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Sensemaking and the co-production of safety: a qualitative study of primary medical care patients

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Abstract This study explores the ways in which patients make sense of ‘safety’ in the context of primary medical care. Drawing on qualitative interviews with primary care patients, we reveal patients’ conceptualisation of safety as fluid, contingent, multi-dimensional, and negotiated. Participant accounts drew attention to a largely invisible and inaccessible (but taken for granted) architecture of safety, the importance of psycho-social as well as physical dimensions and the interactions between them, informal strategies for negotiating safety, and the moral dimension of safety. Participants reported being proactive in taking action to protect themselves from potential harm. The somewhat routinised and predictable nature of the primary medical care consultation, which is very different from ‘one off’ inpatient spells, meant that patients were not passive recipients of care. Instead they had a stock of accumulated knowledge and experience to inform their actions. In addition to highlighting the differences and similarities between hospital and primary care settings, the study suggests that a broad conceptualisation of patient safety is required, which encompasses the safety concerns of patients in primary care settings.

Keywords: safety, primary care, quality of care

Introduction

Studies investigating primary care patients’ understandings of safety have been largely concerned with how patients define errors in their care and reveal that the scope of patient reported harms and their causes tends to be wider than that recognised by healthcare professionals (e.g. Burgess *et al.* 2012, Kuzel *et al.* 2004). However, patient safety is broader than

absence of error (Amalberti *et al.* 2011), not all errors result in harm and not all harm is the result of error (Vincent *et al.* 2013).

Recent sociological work has exposed the ways in which ‘medical errors’ and ‘safety’ are continually and contingently re/defined and re/negotiated by practitioners (e.g. Hor *et al.* 2010, Yeung and Dixon-Woods 2010). Thus, safety can be perceived as an on-going, practical accomplishment of health professionals interacting with each other, their resources, spaces and tasks in the course of their work (e.g. McDonald *et al.* 2006, Mesman 2009). More recently there has been recognition of the role of patients and their friends and family in the co-production of healthcare safety (Doherty and Saunders 2013, Hor *et al.* 2013, Hrisos and Thomson 2013). This means that, as ‘safety’ involves professionals and relevant lay people in a re/negotiation and re/definition process, it can never be ‘fully mapped out *a priori*’ through prospective design (Iedema *et al.* 2006: 1210).

Patients’ perspectives and experiences of safety are likely to vary in different contexts. Existing work has tended to be based on hospital or hospice settings. However, primary care is an important domain for researching patients’ perspectives, as it provides direct access to medical professionals. As a first contact point, many consultations are mainly initiated by patients, and medical expertise in primary care is of a generalist nature unlike for example, more specialised hospital care. Although surveillance has increased in this setting (Chew-Graham *et al.* 2013), for conditions which are not subject to financial incentives, care may be less systematised (McDonald *et al.* 2013). Yet little sociologically informed work has examined this topic.

Sensemaking and safety

Various studies have used Weick’s (1995) concept of sensemaking as a lens through which to view professional behaviours and actions in relation to patient safety. For example, Doherty and Saunders (2013) have examined elective surgical patients’ sensemaking and the implications of this for the co-construction of safety. According to Weick, sensemaking is the process by which people enact their environments. It requires an articulation of the unknown in order to make sense of complexity, ‘turning circumstances into a situation that is comprehended explicitly in words and serves as a springboard to action’ (Weick 2005: 409). Sensemaking is a social process with individuals interacting with people and objects to interpret their surroundings. Whilst some have depicted this as a cognitive information processing activity (Weick 1995), more recently there has been an emphasis on the emotional and embodied aspects of sensemaking (Cunliffe and Coupland 2012). As we discuss later, not everybody has a fully formed set of views on safety in primary care. Indeed, for many, an assumption that primary healthcare settings are safe (Fotaki 2014) may indicate lack of prior reflection on the topic of their safety. Asking people to talk about their experiences and perceptions in this context is a way of tapping into and prompting their sensemaking processes. Sensemaking is about action, as much as it is about talk. Yet being able to articulate one’s perceptions is a key part of the sensemaking process.

Sensemaking has implications not just for how we see the world around us, but also for our understanding of who we are. To maintain our self-esteem and approval of others we must tell stories which fit with the wider environment. Individuals are not social dopes but they make sense of the world in the context of their personal life and experiences, which means that they may be subject to ‘taken for granted’ beliefs about the ‘natural order’ of things. In the context of knowledge asymmetry, there may be a readiness to defer to medical professionals. A breach or disruption to normal activities, which means that available cues and frameworks are insufficient to facilitate immediate understanding, is likely to prompt sensemaking of a more episodic

nature (Weick 2012). This has been seen to occur when individuals spend time as hospital inpatients, a setting which is largely unfamiliar to them, and where control has to be surrendered to medical protocols and treatment procedures. Doherty and Saunders (2013: 35) describe the surgical patients in their study as vulnerable and uncertain, passive and subordinate making 'excuses to mitigate any negative inferences that could be attributed to clinicians' actions'. Compared with hospital settings, people have much more experience of primary medical care encounters, with visits to the local general practice following routines and patterns, which are to some extent predictable. The nature of primary care then, arguably offers more opportunities for action than is the case in secondary care.

In this paper, therefore, we ask how individuals make sense of their experiences of primary medical care and how that sensemaking shapes and reshapes their conceptualisation of safety. We also ask to what extent this resonates with findings (Doherty and Saunders 2013) about the way hospital patients engage in sensemaking and co-production of safety.

Methods

Ethics approval was provided by the Proportionate Review Sub-Committee of the National Research Ethics Service (NRES) Committee London – City & East, REC reference: 12/LO/1588. Participants were initially recruited through five general practices in the northwest of England. We aimed to have a maximum variation sample according to age, education level, carer status, socioeconomic and ethnic background. We deliberately over-sampled for people with multiple long-term conditions, due to increased vulnerability to patient safety incidents (Scobie 2010).

Fourteen men and 24 women were interviewed and age ranged from 18 to 78 years (60% over 50 years). Fifteen people were recruited through their practice, the remainder through snowballing. Participants were registered with 19 practices across the northwest of England. Participants had visited their GP an average of 5 times (range = 1–12). Twenty-five respondents had one or more long term conditions, 12 of whom had more than one condition.

Interviews were mostly conducted in participants' homes, depending on preference; and all participants signed a consent form. All interviews were conducted by the same person (PR), lasted between 30 minutes and 2 hours, were audio-recorded and transcribed. Participants were asked basic socio-demographic details (age, marital status, length of time at current practice, number of visits to practice in past 12 months, presence of long term conditions). A topic guide was developed and interviews began with broad questions, (e.g. 'If I mention patient safety in general practice, what would you think of?'). We deliberately did not frame questions around formal concepts such as 'error' or 'harm', and, in order to elicit their own understandings, participants were enabled to introduce topics they considered relevant. Patient initiated topics included access, continuity, privacy and doctors' manner. As it became apparent that perceptions of quality and safety were often interlinked, later interviews sought to unpick the distinction. Where there was ambiguity, the interviewer sought clarification.

All transcripts were anonymised with participants identified by gender (M/F) and assigned a unique identification number. Transcripts were entered into NVivo10 (qualitative data software package; Brisbane, QS International) and analysed thematically and iteratively, drawing on grounded theory techniques to generate open codes which were constantly compared across cases (Corbin and Strauss 2008). We used memos and team discussions to distil the core themes and to identify and discuss unusual cases. Initial coding was carried out by one author (PR) and selected transcripts were read and coded by additional authors to identify key themes. Sixty four first order codes were categorised within seven main themes comprising:

physical, psychological and interpersonal safety; medical safety; communication safety; systems safety; timely access; holistic care and relationship continuity; flexibility in the interpretation of rules. Through further analysis and discussion, these initial themes were distilled into three core themes: (i) trust and psycho-social aspects of professional-patient relationships; (ii) choice, continuity, access and the temporal underpinnings for safety and (iii) organisational and systems-level tensions constraining safety. The main findings in relation to these core themes have been reported elsewhere (Rhodes *et al.* 2014, 2015). However, for this paper, we have reanalysed the data using Weick's framework to understand sensemaking around primary care patient safety amongst primary care patients.

Findings

The narratives in policy and academic literatures about safety in primary care tend to focus on designing and maintaining safe systems and disseminating guidelines aimed at reducing error. The accounts of patients suggested a somewhat different conceptualisation of safety, as we describe below.

Sensemaking and the articulation of safety

When initially asked how they understood safety in primary care, people were unsure how to respond and would throw the question back:

What do you mean by safety issues? (F.25)

I don't know what we mean by patient safety. (F.06)

Many responses seemed to be suggestive of the work to make sense of this concept that they had not previously thought about in any depth:

To be honest you never really think about it, do you, until asked. (F.31)

I'd never thought about the safety implications. (F.32)

First thoughts were often about the risks posed by other patients or features of the physical environment, such as dangerous stairs:

I think there's a safety issue around other patients actually as well . . . it has a very cramped waiting room and sometimes people are coughing and spluttering, et cetera, and, if you're immuno-suppressed, you wouldn't necessarily want to sit next to them. And also, when people get very uptight in a GP surgery, it can be a bit unnerving. (F.18)

Before my practice moved to where they are now, they were in an old house with a very, very steep a staircase with very short treads. It was designed to suit people in the 1830s when people were much smaller. (F.05)

Medical competence, seen as the effective application of abstract, encoded knowledge (Nettleton *et al.* 2008), was considered a prerequisite for safety:

Top – safety in terms of my definition, you know, professional competence, the current practical knowledge and peer reviews of performance of that sort – if all that is embraced in

safety, then it's at the top – more important than accessibility, length of time you've got to wait for an appointment, much, much more important than that. The reason that I go to the doctor is because I trust that he is able to deal with me confidently. (M.01)

Participants found it difficult to disentangle safety from quality. Many aspects of care or service appreciated in terms of quality were also aspects that made them feel safe. Systems for allocating appointments on a 'first come, first served' basis, for example, were thought to be unfair on the grounds that not all patients are able to take equal advantage of them, and became unsafe when patients in genuine need of rapid access were unable to obtain it, as happened to one patient who was subsequently admitted to hospital as an emergency.

Accessibility embraced more than the ease or difficulty of obtaining an appointment. References to accessibility included the extent to which patients felt confident in approaching the service in the first place, what one person referred to as 'approachability'. 'Approachability' included references to the physical environment, and the manner and attitude of reception staff (Swinglehurst *et al.*, 2011):

Approachability, meaning a welcoming environment, a good receptionist, an efficient process of booking in, a good appointment system, a variety of general practitioners. (F.06)

As we have written elsewhere, participants' perspectives on safety within primary care comprised psycho-social as well as physical dimensions (Rhodes *et al.* 2015). Psycho-social safety is essentially a relational concept generated both from people's expectations about how a forthcoming relationship might unfold and the interaction within that unfolding relationship, which can reinforce or confound expectations. Many participants for example, described a need for doctors to take time in a context of patient vulnerability:

So I don't want to be with someone that just palms me off, because they haven't got the time ... for someone who comes in and is projecting as fragile and vulnerable. (F.25)

Sensemaking from experience: reflecting on safety in practice

Although people often had difficulty thinking about safety in the abstract, they were more confident in describing specific situations in which they had felt unsafe:

What was handled badly was him not taking my daughter being ill seriously ... And it meant that I felt that I couldn't go back to the GPs because I would just be told, 'Well, what are you worried about?'

Interviewer: So you felt you had no option but to go the hospital route?

Respondent: Yes, and that's what my friends were telling me, 'You'll just have to take her to hospital'. So I felt kind of unsupported, if you like, as a result. (F.07) (Mother whose child was eventually diagnosed at the hospital with a form of encephalitis)

The one time I did see him before the cancer diagnosis he had me in and out of the surgery that fast that I didn't even manage to bring up the reason I'd gone in. (F.07) (woman with mental illness and cancer)

People often drew on their own experiences to substantiate or validate their views. For example, one woman justified her lack of confidence in GPs in general by describing a catalogue of examples of (in her view) poor and unsafe care. A succession of different doctors and their failure to take her concerns seriously compromised both her physical and psychological safety, and undermined her confidence in GPs in general. The negative consequences extended beyond the problem that was misdiagnosed to future relationships with GPs and future consulting behaviour:

I knew there was a problem (and) I needed to go and see a specialist but that still didn't happen. [It was] 'Let's just try you on these tablets'. Because I knew it wasn't an infection, (but) they kept saying for eighteen months I had an ear infection ... I had to actually spell it out to them, that's what I feel ... which worries me for somebody else ... I'm not a pushy person, but the only times I've got referred for something like that is when I've become a bit pushy ... and I've said, 'Look I've been coming since then, I've tried this and that and it's (not any better)'. (F.21)

One respondent had moved practices due to negative experiences and problems with access, and described the reasons why he felt safe in the new practice:

Why I feel safe ... well, the main concern about going to places like that would be, you know, spread of a virus, maybe, or something like that, so it's always clean, you know, people are prompted to wash their hands when they go in, you know, the gel. People, like my father, he's in a wheelchair, you know, he's got a ramp provided, stair lifts, people look after you if you need anything, straight away, you know, one of the receptionists will come out and say, do you need anything? So the whole environment is, you know, and it is a very small house if you go in, you know, it's not very clinical, it's, like, a house basically. (M.32)

Although a good physician will have the ability to make patients feel both psychologically and physically safe, patients recognised that these two dimensions draw on different qualities and skills and not all doctors will be proficient in both: a doctor's poor interpersonal skills, for example, might be balanced by greater technical competence. Some patients therefore had preferred doctors for different types of problem:

(At) my previous practice, there were two doctors. One of whom was lovely, and everybody wanted to see, and the other was grumpy and nobody wanted to see. So, if you wanted to see the first doctor, you might have to wait weeks. To see this other doctor, you could see him any time, but I came to the conclusion that, actually, the one that nobody liked was a better diagnostician. (M.30)

However, in prioritising one (physical or psychological safety), patients could compromise the other, either wittingly (as in the case of the man who was reluctant to consult a GP about his smokers' cough because he knew it to be self-inflicted) or unwittingly. An example of the latter can be illustrated by the case of a woman who persisted with her familiar GP until she was eventually diagnosed with cancer by a new doctor. In reflecting back on these events, she felt her original GP had misattributed her symptoms of cancer to the natural processes of aging. Some participants distinguished between feeling and being safe, in the recognition that a sense of psychological security could be misleading and trust misplaced:

I don't know if that's, you know, in the end, more safe or not, because, if you trust somebody more, you might not check them properly, (check) what they do . . . But you feel safe, definitely. (M.32)

Patients had to balance not only the different dimensions of safety but to weigh them against other priorities and social imperatives. Safety, for patients, was not necessarily always their top priority, and their decisions may not always have been considered 'safe' from the perspective of health professionals. Examples where other social imperatives took precedence include a Muslim woman with diabetes who chose to fast during Ramadan against her doctor's advice, and a man who delayed visiting the GP about his abdominal pain because he could not take time off work.

Perceptions of safety were thus open to multiple interpretations, and achieving safe care was often a matter of negotiation between patient and GP. In some cases, patients tried to persuade GPs of their own (rival) interpretation: for example, the person with a misdiagnosed ear condition (quoted above) who refused more antibiotics and insisted on a hospital referral. Negotiation, however, was not always attempted or successful, and, in other cases, patients bypassed the GP by contacting the hospital directly, simply ignored what they perceived to be unsafe advice and/or treatment, or sought help elsewhere by consulting a different GP:

There was one time I got home and, when I realised, I was so angry because I'd said to them I'd had these tablets and they'd been no good and they'd made me feel ill, and they'd actually prescribed the very same tablets . . . I didn't take the tablets because I knew they made me feel ill and they didn't work. (F.21)

I've been to see a GP in my practice who doesn't know me and he's said something, and I knew that wasn't the way to treat somebody who'd got renal failure and so I just ignored what he said (F.18)

Participants were often drawing attention to the emotions engendered in related healthcare encounters:

And I remember I came back to see her before she left and, you know, there was some actual physical contact. She put her hand on my shoulder. I can't quite remember whether I actually hugged her, but you know, I really felt like she really cared about what was going to happen to me, and there was that human element. It wasn't that I'm a little minion on a conveyor belt through your practice. (F.25)

But then on the day that I was at my worst, literally it was at the worst you could imagine, she said to me . . . I'm going to close the book on your physical health because there's nothing wrong with you, and I'm going to open the book on your psychological because it's all psychologically based. So I was like in tears at that point . . . I could easily have taken my life at that (point), because I was at my lowest. Because I knew something wasn't right and this woman was just ignoring me . . . I feel so angry about . . . even to this day. (F.26)

Trust was not just engendered at cognitive level but at an emotional and affective level. And, for many people, it was this emotional response that was most potent in inspiring more generalised confidence in a doctor's medical knowledge and skill. When people felt safe at a psycho-social level, they also felt more confident in the doctor's medical capabilities to deal with their physical health concerns. Feeling safe, in the sense of avoidance or minimisation of emo-

tional harm was important to patients, but is not articulated in policy guidance and represents a very different conceptualisation of safety from that espoused in official safety discourse:

I would say it was fine, but not personal at all, you know, you didn't feel that connection.

Interviewer: Do you think that connection is just a, sort of, something you like, a quality of service issue or do you think it might have or had safety implications?

Good question that – you feel more safe, I don't know if it has a safety implication, but you feel, as a person, you feel more safe, you feel you trust the other person more. (M.32)

'Feeling safe' embraced feelings of psychological and emotional as well as physical safety. The following comment typified the views of many:

I think your care and approach is just as much part of what you are expecting from a GP or any doctor, really, as the actual medical judgement. (F.07)

Others commented:

They (GPs) don't realise how we have to psych ourselves up to go in the first place.(F.25)

Sometimes it's not an easy thing to go in there ... because sometimes I feel like I'm wasting their time and feeling guilty about being there, that's how I felt. (F.18)

Participants reported developing strategies, based on previous experience, to protect their psycho-social safety. These strategies resonate with previous research on help-seeking and reasons for delayed diagnosis (Smith *et al.* 2005), and included waiting until they have a concern less likely to be judged trivial and appending the 'trivial' concern to the more weighty concern:

And I felt, well, those problems were small, so I'm going ... you know, I will come with three small problems, because one of those problems seems significant ...

Interviewer: Am I putting words into your mouth by saying, if you think something's trivial you won't go, but you will take it once you get something else as well?

Yeah, as a bolt-on to perhaps a more significant thing ... And I got a kind of brusque kind of, you know, I long for a time when you don't come with a long list. (F.25)

Additional strategies included avoiding contact with doctors from whom they have had a poor reception in the past:

A long time ago, I went with quite serious anxiety problems, and he actually said, 'Pull yourself together', and sent me back to work. Obviously I never saw him again. (F.31)

Seeking continuity with a familiar and trusted GP was also a common strategy which is reported in detail elsewhere (Rhodes *et al.* 2014). For example, one respondent talked about the difficulties of managing to get an appointment with a doctor who they had already con-

sulted with, and with whom they wanted a further consultation. The interviewer clarified whether this was perceived to be a safety issue:

Interviewer: Right, do you think that's mainly a convenience issue or do you think there are safety implications?

I think they're safety implications . . . I don't necessarily mind which doctor I see, but if I've started to see one about a particular condition, then I'd like to continue to see that person, because then they have a better picture about how things are progressing, or whether they're progressing and I don't have to do the whole story again and spend time talking to them for too long to tell them the story, so I'd prefer to see the same person. (F.29)

Participants were also anxious about their own performance during the consultation and concerned that they would not be able to express themselves adequately or understand and remember what was said to them:

Not everybody explains themselves well, some people are nervous, it's like visiting a lawyer . . . you're frightened about the language they speak and I think it's the same with a lot of people with doctors. (F.10)

When you go to the doctor, it's like you know you've only got 5 mins and you've got to get it out, you know. The number of times you come away and you think, Oh no, I didn't mention that part about it or something, you know! (F.07)

Proactive patients and the co-production of safety

The degree to which individuals had reflected on the need to actively intervene to contribute to safe or safer encounters varied widely across our participants. Greater awareness of the risks came with greater exposure and responses indicated that patients' experiences changed the nature of their use of primary care services (see also Elder *et al.* 2005). People who were frequent users of health services (both younger and older respondents) had generally become more knowledgeable about the way they operated than those with less experience. Additionally, they were better able to negotiate the interface between self-care and formal, professional care, and more alert to safety risks and aware of measures to guard against them (cf. Hernan 2014). They therefore tended to be less complacent and perceived themselves better able to take proactive measures to protect themselves: examples included checking prescriptions and communications between hospital and surgery; alerting unfamiliar health practitioners to specific risks, such as adverse reactions to specific medication; becoming knowledgeable about their own condition/s and vulnerabilities; finding out about different treatment options; challenging clinicians' decisions and practice procedures. One couple, both with serious co-morbidity, explained:

Husband: When (wife) has got a particular problem, we generally know what the solution to this problem is. We've obviously got to go to the GP, we can't write prescriptions out ourselves, we don't have any formal medical training, it's just experience, really. So, when we go to the GP, it's pretty easy to spot whether they know what they are talking about, rather than just guessing at stuff.

Wife: They're receptive to our knowledge and we respect their knowledge.

Husband: We are very fortunate in that we are reasonably well educated and we kind of know how the system works and that we have been in it for a long time.
(F.08, M.09 joint interview)

As the extract demonstrates, the ability to take a proactive role was dependent on patients' expertise and knowledge accumulated over time, the social distance between doctor and patient, and patients' self-confidence to question and be assertive. In consequence, some patients were more empowered and more capable of adopting a proactive role than others:

I do feel I have to ... sort of lead them, be clued up, be pushy and it's almost like I feel like there are trigger words that you have to say. (F.21)

Safety, and the capacity for agency (individuals acting independently and making their own free choices), were therefore unequally distributed, and allusion to these fundamental inequalities was a common theme in many of the interviews. The couple quoted above, for example, commented:

Husband: We have friends who have not had that level of experience or expertise and they definitely get a worse deal from their doctors than if you are able to present your argument or present your case, and I think that is important, you know. This question of safety does depend a lot on the patient, and maybe there is a need to have a system that isn't so patient-dependent.

Interviewer: So, you feel you are adequately informed and involved in discussions about what you are going to have?

Wife: Yes, we are not sure if it is because of who we are and how we talk to doctors ... I wouldn't have that same trust, if I was less informed and less able myself.

Husband: Or less experienced.

Wife: That's exactly the problem – if you are not aware, you just go ahead and do whatever, you don't check. (F.08, M.09 joint interview)

In one person's view, it was this presumption of safety which posed the greatest barrier to patients taking a more active role:

[Patients] need to be more aware of health and safety around them, and not presume that things are not going to happen. (M.33)

Participants sometimes indicated that they downplayed or forgave mistakes because acknowledging the possibility of unsafe care might have troublesome consequences. For example, one man described his experiences of repeatedly lost test results which he downplayed stating that he did not feel able to move practice anyway, because of difficulty of travelling to a more distant practice and the fact that none of doctors could speak Urdu, the only language of his wife. However, in the following example, this respondent indicated that repeated exposure to problems over time made it increasingly difficult to ignore them, prompting action to mitigate harm and perceived threats to safe care. This suggests that for some patients there may be a threshold for action, although this is likely to vary between patients and contexts:

I think it was gradually, you know, when you go somewhere and you're not happy with the service, but you try to placate yourself, and you try to make yourself believe that it was just a one off, and you've got to give somebody the benefit of the doubt, they might be having a bad day, something like that. So you're continually doing that, and then you reach a point when you think, I've reached saturation level now, and I'm not going to take this kind of attitude. (F.16)

Participants often indicated they were vaguely aware of changes in procedures regulating quality and safety; however, there was general lack of clarity about the nature of the changes or understanding of the rationale underpinning them. Much of what was said indicated that the changes, although designed to enhance quality and safety, were often experienced as obstacles.

The invisibility or opacity of much of the formal architecture of safety meant that it was inaccessible to patient scrutiny or evaluation, leaving patients with only a general sense of more tightly governed practice. Patients expected and assumed GPs would adhere to the tenets of safe practice, but were ambivalent about the erosion of GPs' discretionary space (c.f. Horlick-Jones 2005). Whereas policymakers see the promotion of guidelines as encouraging safe practice, if anything, diminished opportunities for discretion were thought to undermine, rather than promote, safety, with standard rules and procedures: (i) operating as constraints on the provision of individualised care, and disadvantaging for some patients, (ii) seen as a protection more for health professionals than patients, and (iii) making it difficult to judge when doctors were speaking or acting on their own accounts or in accordance with the officially prescribed view:

They just follow the rules and regulations and guidelines . . . and can't be allowed to slightly deviate and use a bit of common sense and be credited with having a bit of intelligence. (F.23)

They are frightened of being sued . . . And, sadly, that is what leads to a lot of the bureaucracy . . . They're given a script and they follow it, they're scared of moving off the script. (M.09)

I feel that they've got their targets and that seems to override their own thoughts. . . And it is very hard, because they are . . . paid according to those targets, to know how much they are just pushing it because they have to or whether they really do believe in it.

Interviewer: So, what you are saying is that it distorts.
.... having a meaningful discussion with your medical practitioner. (F.07)

In participants' opinions, many of the visible bulwarks of safety – home visits by a familiar doctor, continuing personal relationships with specific practitioners and engagement with patients as individuals – have been steadily eroded, to be replaced by a less visible or accessible framework of standards and protocols.

Discussion

The accounts of patients in our study suggested that what makes them feel safe is often very different from the sorts of things which focus the attention of policymakers and clinicians. Patients' accounts suggested that safety was not something 'out there' that could be readily identified, codified in guidelines and measured, but in many cases was an emergent product of

interaction between people, and between people and their environment. Safety was understood, not as a unified, objective and apolitical conception of what it means to be safe, but as a fluid, contingent, contestable, and negotiable accomplishment. Patients found it much easier to draw on experience when making sense of safety than to conceptualise and articulate it in abstract terms. At the same time, when questioned, some participants began to reflect and articulate aspects of primary care (such as approachability) which were important to them in terms of making them feel safe.

Safety, for patients, was multi-dimensional and the different dimensions could variously complement, reinforce, undermine, compete or conflict with each other, depending on the situation. The constitution of safe care was, therefore, inherently unstable – what might be considered safe in some circumstances, might be considered less safe or unsafe in others. It was also personal: one person's conception of what it means to be safe might be different from that of another, different in different contexts and, crucially, different from that of health practitioners. Achieving safe care was therefore a matter of individual negotiation between patient and practitioner.

Patients' understandings recognised that the dimensions of safety might be in tension with each other and with other priorities at the personal, practice and wider local and national level. Patients were aware of a need for difficult trade-offs at the level of individual patients' strategies (e.g. accepting an early appointment with an unfamiliar GP or waiting longer for an appointment with a familiar GP) and broader policy (e.g. prioritising accessibility, in terms of length of consultation, over flexibility in matching timings to individual patients' needs), and that the imposition of standard rules would create 'winners' and 'losers'. Standard rules, such as those regulating access, were often perceived to be neither fair nor safe and the safest systems to be those which offered some flexibility.

We did not observe patients and have to rely on their accounts, but many reported employing informal strategies to protect their own safety. Their strategies were shaped by a more expansive interpretation of safety than that which inspires formal safety schemes, and were constrained, not just by limited knowledge of the risks to which they might be exposed but by aspects of service organisation and wider policy, and might not always be deemed 'safe' from the perspective of health professionals. Weick (1995) observes that a sense of powerlessness can account for the maintenance of faith and trust in safety systems because the alternative is to face anxiety and fear without any means of addressing the source. On the whole, patients presumed that there were systems in place to protect their physical safety but had little or no knowledge of what they were or how they operated. Given the invisibility or opacity of much of the technical apparatus of safety, it is not surprising that participants' accounts often gave greater prominence to the more accessible psycho-social dimension of safety in which they were both more knowledgeable and more proficient in taking an active role.

Sensemaking encompasses presumption and entails actively connecting the abstract and concrete in a way that draws on experience. Experiences which involve a breach in one's presumptions (such as interactions with unfriendly receptionist or incompetent doctors) appeared to prompt reappraisal and reshaping. Whilst sensemaking is retrospective (i.e. people try to make sense of what happened in the past), it has implications for the present and the future. In particular, patients' presumptions are important since they are a basis for future action (or avoidance of action). Several patients reported being proactive and 'on their guard' as a result of prior negative experiences. At the same time, other presumptions (around doctors' behaviours towards smokers, or their views of some consultations/concerns as being trivial) appeared to be based on an appreciation that particular identities (the smoker, the NHS resource waster, the hypochondriac) are viewed in a negative light. To some extent this resonates with the concept of 'identity threat' (Coyle 1999) which involves a challenge to

personal identity as a result of experiences which are felt to be disempowering and devaluing. For our participants, the way that they made sense of things resulted in them taking action in anticipation of events, rather than undergoing such experiences.

Sensemaking organises flux. But participants' accounts often described the routine and the familiar, which appears to reflect the fact that most of the people interviewed were experienced users of primary care. Rather than viewing doctors as powerful and trusting them unconditionally, many participants reported using judgments, often based on prior experience, to structure their interactions with doctors. This contrasts with Doherty and Saunders's (2013: 35) findings that 'patients generally constructed themselves in a subordinate trusting role, where they should follow the rules laid down by clinicians, the people they believe are the most qualified to make the decisions because they have the requisite technical knowledge. 'Doctors in our study were constructed as having to follow 'rules and regulations', being 'scared of moving off the script' and having 'targets that seem to override their own thoughts'.

Despite this, participants also displayed a high degree of trust in many cases, in a way which resonates with Giddens's (1990) ideas about trust in abstract systems. Such trust may be reinforced or reduced as part of our interactions which form our concrete experiences. Of course, such trust occurs within relationships characterised by inequality, given the gap between medical professionals and patients in terms of medical knowledge. At the same time, patients with chronic conditions are likely to develop expertise about their condition and, as our data show, do not necessarily defer to medical opinion in all cases. However, patients also appeared constrained as a result of their awareness of the rules of interaction with their doctor. Their fear of being judged by them and reports of continuing to consult (as opposed to going elsewhere) despite reservations, suggest that patients do not always take action to avoid unnecessary harm.

Weick *et al.* (2005) have described how health professionals engage in labelling and categorisation as part of a process of making sense of a potentially chaotic situation. This enables imposition of diagnostic labels which imply plausible treatments. Our findings suggest that patients also engage in this process, labelling and pigeonholing doctors, receptionists and premises and such labelling carries implications for action.

This means that whilst both groups engage in sensemaking, the sense made differs between them. This is understandable, but it has important implications. Patients do not, necessarily voice concerns in consultations, but a lack of trust in a doctor's abilities, a fear of being judged or presumptions about guidelines constraining doctors can lead patients to ignore or avoid medical advice, which may have consequences for patient safety. Whilst the patients in our study appeared less passive than the hospital patients studied by Doherty and Saunders (2013), in both cases, accounts highlight the gulf between clinicians and patients in the way that sense is made of interactions and contexts. In addition, Doherty and Saunders (2013: 35) suggest that 'guided sensemaking is required to enable shared understanding and more reliable decision making'. This process involves clinicians being more interactive, rather than didactic and takes time. In the context of primary care, which has traditionally been characterised by relational continuity, the potential exists for clinicians to pick up on cues and broaden the scope of noticing and labelling beyond the availability of medically formulated mental models. Interactions as part of an ongoing relationship provide an opportunity over time, to significantly bridge the gap between the sense that is made by patients and clinicians. This is not a suggestion that we should return to a mythical 'golden age' when such gaps did not exist. Furthermore, as highlighted by some of our patients, locums or other unfamiliar doctors can spot things that the patient's 'usual' doctor has missed. However, the shift in emphasis away from relational continuity with a single doctor (Hill *et al.* 2011) means that the potential for the development of shared understanding as part of an ongoing relationship is diminished.

Conclusions

Our study explored primary care patients' sensemaking, with an explicit focus on safety. Contrary to the findings in a recent study examining sensemaking amongst hospital surgical patients, we found participants were often proactive in taking action to protect themselves. The somewhat routinised and predictable nature of the primary medical care consultation, which is very different from 'one off' inpatient spells meant that patients had a stock of accumulated knowledge and experience to inform their actions. This also seemed to equip them with a wider repertoire of potential options for action. Participants' accounts underscore the salience of a psycho-social dimension to harm and the importance of psycho-social safety, which can exist independently of any association with physical harm or functional impairment. This highlights the need for a much broader conceptualisation of what it means to be safe. Despite increased recognition of the importance of psychological and emotional harm in healthcare settings (e.g. Burgess *et al.* 2012, Kuzel *et al.* 2004), conceptualisations of harm remain largely confined within a biomedical focus on functional impairment (World Health Organisation 2009).

Much of the writing from the patient safety literature has focused on minimising risks and hazards drawing on lessons from the aviation industry. The result has often been a focus on rules and checklists intended to prevent error (Waring 2009). This approach tends to neglect the different ways in which safety is conceptualised by different groups within such systems (Brown 2008). Yet even among health professionals and within organisations, there are likely to be multiple voices and perspectives on this issue (e.g. Currie *et al.* 2009, McDonald *et al.* 2006, Powell and Davies 2012, Rowley and Waring 2011). Although professionals' and patients' views may often coincide, our findings suggest that obtaining patients views requires them to have time and space for reflection. Unpacking accounts of preferences concerning GP consultations and their relationship to safety is a complex task which takes time. Our study also highlights the importance of processes to facilitate shared understandings. In the absence of such mechanisms, patients are likely to continue to use the strategies we describe, which may avoid harm, but are likely to expose them to risk at the same time.

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