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Heavey, Emily; Waring, Justin; De Brún, Aoife; Dawson, Pamela; Scott, Jason

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**Patients' Conceptualizations of Responsibility for Healthcare: A Typology for
Understanding Differing Attributions in the Context of Patient Safety**

Dr Emily Heavey*, University of Huddersfield

Professor Justin Waring, Nottingham University

Dr Aoife De Brún, University College Dublin

Dr Pamela Dawson, PD Education and Health Consulting Ltd

Dr Jason Scott, Northumbria University

***Corresponding Author**

School of Human and Health Sciences, University of Huddersfield, Queensgate,

Huddersfield, HD1 3DH, United Kingdom

Email: e.e.heavey@hud.ac.uk

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Abstract

This study examines how patients conceptualize ‘responsibility’ for their healthcare and make sense of the complex boundaries between patient and professional roles. Focusing on the specific case of patient safety, narrative methods were used to analyze semi-structured interviews with 28 people recently discharged from hospital in England. We present a typology of attribution, which demonstrates that patients’ attributions of responsibility to staff and/or to patients are informed by two dimensions of responsibility: basis and contingency. The basis of responsibility is the reason for holding an individual or group responsible. The contingency of responsibility is the extent to which that attribution is contextually situated. The paper contributes to knowledge about responsibility in complex organizational environments, and offers a set of conceptual tools for exploring patients’ understanding of responsibility in such contexts. There are implications for addressing patient engagement in care, within and beyond the field of patient safety.

Keywords

narrative, patient experience, patient safety, qualitative research, responsibility

After almost 20 years of sustained attention, patient safety remains a global health policy priority (Berwick 2013; Kohn, Corrigan, and Donaldson 2000). Broadly speaking, patient safety is concerned with “the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum” (Runciman et al. 2009:19), but there remains much debate about how safety should be defined and where responsibility for safety should rest. For example, definitions of safety often differ between patients and clinicians (Scott, Dawson, and Jones 2012), while a “shifting locus of responsibility” (Armstrong 2014:171) recognizes patients’ agency and concomitant responsibilities within healthcare in general and safety in particular. In addition to managing health risks and making appropriate use of healthcare services (Kitson et al. 2013; May et al. 2014; Pedersen and Kjær 2017), these responsibilities include engaging in safety-creating behaviors such as challenging healthcare professionals and alerting them to the patients’ needs (De Brún et al. 2016; Rhodes et al. 2016; World Health Organization 2009:part v).

Previous research has explored patients’ conceptualizations of safety (Doherty and Saunders 2013; Rhodes et al. 2016), yet there remains little understanding of how they conceptualize *responsibility* for safety. This absence is striking, given the current emphasis on engaging patients as active participants in their own healthcare, including their own safety. Such involvement requires patients to recognize and accept some level of responsibility; understanding whether and how they perceive this responsibility, and how it relates to their perceptions of professional responsibility, is a vital step in encouraging engagement and—of equal importance—mitigating an absence of engagement.

This paper explores patients’ attributions of responsibility for their safety in clinical settings. We demonstrate that, while patients may cite professional roles when asked directly about who is responsible for patient safety, analysis of their reflective narratives reveals a more complex process of attribution. Patients’ stories variously attribute responsibility to

professionals, to patients, and to a mix of both, with attributions framed in terms of (1) the *basis of responsibility* and/or (2) *the contingency of responsibility*. We outline these dimensions of responsibility in a typology and consider the implications for the emerging role of the “responsibilized patient” (Pedersen and Kjær 2017:94) and patient participation in safety work.

BACKGROUND

In broad terms, responsibility concerns both causality, “what *was* done”, and accountability, “what *should have been* done” (Hamilton 1978:316; c.f. McKeon 1990). There is little in the way of a formal sociology of responsibility (Strydom 1999), but it is arguably a key concept that operates across the levels of individual action and social structure, where ‘being responsible’ involves internalizing and demonstrating adherence to institutionalized obligations and moral norms (Giddens 1984; Heimer and Staffen 1998). In classical sociological theory, for example, notions of ‘individual responsibility’ are linked to socialization within particular groups (Durkheim 1957). In more recent theory, responsibility is often discussed as being based upon shared and community decision-making (Habermas 1979), while contemporary technological and environmental risks reveal the limits of individual responsibility and necessitate ‘co-responsibility’ (Strydom 1999).

In organizational settings, responsibilities are often allocated to defined roles within the division of labor (Weber [1946]1958). For example, Strauss (1985:8) describes how different types of ‘work’ imply particular forms of responsibility through which actors are “rendered accountable for accomplishing tasks according to certain criteria: when, where, how, how soon, level of quality”. In this context, notions of responsibility are often associated with ‘professional duty’ or ‘codes of conduct’, with the fulfilment of responsibilities reflecting and reinforcing status and authority (Abbott 1988). The sociology

of organizational accidents, as found in the work of Turner (1978), Perrow (1984), and Vaughan (1997), suggests responsibility for accidents and mistakes often rests on the complex relationship between local actors and wider social and cultural institutions. These studies suggest the technical allocation of responsibility is problematic because of the complex social systems in which accidents occur and because accidents are inherently cultural and political in nature, where the allocation of responsibility is often a normative judgment as much as a technical one.

Healthcare systems exemplify the allocation of responsibilities to professionals, although there is debate over what obligations patients might also have in this organizational context (English 2005; Evans 2007), and sociological studies pre-dating contemporary patient safety research highlight the complicated nature of professional responsibility. For example, Bosk (1979) showed how responsibility for unsafe practice is constructed with reference to shared normative standards, and Fox (2000) illustrated how professionals invoke uncertainties of medical practice to mitigate responsibility for wrongdoing. Of particular relevance to our study, Heimer and Staffen (1998:4) shifted the focus from professional responsibility to explore the conditions under which parents “embrace or reject responsibility” for their children’s care in neonatal intensive care units (NICU). They suggested responsibility was often a “joint enterprise” between patients, staff, and the state, defining responsibility along five dimensions:

[T]aking the interests and needs of others seriously, focusing on both present actions and future outcomes, defining obligations broadly (even following them across institutional boundaries), using discretion to meet unforeseen contingencies, and accepting whatever costs and benefits are entailed. (Heimer and Staffen 1998:77)

Developments in the patient safety movement shed further light on the complexities of responsibility. The promotion of a ‘systems’ approach within international health policy (Kohn et al. 2000) frames safety improvement as a technical exercise of reactively identifying and addressing ‘latent’ sources of risk. From this perspective, responsibility for safety is not seen as residing solely with individual clinicians or teams, but with the wider system of care, including those in management roles (Berwick 2013; Parand et al. 2010; Reason 2000). Yet such approaches have been criticized as ignoring individual accountability on the ‘shopfloor’ and the responsibilities of external agencies such as drug suppliers (Peerally et al. 2017). Policy discourse has shifted from a ‘blame-free culture’ that removes individual responsibility in order to encourage safety reporting, towards a ‘just culture’ that reintroduces appropriate and fair individual responsibility for safety violations (Weiner, Hobgood, and Lewis 2008).

While policy around patient safety affects the professional and legal obligations of those working in healthcare, determining and accepting responsibility within everyday clinical practice is a social process, shaped by cultural and moral norms and the dynamics of social power (Nicolini, Waring, and Mengis 2011; Waring 2009). Much work has been done to examine professionals’ understandings of their roles and responsibilities within the shifting landscape of patient safety. For example, Waring (2005; 2007) demonstrates how professional practice and culture can influence clinicians’ constructions of their own responsibilities for safety. Conversely, Szymczak (2016) shows that service leaders’ talk of safety culture often centers on individual behavioral traits, obfuscating organizational processes and allocating responsibility to groups with the least authority to affect improvement. Meanwhile, Aveling, Parker, and Dixon-Woods (2016) illustrate how healthcare professionals perceive moral responsibility for safety as an irreducible element of practice, which must be balanced with other organizational pressures and responsibilities.

They suggest the distinction between individual and systemic accountability can be unhelpful, when professionals' opportunities to act responsibly are made possible by the systems in which they work.

As yet, there has been no such exploration of patients' interpretations of responsibility for their safety in the clinical setting. The following analysis considers how patients' stories about their own experiences and expectations work to make sense of that responsibility, calling particular attention to how patients frame the division of responsibility between themselves and hospital staff.

DATA AND METHODS

Methodological Approach

Narratives are acknowledged as the primary means by which patients experience and make sense of illness and healthcare (Hurwitz, Greenhalgh, and Skultans 2004); in relation to safety, Reason (2007:xiv) suggests “[n]arratives rather than numbers are the primary data of the safety sciences.” Narrative approaches have been used to show how patients emphasize personal experience and psychosocial dimensions of safety (Doherty and Saunders 2013; Ocloo 2010; Rhodes et al. 2016), and how clinicians make sense of safety events in ways that resist managerial control and construct competent clinical identities (Currie et al. 2009; McDonald, Waring, and Harrison 2006; Waring 2009).

Narratives are not objective reflections of events, but constructions of reality (Bruner 1991; Sparkes and Smith 2008). Reflecting on patients' stories can therefore offer insight not only into what *happened* to them, but how they interpret those events and the actions of people involved. Constructionist approaches to narrative emphasize the social nature of narrative, “tak[ing] into account the broader social construction of that story within interpersonal, social and cultural relations” (Esin, Fathi, and Squire 2014:204). In this paper,

we are concerned with participants' interpretations of their own and others' responsibilities for safety in the clinical setting. However, we do not view their narratives as reflective of internal states or inner scripts, but consider them within their broader sociocultural contexts (for example, shared norms within and outside hospital settings) and the immediate interactional context of the interview. Our analysis does not seek to make claims about who participants hold responsible for their safety *per se*, but about how they subjectively reconstruct experience to 'frame' such responsibilities (Strydom 1999) in the stories they tell.

Interview Design and Sample

As part of a study to determine the feasibility of patients providing feedback on their experiences of safety following a care transfer (Scott et al. 2014), qualitative interviews with patients were conducted by two authors (EH and JS) between July 2014 and June 2015.¹

Interviews began by exploring participants' recent experiences of hospitalization and transfer, and their understandings of and attitudes towards safety in a healthcare context. Interviews were semi-structured, with a topic guide used to inform main areas of discussion. In keeping with the narrative approach, participants were encouraged to speak about any experiences they considered relevant, and to say as much or as little as they chose. A number of common prompt questions were asked to most participants to initiate these discussions (see Box 1). However, not all questions were asked of all participants, nor were questions necessarily asked in the same order. For example, if a participant had discussed their view that staff were responsible for looking after the safety of patients, the participant might not be asked who they felt was responsible for their safety. This approach was intended to keep interviews conversational in nature and avoid excessive repetition. **[Box 1 here]**

Participants were recruited from 16 wards within four hospitals in two regions of the English National Health Service (NHS). Wards were selected on the basis of clinical

specialties that typically treat older patients (cardiac care, care of older people, orthopedic care, and stroke care), because older patients are at increased risk of safety incidents due to complex care transitions (Tsilimingras, Brummel-Smith, and Brooks 2009). Participants were recruited following completion of a survey about their experience of a care transfer, in which they indicated their willingness to participate in a follow up interview. They represented a convenience sample, and were neither included nor excluded based on experiences of harm. In total, 28 patients participated in interviews. **[Table 1 here]**

Interviews were conducted in participants' homes after discharge from hospital and audio recorded with informed consent. One participant made use of an interpreter. Interviews were transcribed verbatim using a transcription service; data presented here have been 'cleaned up', with false starts and non-lexical utterances removed for clarity and space. All names are pseudonyms.

Data Analysis

Transcripts were closely read and searched by one author (EH) for narratives that implicitly or explicitly attributed responsibility for patient safety to one or more parties. Narratives were defined as relaying sequential events from the perspective of the speaker, such that particular meanings are conveyed to an audience (Riessman 2008:3), and both 'safety' and 'responsibility' were broadly defined at this stage. For example, narratives were coded as being about 'safety' if they were about (real or hypothetical) events leading to a general feeling of being safe or about the avoidance of specific risks or harms. Narratives were considered to attribute responsibility if they stated or implied that safety did, could, or should result from the actions of one or more parties. Narratives about responsibility for safety were recorded using NVivo software, and then reviewed by another author (JS) with disagreements discussed. Many of the narratives were responses to specific questions about responsibility

for safety, but participants also offered relevant narratives in response to other questions, such as questions about their understandings of safety. We address the effects of the interview questions on participants' narratives in the analysis.

Narrative data were tentatively grouped according to which parties appeared to be solely or primarily held responsible for patient safety. The initial groups were 'patients', 'staff', and 'institution'. The narratives were then examined more closely in terms how events were presented as linked or consequential (Polkinghorne 1991), with particular attention paid to the causal roles and actions of different groups. This led to the refinement of our attributions into 'patients', 'staff', and 'patients and staff'. Narratives were further explored in terms of their evaluative framing or characterization of these events, actions, and actors, to inform our interpretations of why and when responsibility was attributed to different groups. Recurring patterns were discussed within the wider study team and alternatives considered, before we agreed upon two recurring dimensions of responsibility that enabled us to form a typology of attribution.

RESULTS

When participants were asked directly who they thought was responsible for their safety, most responded that healthcare professionals were responsible, with many suggesting a hierarchy of responsibility, for example "*the nurse in charge*" (Adam) or "*hospital administration*" (Michael). A small number talked of patients having some responsibility, while still ascribing an overarching responsibility to staff: "*I'd say the nursing staff first and then the patient*" (Meredith). Equally, when participants were asked whether they, as patients, had a role to play in their own safety, they tended to agree that they did have some role.

The direct, non-narrative responses to these two questions suggest, respectively, perceptions that patient safety is primarily the responsibility of professionals, and perceptions

that patients have a role to play. Yet, participants' stories revealed complexities within these attributions. Narratives attributed responsibility to professionals and/or patients, while also indicating *why* these particular groups were responsible (which we call the *basis* of responsibility) and/or *whether the situation or context* affected this attribution (the *contingency* of responsibility). The overall impression is that patients can experiment with possible attributions for responsibility, drawing on their own experiences and prevailing cultural assumptions, and often influenced by the context at hand.

Narrative Attribution of Responsibility

Patients' narratives tended to focus on specific events experienced during their time in hospital, although some were about hypothetical situations, including how participants thought past events could or should have transpired. In broad terms, narratives presented safety as a (potential) consequence of (possible) actions by staff and/or patients, sometimes in response to specific perceived hazards. That is, narratives assigned causality by presenting a sequence of actions for keeping patients safe following a basic plot:

[hazard(s) occur] → actor(s) perform actions → as a result the patient is safe.

For example, in Extract 1 (analyzed below) a patient anticipates a medication error and insists on his notes being checked, presenting the plot:

Nurse makes error in dispensing medicine → patient anticipates and corrects the error → (implied) correct medication is given.

The narrator's evaluative framing of such events and characterization of actors explicitly or implicitly attributed responsibility for ensuring the appropriate sequence of events to staff and/or to patients, by invoking *the basis of responsibility* and/or the *contingency of responsibility*. The basis of responsibility is the reason *why* a particular party is held responsible; in our data patients cited particular forms of expertise or duty linked to that party's role (c.f. Heimer and Staffen 1998:77–8), as defined in Table 2. The contingency of responsibility is the extent to which the situational context affects or moderates the attribution of responsibility, in particular the capacity of an individual to apply their expertise or fulfil their duty. [Table 2 here]

Attributions occurred on a spectrum, in that responsibility could be attributed wholly or primarily to staff, wholly or primarily to patients, or relatively equally to both. Within this spectrum, a typology was evident, whereby participants' attribution of responsibility to particular individual(s) or group(s) was determined by at least one of the two dimensions (see Table 3). We explore how these dimensions affect the attribution of responsibility in more depth in the following sections. [Table 3 here]

Patient Responsibility for Safety

Heimer and Staffen suggest that taking responsibility involves accepting a broad set of obligations and “only rarely saying “not my job”” (1998:93). This assertion was reflected in narratives that attributed responsibility for safety solely or primarily to patients. Such narratives presented responsibility for patient safety as having *low contingency*, in that that neither the clinical setting nor the immediate context of a particular situation alleviated an individual's responsibility to keep him or herself safe. In such narratives, the basis of responsibility was *personal expertise* and/or the *duty of self-care*. Personal expertise, the more commonly cited basis, was experiential expertise held by patients rather than clinicians.

This included patients' knowledge about themselves and their bodies, for example their medication needs, dietary requirements, and levels of mobility; awareness of their own immediate surroundings; and knowledge gained from past experiences in healthcare settings and elsewhere. The duty of self-care was the generalizable 'duty to oneself'; that is, the obligation to look after oneself (c.f. Kant [1797]1996).

Richard, 68, had regular hospital stays over a two year period due to complications following a bowel operation. When asked, "*do you think as a patient, you should have a role to play in your own safety?*" he spoke for several minutes about times he had to take responsibility for his own safety in hospital, including through checking to ensure that his diabetic dietary needs were met and that his medication was properly administered.

Extract 1

The other is thing—like I told you, you get used to the system—is tablets. When [the nurses] come round with the tray and you needed the tablets, on two or three occasions I've been given the wrong ones and I knew 'cos I always look at my medication and pull 'em up and say I haven't got this, that or the other. "Oh I'm sorry." But you get the wrong medication... On occasions I've said "look I haven't got my lansoprazole for example, "oh no, you don't need it." "Well yes I do need it, I've got to have it every single day and I've been told never to miss." "No, no it's not you, it's not on the form." I said, "well it must be on the form." "No, no it's not." "Well turn the pages over and let me have a look?" Turned the page over, and it's on the other page.

The question Richard was asked necessarily prompted him to consider the patient's role; of interest to us here is how the narrative frames that role and specifically when and why the patient holds it. The narrative presents a hazard (the nurse's medication error), which Richard habitually acts to mitigate (by "always" checking his medication and challenging the nurse when it is incorrect) in order to ensure his own safety. The *basis* of his taking responsibility in this way is his personal expertise: specifically, his knowledge of his own medication needs and his previous experience of having that medication mismanaged by staff. In other words, experience has taught Richard that his expertise usurps the professionals' expertise, and thus *necessarily* becomes the basis for him taking responsibility for his own safety by checking his medication. His statement that he habitually takes on that responsibility, even in the face of repeated dismissals from the nurse, suggests a framing of *low contingency*, in that his responsibility for his own safety is not alleviated by the presence of that professional. To paraphrase Heimer and Staffen, the clinical setting does not prompt Richard to say "my safety is not my job".

Richard's story echoes Heimer and Staffen's (1998) argument that NICU parents who distrust staff are more likely to take on responsibility themselves, and Rhodes et al.'s (2016:270) more recent finding that self-protective behaviors are informed by patients' "accumulated knowledge and experience" of care. However, not all narratives emphasizing patient responsibility presented negative encounters with healthcare staff. When asked the same question as Richard, Rachel, 81, responded effusively: "*oh yes, oh yes. I think you should take care as well. Don't expect the staff to do everything, they have enough to do.*" Asked for an example of what she meant, she told the following hypothetical narrative:

Extract 2

When they're walking about, if they can't walk themselves then they should get something to help them like a Zimmer frame or a walking frame or something like that. They should know themselves if they can do these things and if they can't they shouldn't try to walk without.

Again, the question prompts Rachel to consider the patient's role, but in contrast to Richard's more individualistic story, she offers a generalized narrative about how patients should behave to ensure their own safety. Personal expertise is again a basis of this responsibility, specifically patients' knowledge of their own limitations and capabilities, which they are assumed to recognize and obliged to act upon. That the narrative suggests patients are obliged to act independently (rather than, for example, requesting help from staff) suggests a fundamental 'duty to oneself' (English 2005:146–7; Kant [1797]1996), which we call the duty of self-care, as another basis of responsibility. Rachel's opening assertion that the patient cannot "expect the staff to do everything" frames the narrative with the expectation of this independence. Implicit here too is *low contingency*, in that neither the hospital context nor the presence of these healthcare professionals alleviates patients' responsibility look after themselves.

Some narratives attributing responsibility to patients were even more explicit about the patient carrying their responsibilities between the "organizational boundaries" of hospital and home (Heimer and Staffen 1998:77). In response to the question "*have you ever played a role in your own safety?*", Mark, 54, told the following story:

Extract 3

After the angio[gram] I needed to monitor my own bleeding. You have a special wristband that they put on and the nurse needs to get the pressure off

but you've got a hole in your artery so it's a balance between getting this thing off and not having spurting blood coming. Yeah, that type of thing. And making sure before I got out of bed that I sit up and sit in the side of the bed and make sure just to keep things steady and easy. Being sensible. You would be sensible at home.

In this narrative, Mark's vigilance and care when moving about in bed ensure his safety. His personal expertise, specifically his knowledge of his own body, movement, and surroundings, is one basis of his taking this responsibility. Duty of self-care is a second, indicated by Mark's evaluation of these actions. Characterizing his actions as "sensible", he states that such behavior should be expected within the clinical setting just as it is outside it, suggesting that patients have the responsibility to keep themselves safe as part of a generalized obligation look after themselves in any setting. Concomitantly, the evaluation frames that responsibility as having low contingency, in that it explicitly rejects any alteration or loss of this duty when moving from clinic to home. Echoing the stance of NICU parents who take responsibility for their children on the ward as they would at home (Heimer and Staffen 1998), in Mark's narrative the physical location of the hospital and the temporary identity of 'patient' does not change the basis of responsibility and therefore does not alleviate it.

Professional Responsibility for Safety

Narratives that attributed responsibility for patient safety solely or primarily to staff did so based on *professional expertise* and/or *professional duty*. Professional expertise was expertise held by members of staff, particularly but not exclusively clinicians, and not held by patients; this could include clinical or technical expertise, or particular knowledge about the

clinical setting. Professional duty refers to the obligation held by all staff members, including clinical, nonclinical, and managerial staff, to look after all hospital patients, with patient safety an integral part of that duty of care. In these narratives, responsibility was presented as having *limited contingency*, with the clinical setting having two specific effects on its attribution. First, professional duty and expertise are made relevant by that general setting, and second, specific professional groups could be presented as more or less responsible in different clinical scenarios. However, professionals *as a whole* were not alleviated of their responsibilities by unforeseen events or other contextual factors.

When professional expertise was cited as the basis of professional responsibility, narratives often described specific areas of clinical knowledge and skill, whose competent execution led (or should lead) to patients being safe. Many also described less specific but equally essential caring skills. When asked who should ultimately be responsible for her safety, Fiona, 68, explained that, while hospital staffing had changed over time, the dedication of nurses remained essential, before telling the following story:

Extract 4

When you have an angiogram of course, they put the tube in and then it's in one of your main arteries, so they have to go to make sure that you're not going to bleed to death when they start taking it out. So they have this big tight belt across your tummy that they release steadily all day long for so many hours and they told you exactly what they were going to do and do you know, this nurse was with me all day and she was good with everybody, and it was smashing that she was so caring and you just felt, you know. I just kept drifting off to sleep and coming back and you knew that you were getting looked after, and I just think it was brilliant to be on that ward, knowing that the staff knew what they were doing. They were all well trained up, I

mean you knew they were well trained up ‘cos they knew exactly what to do at what point.

The narrative presents the nurses’ actions—both their execution of clinical tasks and their caring behaviors—as ensuring Fiona’s safety. Moreover, the highly detailed description of the clinical tasks they performed and the explicit characterization of the staff as knowledgeable and “well trained” present their professional expertise as a necessity for performing such actions and hence a basis for staff responsibility. The implication is that individuals without such expertise could not perform such tasks and could therefore not be held responsible for Fiona’s safety in the situation she describes. It is notable that Fiona chose to narrate a situation in which she, the patient, was barely conscious and therefore incapable of contributing to her own safety; in doing so she emphasizes the nature of the clinic as a context where normal rules about looking after oneself may not apply. In this context, Fiona’s patient identity alleviates her responsibility, as the nurses’ unique expertise becomes both relevant and essential to her safety. The narrative has echoes of those of pre-operative patients whose expectation of—and trust in—the expertise of clinicians enabled them to understand the hospital as a place of safety, and thus to discharge to clinicians responsibility for keeping them safe (Doherty and Saunders 2013).

Professional duty was the basis cited in most narratives emphasizing professional responsibility; on this basis, different groups of hospital staff could be held responsible for safety, including those without clinical training. Following an epileptic fit, Daniel, 56, had been discharged from a stroke care ward. When asked what he understood by the term ‘safety’, he said:

Extract 5

I've never really thought about safety. I just expect everyone in the hospital to know their job and be professional and so far they have been. I can't fault them at all, from the cleaners to people that go round with tea, to the nurses, staff nurses, everybody has been great.

Daniel's narrative presents his perception of safety as resulting from the actions of various staff groups, including nonclinical staff. Indeed, by mentioning "people that go round with the tea", he acknowledges the importance of nonclinical labor in ensuring he felt safe; the emphasis here is not on particular skills or expertise, but on the (fulfilled) expectation that various staff groups adhere to the requirements of their particular roles, whatever those roles may be. In other words, his safety is the collective responsibility of clinical and nonclinical staff based on their professional duty to look after him. In highlighting the importance of nonclinical professional duty, the narrative recognizes the sort of "moral community" identified by Aveling et al. (2016), in which clinical and nonclinical staff of all levels are responsible for acting together to ensure safer care. Daniel's assertion that he has never thought about safety enforces the importance of this community fulfilling their professional duties by highlighting the contextual effect of the clinical setting: within this organizational boundary, professionals *must* take responsibility for his safety because he, the patient, does not.

Both Fiona and Daniel's narratives presented situations in which the patient felt safe, enforcing the idea that expert and dutiful professionals obviate the need for patients to take responsibility for their own safety. This reflects previous research showing that patients take a less active role in their care when they perceive their contribution as unnecessary (Flink et al. 2012), with those who have never experienced harm more likely to acknowledge their own lack of expertise regarding patient safety (Hernan et al. 2014). However, not all narratives

emphasizing professional responsibility presented situations in which participants felt safe. When asked “*when you’re in hospital, who do you think should ultimately be responsible for your safety?*” Roy, 82, responded “*well it depends what it is*”. He then spoke for several minutes about times he had felt unsafe, identifying what he perceived as management failures:

Extract 6

One time I was in the hospital and the cleaning staff came on, and it was when the National Health [Service] had given that over to private, to somebody to come and do the cleaning privately and so the nursing staff weren’t talking to the cleaning staff because they were pinching their jobs... I mean there was bits of blood and bandages and stuff on the floors because the nursing staff weren’t cleaning up. They’d got left until the cleaning staff came on. What’s good about that? Why didn’t they leave the nursing staff doing what they are doing? Because they could get rid of some of the nursing staff to save money.

The narrative presents nurses’ actions as creating a messy, unhygienic, and potentially unsafe ward. However, it frames this lapse in professionalism as a consequence of wider service constraints and restructuring, implying that hygiene and safety would be improved if this restructuring was reversed. In doing so, it extends the attribution of responsibility beyond the ward staff to those with a role in the planning or ‘articulation’ of safety work (Strauss 1985), by highlighting *their* professional duty to ensure appropriate staffing structures. This reflects Aveling et al.’s (2016:216) argument that professionals’ “opportunities to be good” are made possible by the systems in which they work, mitigating

the nurses' (and cleaners') *individual* responsibility for safety by sharing that responsibility between ward staff and management, while ultimately holding the latter responsible. It also demonstrates the limits of contingency in professional responsibility narratives. As in the previous two narratives, the attribution of responsibility to professionals is necessarily contingent on the clinical setting; in Roy's narrative we also see the extent to which that attribution can be affected by specific situations, as structural conditions limit the ward staff's responsibility. Crucially, attribution shifts *between* professionals rather than away from them; there is no suggestion, for example, that patients are responsible for cleaning the ward or even for alerting staff to the mess.

Shared Responsibility for Safety

Narratives that attributed responsibility for safety to both staff and patients could recognize any of the previously identified bases (*personal expertise, duty of self-care, professional expertise, professional duty*) and/or the additional basis *patient duty*. Patient duty relates to being a 'good patient', through compliance to hospital rules and clinical instructions (c.f. Evans 2007); thus, like professional duty and expertise, it is made relevant by the clinical setting. Shared responsibility narratives tended to place greater emphasis on such contextual factors, which affect or inhibit a group or individual's ability to exercise their own expertise or duty. In addition to hospital rules and other features of the clinical setting, such factors included more idiosyncratic or localized impediments to action. In other words, narratives that emphasized shared responsibility for patient safety presented that responsibility as *highly contingent* on the situation at hand, implicitly or explicitly pointing to reasons why staff and/or patients might be unable to act autonomously to ensure patient safety. In such narratives, both groups are obliged to work together as 'coproducers' of safety (Hor et al. 2013; Rhodes et al. 2016).

Asked, “*when you’re a patient in hospital do you think that you have a role to play in your own safety?*”, Adam, 80, responded:

Extract 7

Oh yes, I mean there are rules and one thing or another that they ask you to obey. I can’t particularly name anything at the moment but if I knew I had to get help, I would ring and get help. I wouldn’t try and do something on my own that would result in me falling or something like that. I was too conscious of the fact that I would fall or could fall very easily, so I always called for help, to make sure that I had somebody with me, even if they were just holding my elbow or something.

Adam’s narrative offers a contrast to Rachel’s ‘Zimmer frame’ narrative, illustrating how narratives about similar situations—told as an affirmative response to the same question—can frame responsibility for safety differently. Both narrators suggest that mobility-impaired patients have a role in mitigating falls risks through some form of intervention that will keep the patient safe. However, where Rachel’s narrative holds the patient solely responsible for intervening on his or her own behalf, Adam’s suggests a shared responsibility: the patient should call for assistance and a staff member should provide it. Like Rachel’s, Adam’s narrative acknowledges the importance of the patient’s personal expertise about their own limitations, but his narrative places greater emphasis on how contextual factors can limit that patient’s ability to take full responsibility. First, he acknowledges the patient’s duty to follow hospital rules, which necessarily limits that patient’s autonomy; second, he points to the mobility impairment itself as a limiting factor, explicitly stating that *because* he was at risk of falling, he would not attempt to act alone (for

example, by fetching a mobility device himself). In other words, Adam's narrative frames responsibility as highly contingent on such contextual factors.

Hospital rules and varying levels of impairment among patients are contextual factors that could reasonably be expected in a clinical setting. Other narratives of shared responsibility presented more incidental or unexpected contextual factors that mitigated individual staff or patients' responsibility and necessitated this kind of coproduction of safety. These factors could include errors, accidents, and other unforeseen eventualities. When asked who she felt was ultimately responsible for patient safety, Emma, 54, responded, "*the hospital itself, primarily, but I think everybody is, in their own way.*" She then described an interaction with a nurse:

Extract 8

I think it's up to you to point things out. Like when I was on [name of ward], I went to the toilet, and there were two blood spots on the floor, and you could tell they hadn't been there very long. I just went and pointed it out and she put a sign up, 'Do not use this toilet', straight away, did the nurse that I spoke to. And then within about five minutes, the cleaning trolley was there. *[Interviewer: Okay, so kind of like flagging things up and pointing-]* Yes, if you're able to, yes. *[Interviewer: And do you think you can make a difference to your own safety in that way?]* Yes, because sometimes, something can happen, like the cleaner can go around and do the toilets, whatever, and someone can go in and if they're not very well, have an accident or whatever, and because of how the rotas work, it might be half an hour before a cleaner comes back to check that toilet again. So if you point it out then obviously they'll come back and they'll do it.

The extract is another example of similar situations being interpreted and narrated differently. Like Roy, Emma was asked who should ultimately be responsible for her safety, and responded with a story about a potential hygiene hazard on the ward. While Roy's narrative attributed responsibility for maintaining cleanliness and hence patient safety to staff within a structural hierarchy, Emma's presents that same responsibility as shared between patients and staff through a series of interactions at a local level. The patient notices the blood and notifies a staff member, initiating a chain of events that results in the blood being cleaned up and—in the interim—other patients being warned about the hazard via a sign. The patient's responsibility to notify staff is based on her personal expertise (in this case, knowledge of her immediate surroundings in the toilet, which staff lack). However, she has no implied responsibility to clean up the blood herself (or to notify other patients); these responsibilities fall to staff, based on their professional duties. Also implied in the narrative is the responsibility that other patients have to follow the instructions on the sign, based on their own patient duty to adhere to such instructions in the clinical setting.

This complex interplay of responsibilities is explicitly premised on unforeseen eventualities: even if all staff perform their professional duties appropriately, “sometimes, something can happen” which compromises their ability to deal with a hazard. In this case, the timing of cleaning rotas and an accident in the toilet leads to staff having incomplete knowledge of hazards in the environment, which mitigates their responsibility for those hazards: a microcosm of the incompleteness of medical knowledge mitigating clinicians' broader responsibility for safety (Fox 2000). In such situations, when a patient gains knowledge of the hazard, she also gains a responsibility to intervene by communicating with staff. Crucially, the narrative does not suggest that it is always a patient's responsibility to notify staff of their cleaning responsibilities; rather, the responsibility emerges in a particular context and *only* “if [the patient is] able to”. Stories like these recognize both the capabilities

and limitations of staff and patients; the capabilities highlighted show how each *can* be (co-) responsible, while limitations demonstrate reasons why the other *must also* be (co-) responsible when the situation demands it.

DISCUSSION

Previous research has shown that understandings of patient safety, and the patient's role in fostering safety, can differ between patients and clinicians, between patient groups, and even for the same patient (Doherty and Saunders 2013; Rhodes et al. 2016; Sutton, Eborall, and Martin 2014). Our analysis expands this work to suggest that understandings of *responsibility* for patient safety can be equally complex and diverse. Heimer and Staffen (1998) demonstrated how, although particular roles (such as 'parent') entail particular responsibilities, role incumbents differ in their engagement with those responsibilities. The responsibilities entailed by the 'patient' role are less clearly defined than those entailed by the 'parent' role (English 2005), although those responsibilities do seem to be increasing, including through an expectation of safety-creating behaviors on the part of the patient (Rhodes et al. 2016; Schwappach 2010). In this paper, we sought to address the current lack of knowledge about patient understandings of such responsibilities, which will hamper attempts to engage them in these types of behaviors.

The typology we present demonstrates how, when patients attribute responsibility to staff and/or to patients, they frame these attributions in terms of the *basis* and the *contingency* of responsibility. This offers a new framework for understanding patients' engagement—or not—with the emerging role of "responsibilized patient" (Pedersen and Kjær 2017) and their expectations of hospital staff. In addition to contributing to the theoretical understanding of responsibility, there are implications for practice in the field of patient safety and healthcare more broadly.

Narratives that emphasized patient responsibility for safety tended to base this attribution on personal expertise and/or the duty of self-care, while those that emphasized staff responsibility based the attribution on professional duty and/or professional expertise. Narratives that emphasized shared responsibility could recognize any of these bases, and/or the additional basis, patient duty. Patient recognition of various bases has positive implications. For example, recognition of their own personal expertise can be empowering (Ocloo 2010), while recognition of duty of self-care and patient duty is likely to ease the burden on staff. At the same time, recognition of professional expertise and duty is likely to be reassuring for patients, at least when those bases are seen to be appropriately acted upon by staff. The potentially negative implications of overemphasizing either patient or staff responsibility are revealed in narratives' framing of contingency.

Narratives attributing responsibility primarily to patients framed that responsibility as being relatively unaffected by the hospital setting (as having low contingency), in that patients retain responsibility within that setting as they would outside it. This may indicate distrust of healthcare professionals, which could have implications for patients' willingness to cooperate with staff (c.f. Heimer and Staffen 1998:230–1). This framing of responsibility also risks placing an undue burden on patients, and may discourage them from certain forms of safety work such as asking for help from staff (Sutton et al. 2014). Indeed, as with any 'burden of treatment', there are limits to patients' agency and ability to undertake such burdens (May et al. 2014), which we discuss in more detail shortly. Conversely, when patients see responsibility for safety as being contingent on the hospital setting but otherwise unaffected by contextual factors (limited contingency), as in narratives that emphasize staff responsibility, patients' promotion of their *own* safety may be inhibited. For example, they may decline to monitor or question staff, based on the assumption it is literally not their 'place' to do so (Davis, Sevdalis, and Vincent 2011; Hrisos and Thomson 2013). Total

deference of responsibility to staff can also lead to feelings of lost control, fear, and anger when expectations of care are breached (c.f. Doherty and Saunders 2013:34).

Narratives that emphasized shared responsibility presented responsibility as more contingent than the other narrative types, thus necessarily recognizing multiple forms of duty and expertise. In these narratives, unforeseen circumstances, as well as expected or by-design contextual factors, necessitate communication and cooperation between different individuals or groups to ensure patient safety (c.f. Davis et al. 2011; Rhodes et al. 2016). Rather than responsabilizing only patients or only professionals, such narratives suggest a role for patients *within* the moral community of the clinic (Aveling et al. 2016). This role may include speaking up about concerns, providing feedback on their experiences, or following the instructions and advice of staff. Crucially too, these narratives suggest that *patients* can recognize this moral community and the necessity of “joint enterprise” (Heimer and Staffen 1998:137) in the context of patient safety.

Aveling et al. (2016) demonstrate how the ‘problem of many hands’ can obscure responsibility for patient safety, but that institutions must nevertheless provide healthcare professionals with “opportunities to be good”. Advocating the benefits of co-responsibility through recognizing mutual duty and expertise and greater contingency necessarily recognizes yet more hands and further complicates responsibility; however, it also identifies more opportunities to be good, for both staff *and* patients. These possibilities must be made visible, through educating patients on what patient safety involves, and educating staff and patients on the roles that both can play. However, the possibility of shared responsibility should not be idealized. Certain clinical scenarios have little scope for patients to take responsibility, and there are various contextual factors that will affect patients’ understandings of responsibility or otherwise limit their ability and willingness to take a shared role in safety-creating behaviors, or in any other aspect of their care.

First, the organizational context of the clinical setting can pose an obstacle to patient involvement in care in general, in that the patient is a ‘novice’ in that setting. Unequal power dynamics with staff (especially clinicians) may dissuade patients from playing a role, and even with greater patient education, patients may remain uncertain as to what role they are expected to play. Heimer and Staffen’s (1998:5) observation that it is hard to know one’s own responsibilities “on someone else’s turf” takes on even greater resonance in the context of patient safety, because of the ever shifting policy landscape and the concomitant confusion about the role of the patient within it. Second, while the shifting locus of responsibility ostensibly includes all patients, individual patient characteristics will affect their willingness and ability to accept and enact (co-)responsibility. Relevant characteristics are likely to include physical and cognitive impairments, unique past experiences of care, and expertise (or otherwise) in their own health condition (c.f. Doherty and Saunders 2013; Kraetschmer et al. 2004; Rhodes et al. 2016). They will also include characteristics such as gender, age, and socioeconomic background (c.f. Heimer and Staffen 1998), and, relatedly, patients’ level of health literacy (Longtin et al. 2010). Crucially, such characteristics might negatively affect patients’ willingness or ability to *take on* ‘their share’ of responsibility *or* their willingness to *give up* any of that share in the name of co-responsibility. This raises a challenge around how to pitch the concept of shared responsibility to patients. Finally, patients’ understandings of their own and others’ responsibilities, and their engagement (or not) in safety work and other aspects of their care will be affected by the socioeconomic and cultural context. While the participants interviewed for this study all received treatment ‘free at the point of care’ within the English National Health Service, in fee-paying health systems (in the UK and elsewhere) responsibility may well be constructed differently. In such cases, patients might be more likely to position themselves as consumers (Bergen and Stivers 2013; Pedersen and Kjær 2017), with implications for how they construct their own and hospital staff’s responsibilities.

Further research is needed to understand the effects of these different factors in the field of patient safety and in healthcare more broadly.

Given this variety of contextual factors, some patients will always remain unwilling or unable to share responsibility for their safety. It might therefore be recommended that healthcare professionals are educated about patient's variable *understandings* of responsibility for safety. Making staff aware of and sensitive to these variable understandings will enable them to recognize why some patients do not engage with certain safety processes, while other patients do. In turn, staff can ensure that the informal 'working around' strategies that they necessarily adopt to ensure safer care (Aveling et al. 2016) include working with and around patients' different understandings of responsibility for safety and associated levels of engagement with safety practices. The usefulness of patient experience data to improving patient safety is well established (Reason 2007), as is the unique and subjective nature of narratives as an asset for clinical education (Hurwitz 2000). Capturing such nuances can enrich or counter existent measures of patient safety, and inform the codesign of safety enhancements that will have greater relevance to patients and legitimacy to clinicians. If healthcare professionals are to be educated on patients' understandings of responsibility, exposing them to such stories is an excellent place to start.

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NOTES

1. The larger study collected interviews with healthcare professionals and patient survey data, but the current study did not draw on these data.

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Dr Emily Heavey is a lecturer in health and community development in the Department of Behavioural and Social Sciences at the University of Huddersfield. Her research explores patient and service user experiences of health, illness, and care. Emily has a particular interest in discourse and narrative methods in the context of sociologies of disability and embodiment.

Justin Waring is Professor of organizational sociology in Nottingham University Business School at University of Nottingham. Justin's research investigates the changing organization and governance of healthcare professional work, culture, and identity. He is an international expert in the sociological study of quality and safety in healthcare settings.

Dr Aoife De Brún is a research fellow and chartered psychologist in the School of Nursing, Midwifery and Health Systems at University College Dublin, Ireland. Her research explores a range of topics in applied health and organizational psychology including team dynamics, collective leadership, medical decision-making, and patient safety.

Dr Pamela Dawson is director at PD Education and Health Consulting Ltd. She is an independent health consultant with a research track record in patient safety, including falls prevention and organizational care transfers. Pamela is a chartered physiotherapist by professional background and consults within higher education and healthcare organizations.

Dr Jason Scott is senior lecturer in public health in the Faculty of Health and Life Sciences at Northumbria University. Jason's research focuses on quality improvement and patient safety in health and social care. His primary research interests include understanding the role that

patients can play in their own healthcare, and the disposition of care as it spans organizational and cultural boundaries.

Box 1: Key interview topic areas and prompt questions

In terms of the care that you receive, what do you understand by safety?

Have you ever been involved in something to do with your care that may have or did affect your safety?

Have you ever experienced something that made you feel particularly safe?

Do you think that as a patient, you should have a role in your own safety?

Who should ultimately be responsible for your safety?

Do you think patients should be providing feedback on their safety?

Table 1: Demographics of interview participants by discharge ward

Participant pseudonym	Gender	Age	Ethnicity (as stated by participant)
<i>Cardiology ward</i>			
Meredith	Female	55	White British
Matthew	Male	61	White
Fiona	Female	68	White English
Rachel	Female	81	English
Stephanie	Female	79	White British
Roy	Male	82	White
Alexander	Male	86	British/English
Caleb	Male	65	British
Tobias	Male	59	British
Mark	Male	54	White English
Jade	Female	67	White British
Emma	Female	54	British
James	Male	60	White British
<i>Care of older people ward</i>			
Liam	Male	83	English
Richard	Male	68	English
Noah	Male	71	White British
<i>Orthopedics ward</i>			
Harry	Male	80	White English
Michael	Male	53	White English

Benjamin	Male	77	English
Isaac	Male	65	English
Sofia	Female	65	White European
Christopher	Male	69	White British
Lena	Female	56	White British
<i>Stroke ward</i>			
Daniel	Male	56	White British
Carice	Female	56	British
Adam	Male	80	English
Nathalie	Female	80	White British
Jon	Male	62	White British

Table 2: Bases of responsibility for patient safety

Term	Definition
Personal expertise	Knowledge held by the individual patient and not by members of staff (e.g., knowledge about patient's past experiences of care).
Professional expertise	Knowledge or skills held by hospital staff and not by the patient (e.g., clinical knowledge).
Duty of self-care	The obligation held by all people (not only patients) to take care of themselves.
Professional duty	The obligation held by all professionals to do their jobs properly (e.g., by completing designated tasks).
Patient duty	The obligation held by all patients to behave appropriately in healthcare settings (e.g., by following hospital rules).

Table 3: Effects of basis and contingency on attribution of responsibility

Attribution of responsibility	Possible basis of responsibility	Contingency of responsibility
Patients	Personal expertise Duty of self-care	Low (i.e., responsibility is largely unaffected by context).
Staff	Professional expertise Professional duty	Limited (i.e., hospital context affects attribution responsibility, but context/situation has little effect beyond that).
Patients and staff	Personal expertise Professional expertise Duty of self-care Professional duty Patient duty	High (i.e., the immediate context/situation can affect attribution).