. The employees ask

themselves “what’s the use”. What is the use of changing the document? It worked like it was before.

When it comes to reactions to the transformed patient record they are suddenly all negative. The employees have no time to observe the patient because of the new patient record. The clinical eye weakens. They do not know the patient anymore. There is a conflict in that everything is done for the patient but at the same time health care as a collective owns the patient. Change processes are difficult because employees do not want to “*take time*” from the patient. The new patient record is difficult to use because “*the patient comes first*”. But at the same time change processes are initiated because of the patient. “*We will start sketching on a new anesthesia patient record, for the best of the patient of course...*” So the difficult period here is when the project group want to try out the new patient record. Employees prefers to continue using the old record since it caves less energy from them to do the same thing they have done for several years now. In the reconstructed patient record they have to search for where to fill in information since they are not used to how the record looks like.

Comments related to health care in general picture the patient as kind, having a lot of patience and “owned” by the health care system. This is contradictory to the norm that “the patient comes first”. One of the physicians also says that it is disgusting to start labelling the patient a customer since the patient doesn’t have a choice. She or he cannot go out on the street and shop for what he or she wants as a customer is supposed to be able to do. That the patient is “owned” by the health care system is an interesting comment in reference to what I theorize about here, that the patient is used by different stake-holder groups to forwards their own interests.

Implications of research and discussion

This research takes place among a group of employees in a very specific organizational setting, the anesthesia and intensive care unit. It is a knowledge management project and the purpose has been to identify a core in a practice and find out how it influences the project of reconstructing a patient record. In this setting the core norm is that the patient comes first. But what does it really mean that the patient comes first? And more importantly does the patient really come first? The contribution of this paper is to suggest that the patient as a phenomenon is used for many different purposes by different stake-holder groups. Some of these might even delay or make difficulties in connection with finishing the project of reconstructing the patient record successfully. The patient is used according to what the anesthetist perceives as his or her professional identity.

The purpose of writing this paper has been to create awareness of how health care employees might use the patient to avoid needed change processes. But they might also use the patient for pushing for improvements. The patient as a construction might be used to exercise power and dominate over the outcome of the change-project in this study. I conclude that the employees use the patient to legitimate certain behaviour. The implications of what is presented in this paper are that we should question the motives for some of the behaviour we may see during change processes. There is a need for an awareness of that there is a core in every practice that might influence the behaviour of the employees and how they act when change takes place.

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