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Abstract

This paper contributes a discussion of how the concept of *the patient* is constructed and used by employees for different purposes enabling or disabling change in health-care. The findings suggest that the core expression in a practice such as “*the patient comes first*” has implications for how management of change-projects are conducted and how a patient-record is reconstructed in a hospital. The results presented in this paper are based on a three year interpretative study of how a patient record was computerized in two different cases. The questions asked were: How is the patient constructed? Why is the patient constructed like she is? When is the patient constructed in the way that she is? Data has been collected using interviews and then analyzed within a framework consisting of theories about social life as a multi-stage drama, thought collectives and institutional talk. The results show that in the first instance the expression “*the patient comes first*” was used to manipulate the project in various directions and in the second instance it was used to delay the project indefinitely. One of the implications of this research is that the motives behind some of the behavior that might be observed during change processes in health care should be questioned.

Introduction

Medical work has been 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 such as 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 where critical data concerning medical care, patient history, lab results, x-ray results and so on are gathered. 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 patient, between doctor and nurse, as well as on many other levels in both organization and society. The purpose of this research is to contribute insight for the first time into how the patient is used as a construction in connection with a change project such as reconstructing a patient record at the anesthesia and intensive-care unit of a hospital. The questions asked are: How is the patient constructed? Why is the patient constructed in the way that she is? When is the patient constructed in the way that she is? The word “construction” is used in this study as it is in ‘The Social Construction of Reality’ (Berger, P. L., and Luckmann, T., 1966). The authors argue that all knowledge, even basic daily knowledge is derived from and maintained by social interactions. When people interact, they do so with the understanding that their respective perceptions of reality are related, and in acting upon this, their common knowledge of reality becomes reinforced.

The purpose of this research rests on an assumption, based on what this

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The purpose of this research rests on an assumption, based on what this author observed during other research projects, that the patient as a construction might be used by employees for doing or not doing certain things that are in the interest of the employees, but not the patient. Earlier research has focused on how the patient is constructed in a therapeutic relationship in general practice, as a gendered patient, as a consumer, as being difficult, in relationship to the doctor and in different types of medical narratives (C May, C Dowrick, 1996; C Foss, J Sundby, 2003; GA Sulik, A Eich-Kroh, 2001; JS Gans, A Alonso, 1998; S Eggly, 2002).

This paper is meant to be thought provoking and is directed at researchers focusing on how the patient is constructed in health care and people who are involved in different kinds of projects related to improving work processes in health care settings. It is also meant to add another angle to how the patient is viewed and constructed in different situations in society. This research is relevant as so many change projects take place in health care, and nowadays change is a continuous part of everyday life.

The section that follows presents symbolic interactionism and a theoretical framework consisting of theories about thought collectives, communication as institutional talk and social life as a multi stage drama that guides this study. Research design and how research has been conducted in this case study is then reported. The researcher applies the theoretical framework to the empirical data in the analysis. The paper subsequently ends with a section that focuses on conclusions and a discussion of the implications of this research and the contributions it makes.

Thought collectives, communication as institutional talk and social life as a multi stage drama

To fulfil the purpose of this study and to answer the questions set, a theoretical framework has been compiled, influenced by symbolic interactionism and consisting of theories about thought collectives (Fleck, L., 1934/1997), communication as institutional talk (Norrby, C., 1996; Agar, M. 1985; Heritage, J., Maynard, D. W., 2006; Mishler, E.G., 1984) and theories about social life as a multi stage drama in which the participants perform different roles. Life in a hospital can be described as an ongoing drama performed by doctors, nurses and others who have learned how to think, talk and behave in a certain way. They belong to a thought collective. Symbolic interactionism, communication as institutional talk and theories about life as a multi stage drama are described in more detail in the following sections.

Symbolic interactionism and thought collectives

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, H., 1969/1998). Human beings participate in a social world by playing roles. Internalizing these roles enables the same world to

become subjectively real to human beings (Berger, P.T., and Luckmann, T., 1966/1991). According to social interactionism, humans act towards artifacts and phenomena on the basis of the meanings these have for humans. And that meaning is derived from, or arises out of the social interactions humans have with other people. Humans also belong to several thought collectives (denkkollektiv), each characterized by a special thought style (Fleck, L., 1934/1997).

A thought collective 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 thought collective can be a professional, a national or a political group of people acting within a certain framework. Human beings normally belong to several thought collectives and they sometimes overlap.

Communication as institutional talk

Communication is the process of using messages to generate meaning (Pearson, J.C., Nelson, P.E, Titsworth, S., Harter, L., 2006). Communication is a complex process in which thoughts are formed through talking and then socially produced (Norrby, C.,1996). Both parties must have a mutual understanding of the message (the encoding) for the receiver to succeed in understanding (decoding) it. The culture of individuals influences their processing of perceptions and interpretation of reality and the ways in which they create meaning. Verbal or non-verbal codes are systems suitable for creating messages. Nonverbal behavior is a powerful medium for conveying meaning during communication especially when there is a contradiction between verbal and non-verbal messages (Norrby, C., 1996).

In institutional talk, the power differential in relationships between two persons, which can be defined by who controls the other's behavior or thoughts, affects the degree of asymmetry. When one of the participants has the power to control the interactions there is asymmetrical communication between health professionals and patients. Independent of variations in power between health professionals and patients, health professionals must take responsibility for minimizing strain on the health professional–patient relationship, while benefiting the patient in the interaction. There is power, there is resistance and resistance cannot be understood as non-power but as a counterforce, the one who is powerless from one perspective processes power from another perspective. Patients need to be viewed as active participants rather than passive recipients in their own health care (Foucault, 1980; Playle, J.F., Keeley, P., 2001).

Patients and health professionals represent different perspectives; this can complicate their understanding of each other. Mishler's concept of institutional talk asserts that physicians often speak with a medical voice and from a biomedical perspective. Mishler also showed how health professionals shift the focus of conversation away from the patient's life–world back to the world of medicine. An institutional way of seeing the world that includes a specific way of classifying patients and their concerns informs health professionals. In order to achieve medical tasks matters involving patients life–worlds need not be re-

strained by moving the discourse to bio-medical matters. Health professionals can communicate competently in both worlds; they can speak in either the voice of the life-world or that of medicine, whereas patients can speak in only one of these voices. Health professionals therefore have the responsibility to translate patient's life-world perspectives into medical terms and medical perspectives of problems into patients terms (Mishler, E. G., 1984).

Goffman (2002) describes social life as a kind of multi stage drama in which the participants perform different roles in different social areas, depending on their particular roles in them and the nature of the situations. The participants involved can take positions as speakers, recipients, side-participants and observers (Goffman, E., 1959). Relationships with the people with whom we communicate are of great importance and how we communicate with each other always depend on the people around us. When we interpret what happens in interactions, we join different perspectives by basing our understanding on that of similar situations that we have experienced previously. For example, patients relationships with nurses or physicians are important in determining how patients communicate with them. Goffman also discusses patients roles as "nonpersons", persons with peripheral roles in relation to experts. Those who are in a position of authority often are the ones who dominate interactions (Goffman, E., 1981).

A summary of a theoretical framework

The theoretical framework that is used in this study may be summarized like this:

- What takes place at the hospital is considered a multi stage drama. The patient is a "non-person", a person with a peripheral role in relation to the doctor, when computerizing a patient-record. In this change project the doctor is in a position of authority and dominates the interactions (Goffman, E., 1981).
- This doctor belongs to a *thought collective* and has learned how to think, talk and behave in a certain way (Fleck, L., 1934/1997). The expression "*the patient comes first*" is supposed to influence and dominate action.
- In this drama, communication is a process in which thoughts are formed through talking, and are then socially produced (Norrby, C., 1996).
- Compared with daily talk, asymmetry in interaction, skills, interests and perspectives characterize institutional talk. It has rules for the drawing of conclusions and for what and for whom it is relevant. As an example, professionals are the ones who have the right to ask personal questions not the other way around.

- Patients and health professionals represent different perspectives and this complicate understanding each other. Mishler's concept of institutional talk asserts that physicians often speak with a medical voice and from a bio-medical perspective. He showed how health professionals shift the focus of conversation away from the patient's life-world back to the world of medicine. An institutional way of seeing the world that includes a specific way of classifying patients and their concerns informs health professionals. In order to achieve medical tasks matters involving patients life-worlds need not be restrained by moving the discourse to bio-medical matters. Health professionals can communicate competently in both worlds; they can speak in either the voice of the life-world or that of medicine, whereas patients can speak in only one of these voices. Health professionals therefore have the responsibility to translate patient's life-world perspectives into medical terms and medical perspectives of problems into patients terms (Mishler, E. G.,1984). They do that differently in different situations.

Method

This is an interpretative case study with the aim of exploring, describing and interpreting a phenomena in a real-life situation (Garfinkel, H., 1972, Denzin, N.,1983). Interpretative case studies may also be pictured as studies in particular localities or efforts to elicit the impact of a particular environment and the problems it presents on something researched. The purpose from the beginning was to investigate how a group of people in a hospital constructed everyday work-life in connection with reconstructing a patient record. This researcher wanted to find out how they talked about the project and what they perceived as important.

Empirical data were collected through interviews and then divided into categories. The patient soon appeared as a core category in the interviews, relating to all other categories (Strauss, A., and Corbin, J., 1998). The researcher then continued to study how the patient was used by the employees when trying to reach certain goals. The questions asked were: How is the patient constructed? Why is the patient constructed in the way that she is? When is the patient constructed in the way that she is?

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. A thick description gives the context of an act, states the intentions and meanings that organizes the action, traces the evolution and development of the act and presents the action as a text that can be interpreted (Geertz, C., 1973). A thin description simply reports facts, independent of the circumstances that surround the action while a thick description goes beyond facts to detail, context, emotion, and web of affli-

ation and micro-power (Denzin, N., 1983). In this case the goal has been to give a descriptive account that is so grounded in observational and interview data that it is possible to understand “what is going on here” and analyze “how things work” (Wolcott, H., 1994). This researcher believes that a description that is “good enough” can be a diagnosis and also an explanation of what is taking place. The goal has been to investigate, make visible and interpret how others make sense of and interpret what happens to them in their every-day world.

Two cases

This research takes place at the Anesthesia and Intensive Care unit of two different hospitals. The first case was chosen because this researcher was informed that they were implementing a new patient record by the head of the clinic, when discussing what to focus on in a possible research project. The second case was presented in a newspaper as the most expensive hospital project ever by that time. At this hospital the anesthesia patient record was the last patient record to be computerized. But before that the patient record on paper has to be reconstructed and adjusted according to new legislation and new demands from employees.

Research design

Work has been done in this project over a period of three years and during three phases. The purpose during the **first phase** was to achieve a general knowledge about health care, anesthesia and the patient record. At the first hospital two 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. At the second hospital five interviews were made with the project leader and two physicians and two nurses.

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, J., 1994). Then the interviews became more focused on the patient and the change process itself. During the **second phase** the analysis took place and the researcher 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. The researcher then singled out all sentences in each category in which the word the patient appeared.

The findings have then been analyzed, interpreted and discussed using the theoretical framework reported above. During **the third** and last phase systematic reflection has been used to achieve interpretative awareness. For this researcher that has meant time to go through all interviews from the beginning, reflecting

over what people have said and letting ideas about the empirical data mature. The aim has been to give a detailed description of the phenomena studied and extracts in the text from interviews. A seminar has been held with the interviewees asking for feedback and recognition.

Communicative and pragmatic validity

In an interpretative study truth depends on the perspective taken. Sandberg (1995) writes that to achieve truth within the interpretative research tradition is an ongoing and open process of knowledge claims correcting each other. Inspired by Sandberg (1994) I have applied “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 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 have been observed with what they have said in the interviews, and then observing their reactions to the researchers 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. 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 interpretations that have been made. A thesis about what is valuable for people researched and how they talk about the patient the way they do and why, has been constructed. Since they recognize what have been perceived as important I believe that this research has substance and is of value.

Analysis and findings

Analysis of the empirical data took place like this: (1) First all the sentences that included the word “patient” were selected and presented in a figure. The patient was identified as a core-category. (2) Then the sentences including the word “patient” were divided into five categories: Performing Anesthesia Work, Using the Anesthesia Patient Record, Reconstructing the Anesthesia Patient Record, Reactions to the Reconstructed Patient Record and Health Care. (3) Then *anesthesia work* and *the patient record* are constructed, analyzed and described. (4) How the patient in general is constructed is then analyzed and described. (5)

Then a description of how the patient is constructed during the change process is presented as well as the findings.

1. First all sentences in the interviews that include the word “patient” are selected and presented

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 take care of and protects the patient...”
10. “The patient comes first, then you document what you have n 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 like the patient...it is almost a bit strange how well the general health care employees wish his patient, and if they don’t do that from the beginning...they are trained into wishing the patient the best...”

Figure 1. Sentences from interviews in which the word “patient” is used.

2. The sentences including the word “patient” are divided into categories

Then the sentences including the word “patient” are divided into five categories and presented in figure 2: Performing Anesthesia Work, Using the Anesthesia Patient Record, Reconstructing the Anesthesia Patient Record, Reactions to the Reconstructed Patient Record and Health Care. The concepts “core-category” and “category” are used as in Strauss, A and Corbin, J. (1998) In the last category Health Care the word *patient* is used in general terms. In the first category it is used as during performing anesthesia. In the second category *patient* is used as when using the patient record. In category 3 and 4 it is used as when reconstructing and reacting to the new anesthesia patient record during the change process.

A description of how anesthesia work and the patient record are constructed will be presented in the next section, then a description of how the patient nor-

mally is constructed during daily work in this setting. Finally, there is a section that describes how the patient is constructed during the change process.

1. Performing Anesthesia Work	2. Using the Anesthesia Patient Record	3. Reconstructing the Anesthesia Patient Record
"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 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..."
"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?"
"We take care of and protect 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..."

Figure 2. Category 1-3 Quotes from interviews including the word 'patient'.

4. Reactions to the reconstructed Patient Record	5. Health Care
“The clinical eye weakens-you forget about the patient”	“... and then they say, let’s 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...”
“To have to write all those search-words is difficult-I have no time to see the patient.”	“... most people, myself 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 used to know every millimeter of the patient”.	“... most patients are very kind and have a lot of patience, they deserve better...”
“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 3. Category 4-6 Quotes from interviews including the word ‘patient’.

3. 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 awakesness and pain. About 90% of an anesthetists 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 anesthetica 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 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 (Choo, C.J., 1998, 1995) 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 anesthetics to use. The anesthesia curve is produced during surgery and characterized as a technical record that shows what happens with vital signs. "*The first my eyes focus on in the record are pulse and blood pressure*" (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.

4. The patient as a construction

Health care as well as anesthesia can be described as a thought collective (Fleck, L. 1934/1997) characterized by a certain culture and rule-based knowledge (Choo, CW. 1998, 1995). Members of this collective have a special thought style and use certain words when relating to everyday life. As an example Goffman discusses patient roles as "non-persons", persons with peripheral roles in relation to experts in interactions. Those who are in positions of authority are often the ones who dominate interactions (Goffman, E., 1981). The first thing one notice 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 a client, since the patient does not have a choice. The patient is described as being "*owned*" by the health care system.

The core business in anesthesia is to put the patient to sleep. An anesthetist manages breathing for the patient during surgery. The anesthetist and the anes-

thetia 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. 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 background knowledge or cultural knowledge in this organizational setting (Choo, CJ, 1998, 1995). Emergencies always have to do with patients and since the patient comes first everything else has to wait. Other important properties of anesthesia work are to care for and protect the patient.

5. How the patient is constructed during the change process

In this change project "*Patient safety*" is used for not implementing an information system and for not doing many needed changes since "*The patient comes first*". One of the informants describes how the employees within health care are socialized into thinking that the patient comes first... "*...most people, myself 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 that is researched in in this paper is also described as a "*patient-oriented*" change. It is done so that the anesthetist should be able to remember the name of her patients. The reorganization is described like this: "*One should work oneself 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).

An anesthetist 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 anesthetist should not document to optimistic numbers as happens when he or she documents later, be able to read what is written in the patient record, and search for trends in the history of the condition of patients. Sometimes it is also useful for the anesthetist to be able to go back and read how the patient was anesthetized the last time he or she went through surgery. Documenting takes place in intervals during surgery. What is written in the patient record is sometimes also used during education when employees 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.

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 statements 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 earlier.

One can say that the employees try to send a message in an effort to generate meaning of what is taking place (Pearson, J.C., Nelson, P.E., Titsworth, S., Harter, L., 2006). Also nonverbal behavior is a medium for conveying meaning during communication, especially when there is a contradiction between verbal and non-verbal messages (Norrby, C., 1996) When it comes to reactions to the transformed patient record they are suddenly all negative. The employees have no time to take care of 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 since 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..." The difficult period is when the project group wants to try out the new patient record. Employees prefers to continue using the old record since it demands less energy to do the same thing that 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 new 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 labeling the patient a customer or a client since the patient often doesn't have a choice when it comes to picking a care-giver. 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 is theorized about here, that the patient is used by different stake-holder groups to forwards their own interests.

6. Findings

From the empirical data have following findings been found:

- The patient is constructed in two contradictory ways in this research. First the patient is constructed as kind and *owned* by the health-care system. At the same time the patient is supposed to *come first*.
- The patient is constructed like this since the doctors know that they often manipulate and use the patient to forward their own interests in many change-projects. But according to the culture they are socialized into the patient is supposed to *come first*.
- The patient is constructed as *owned* by the health-care system in daily work-life but according to the culture the patient comes *first* when the doctors want to influence a

change process. The patient as a construction might be used to exercise power and dominate over the outcome of a project such as the one in this study. Health care employees might use the patient to avoid various and necessary changes. But employees might also use the patient when pushing for improvement. In the first case the construction "*the patient comes first*" is used for manipulating the project in different directions and in the second case it is used for stopping and delaying the project indefinitely.

- Therefore, another finding is that one should question the motives behind some of the behavior one might see during change processes in health care settings.

Conclusions and discussion

This research takes place among a group of employees in a very specific organizational setting, the anesthesia and intensive care unit of a hospital. The core in the culture and a norm in this setting is that *the patient comes first*. But what does it mean that the patient comes first? And more importantly, does the patient really come first? There is a conflict in how the patient is constructed by the employees. The patient is first of all constructed as kind, deserving better and having a lot of patience, in this research. Also the patient does not have a choice in this health care system. He or she is 'owned' by the system and should not be called a customer or a client. At the same time '*the patient comes first*'. Everything that happens in this setting should be guided by concern for the patient, according to the employees. So, in general the patient is constructed as kind and having a lot of patience with what takes place in health-care. But suddenly the patient comes first when the physicians do not want to implement a new and computerized patient-record. It seems that the patient is described like this to justify the attitude physicians have toward the new patient record. To implement a new patient record takes a lot of energy away from the patient. Since '*the patient comes first*' the physicians decides to protest against the change project.

The contribution of this paper is a suggestion that *the patient* as a construction might be used for various purposes by different stakeholder groups. Some of these might even want to delay or make difficulties in connection with the project of reconstructing the patient record. Instead patients might be used according to what the anesthetists perceive as the best for his or her professional identity and not for the best of the patient. The patient as a construction might be used to exercise power and dominate over the outcome of a project such as the one in this study. But the employees might of course also use the patient when pushing for improvements and needed changes. This researcher concludes that employees use the patient to legitimate certain behavior, sometimes good and sometimes bad but most of the time in their own interest.

The purpose of this paper has been to create awareness of how health care employees might use patients to avoid necessary changes. One of the implica-

tions of what is presented is that one should question the motives behind some of the behavior one might see during change processes in health care settings. Since change is a continuous part of both society and health care this researcher considers the results in this study relevant and hope they will be useful for employees in the health care sector.

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