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Labelling patients.

Introduction.

The purpose of this paper is to discuss the ways in which diagnostic radiographers attribute labels to their patients whilst working. The example of one department is used as part of a doctoral study to inform these deliberations [1].

Many different patients access the diagnostic imaging department for a variety of radiographic examinations. Within diagnostic radiography, as with other professions, the staff members tend to label or categorise their patients based on the information that they have about them. This could be based on the patient's age, gender, the examination they have attended for, the nature of the injury or pathology that they are being investigated for and the circumstances of the acquisition of the injury [2]. Many professionals form similar judgements about their service users, both in healthcare and other public services [3]. These judgements assist them in dealing with the many different people that they encounter in their work. Goffman [4] studied situations in which people meet and form judgements about one another. He argued that stigma and stereotype are linked and that these are related to people's unconscious expectations and norms. These can be seen in all social encounters. Symonds [5] takes this idea further arguing that moral norms are value-laden and that healthcare professionals categorise patients within an institutional social order.

The ethics of labelling and categorising patients are sensitive issues in current healthcare practice, particularly when the standard of care is under scrutiny [6].

This paper presents some of the data from a doctoral study which was an ethnographic study of the culture in a diagnostic imaging department [1]. The study took place over six months with four months participant observation followed by semi-structured interviews with ten key informants. One of the key themes that emerged from the data was that of 'labelling patients'. This paper is a discussion about this theme and how it informs practice within diagnostic radiography.

Literature review.

A search of the healthcare literature was carried out using the databases CINAHL and Medline. The search terms radiograph*, patient types, categorising patients and labelling patients were used. This search was carried out to identify any healthcare literature about labelling patients and also to look at the radiography literature more specifically. There were very few studies found, illustrating a gap in the literature.

Patient types.

It is generally part of any culture or group to have 'types' of people and to be able to categorise people into groups [7, 8]. When anyone meets another person for the first time they have a tendency to categorise that person. Once a person has been categorised in this was and decision is made about the type of person they are, then it appears to be easier to predict how they will behave and understand their actions. Madison [9] suggests that people use their expectations, images and impressions of people to label and categorise them. Labelling theories derive from the work of symbolic interactionists. These theories suggest that the world is not fixed and given, but depends upon how people define things around them. Becker et al. [10] in their seminal work about the culture in medicine use the term 'labelling' to describe

how society defines different people. Goffman [4] linked stigma and stereotype and suggested that everyone has expectations and norms which are used in social encounters to label people.

Davis [11] in his paper entitled 'the cabdriver and his fare' says that cabdrivers develop their own typology of cab users based on their appearance, demeanour and conversation. In healthcare this also applies, Hollyoake [12] describes this in nursing.

Diagnostic radiographers encounter many different patients. The radiographer's role is both technical and caring, but tends to be characterised by less time spent with the patients when compared to other professions [13]. Therefore the diagnostic radiographer has to make quick decisions about their patients, and the patient may be in pain or have experienced an accident or illness. Categorising the patient into a typology assists the radiographer in their decision making and planning for the radiographic examination [3].

Categorisation of patients in healthcare.

Long et al. [14] carried out an ethnographic study of the culture in a hospital and talk about the identity of the patient, and how the patient loses their previous identity when they take on the patient role. They discuss how patients are labelled according to their medical condition, for example they could be labelled as 'a total hip replacement' or 'an appendix'.

This reductionist language, where patients can be referred to as body parts is endemic within the diagnostic radiography profession [2]. The diagnostic radiographer

will scrutinise an X-ray examination request form, which normally begins with the examination being requested, a body part [15]. This reductionist language is also part of radiography education, so student radiographers are introduced to it early on in their training. Students begin by imaging different body parts [2]. Students become very quickly socialised into this way of referring to patients, and the culture where the patient is discussed in relation to the body part being imaged, e.g the next one is a chest [1].

Various authors discuss how patients can be categorised as unpopular patients [10, 16, 17]. This in turn has a potential to affect the way in which they might be treated. For example the unpopular or difficult patient may be labelled as such and not receive a high standard of care. A student nurse reported an encounter where they felt that labelling a patient as challenging or difficult reinforced poor care standards [18]. She felt that the label influenced the way that other professionals viewed the patient and that it became detrimental to their care.

There were no research studies carried out about this issue in radiography, although Murphy [3, 19] eludes to the fact the radiographers categorise their patients in order to decide how to image them.

Methodology.

This study used a qualitative methodology; ethnography to study the culture in one diagnostic imaging department in the East of England [1]. Ethnography has its roots in both British social anthropology, where researchers went out to study foreign cultures and in American Sociology (from the Chicago school) which used

observation to explore groups on the margins of urban industrial society. The task of these two distinct groups was the same, that of cultural description [20]. Since then ethnography has developed and moved into other spheres such as education, health care and social work. In many respects ethnography is really the most basic form of social research; it bears a close resemblance to the ways in which we make sense of the world around us [21]. Ethnography involves the study of a particular social group or culture in naturally occurring settings [22, 23]. In order to document their findings the researcher needs to become part of the culture being studied to gain understanding and insight. In ethnography the researcher needs to have direct and sustained contact with those being researched within their cultural setting. This involves watching what happens, listening to what is said and asking questions [24]. Ethnography should also be carried out over a period of time in order to reduce the impact of the researcher's presence on the situation being studied. "People can sustain an act or maintain their best image only so long" [25 p49].

Ethnography employs several research methods, which link findings together [24] and allow for what Richardson and St. Pierre [26] call crystallisation. The methods used were participant observation for a four month period and semi-structured interviews with key informants from the department. The observation notes and interview transcripts were analysed using thematic analysis.

The purpose of this research was to investigate the culture in the imaging department amongst radiographers. Qualitative methods provide further insight and rich data about the complex issue of culture [27].

Ethnography was selected as a methodology as it is the study of groups and cultures. It is carried out in natural settings, where people live and work in groups [28].

Ethical approval was obtained from the University Ethics Committee, the local research ethics committee (LREC) and the research and development committee (R&D) at the NHS Trust where the study took place.

Observation.

The observation started with an initial mapping of the department [29]. This involved observing the patient's journey through the department, recording where events occurred and creating a floor plan of the department in order to understand how the space was used. 43 members of staff were observed during the study.

The researcher is a diagnostic radiographer and was therefore observing her own profession. She took the role of 'observer as participant' [30]. Observation prompts the researcher to consider what it means to be a part of the group being studied [31]. It was useful to have some sense of shared cultural knowledge. Holland [32] believes that undertaking research in one's own field of practice reduces the 'culture shock' and makes the researcher more sensitive to the participant's behaviour. However, she also says that there is a danger of data being overlooked because of familiarity. During the whole period of observation the researcher was aware that her insider status could contribute to missing out on important information [33], as she would not necessarily see something as strange or unfamiliar and record this. The researcher had to be aware of over familiarisation [17, 34, 35]. During the period of observation the way in which the department was run, the way in which radiographers worked and

interacted with one another, and the way in which radiographers interacted with patients were noted. Field notes were recorded throughout the observation period by the researcher and these were used during data analysis to highlight events and to illustrate the findings about the workplace culture.

Observations were continued until data saturation had been reached, a point when no new information is generated [36].

Interviews.

Interviews were used following the observations to explore issues further. A cross-section of staff from the department were interviewed. Ten interviews were carried out with a purposive sample of key informants [27]. The staff members interviewed are listed in table 1.

The interviews were semi-structured and explored further the issues highlighted by the observations as recommended by Coffey [34] and Johnson [37]. The interviews were carried out over a period of one month. This was two months after the observation had finished, which allowed some time to reflect on the observations before carrying out the interviews. Interview questions were open and exploratory, based on the themes from the observations. The interviews were recorded onto a digital recording device and transcribed verbatim by the researcher. The interviews allowed for patterns of behaviour, action and interpretation to be explored [29, 38].

The observation and interview data were analysed using a thematic analysis. Data analysis is the process of systematically searching, arranging and making sense of

the data [36]. The data gathered from observations and interviews were analysed to look for common themes, patterns of behaviour and actions [38]. Themes were categorised and coded [39]. Codes were created from the data. Coding is a key process as it begins to create order and serves to organise the data [40]. The number of codes was not restricted, Hammersley and Atkinson [21] advocate this approach as it does not place any limits on the data. Hammersley and Atkinson [21] also suggest a 'funnel shaped' structure within data analysis, so that the analysis becomes more focussed over time with the large number of small codes being grouped together to form a smaller number of themes as the analysis progresses. Thus the coding structure should evolve inductively from the data.

The data were analysed by one person, and this could be considered to be a weakness of the study. However, the themes were discussed with the author's research supervisors to increase the reliability of the findings.

Results and Discussion.

19 themes emerged from the data and these can be seen in table 2.

It is recognised that this is data from just one department; but that the in-depth nature of the study has uncovered important issues which the author feels are applicable to other diagnostic radiography and radiotherapy departments.

One of the themes that emerged from the data was that of 'labelling or categorisation of patients'. This was observed as radiographers worked in the department.

The first aspect of categorisation was about workload. The radiographers felt that typifying patients helped them to decide how the examination would go, how to address the patient and also more crucially it gave them some idea of how long the examination might take so that they could plan. In categorising the patient, based on previous experiences they were able to make judgements about what to expect.

> *"radiographers talked about how they categorise people in order to know how long something will take, they tend to build up a picture in their minds of the patient once they have looked at the request card, they look at the name, date of birth and the reason they are there, and then they can decide what the examination will be like."*
>
> ***Observation 17/11/08, Staff Room***

This was done before the patient was called into the room, a judgement made purely on the information seen on the X-ray examination request card.

Radiographers often refer to their patients by the examination for which they have attended the department, for example, there's a chest outside; the next patient is a knee [2]. The radiographers also referred to patients who had attended for several radiographs as a 'shopping list' or a 'shipping order'. This was observed in most areas of the department in the staff only areas, out of the earshot of the patients. This observation was discussed with the radiographers in their interviews and one of them expressed it thus;

> *"Well, it's our job isn't it to X-ray their foot and that's what you're doing and although we're obviously aware that there's a patient attached to the foot, it's the foot really isn't it?"*
>
> ***Interview with radiographer.***

Long et al. [14] refer to this as depersonalisation in their hospital ethnography. They say that "for many people, hospitals are places in which their previous identities…

are stripped bare" (p73). They go on to say that patients take on the name/role of their condition/pathology and are known by this, for example, a hip replacement, an appendectomy. Murphy [19] also says that in the imaging department patients can become depersonalised and objectified and this is not unique to radiography. Reeves and Decker [2] refer to this as reductionist language and describe it as being part of the way in which radiographers discuss their patients in practice to one another.

It appeared that this labelling of the patient was done in order to build up a picture of the patient and to plan the workload. Radiographers need to make a rapid assessment of their patients and their capabilities and by categorising them into a patient 'type', they can call on previous experiences with similar people and make decisions about how the examination should proceed. In this way the radiographer is using their previous experience and expertise to deal with their patient [41].

The second categorisation observed was that of patients who were considered to be deserving of health care and those who were not. This notion of deserving and undeserving patients comes from the Elizabethan period where the 'impotent poor' (the deserving old or sick) were cared for in poorhouses or almshouses, and the able-bodied (undeserving) worked in houses of correction which some people thought were too comfortable and expensive. The Royal Commission of Inquiry and 1834 Act shifted responsibility from the church to the Poor Law Commission, and the Poor Law aimed to put people off applying by sending them to the workhouse. The principle was that the undeserving poor must be worse off than the worst paid worker so only those in true need would seek relief and support. Many of the public still hold

on to this belief of people who are deserving and undeserving of welfare support or healthcare. When the NHS was created on the 5th July, 1948 it was available on the basis of health care need, and free at the point of use, this aimed to reduce the notion of the 'deserving' and 'undeserving'.

This categorisation is not unique to diagnostic radiographers, in fact many studies in health care talk about the notion of unpopular or undeserving patients; in a hospital emergency department [16], in medicine [10], and in nursing [17]. Other studies also talk about how health care professionals make judgements about patients and categorise them in order to decide how best to treat them; in radiotherapy where radiographers were seen to 'typify' their patients [42], in an emergency department [16, 43], and in health and social care in general [44].

In this study the patients considered to be 'undeserving' were broadly those who had contributed to their own health care issues. For example, due to alcohol consumption;

> *"I observed two DRs talking about a patient who had been referred for an X-ray but was behaving badly and had been involved in a fight. He had been drinking heavily and he was quite rude to the DRs. The DRs commented that he didn't deserve to be looked after."*
>
> ***Observation 14/8/08, A&E,***

in relation to drugs overdose;

> *"A Radiologist came into the staff room to speak to the CT DRs about a patient in resus who had taken an overdose and stabbed himself, he needed a CT abdominal scan urgently. Once she had left the room the DRs discussed this patient and many derogatory and sarcastic joking comments were made."*
>
> ***Observation 6/11/08, Staff room,***

from stabbing themselves;

"the DRs discuss patients from last week, which was busy and talk about the patient who had stabbed himself. The general opinion was that he did not deserve all of the fuss that was made of him as the injury was self-inflicted."

Observation 11/11/08, CT,

and due to obesity;

"DRs talk about imaging obese patients and how difficult it can be. DR5 had had a difficult patient this afternoon to X-ray, he was overweight and she found it a challenge. The DRs commented that obese patients need to lose weight so that they have less chance of having health problems."

Observation 17/11/08, Staff room.

The radiographers were making judgements based on the patient's circumstances and these judgements were verbalised between the radiographers. It appeared that the patient's circumstances contributed to the way in which these patients were perceived by the radiographers.

In contrast to this, when radiographers considered that a patient was in their opinion 'deserving' then they genuinely cared for them. A radiographer was observed caring for a distressed patient;

"one of the patients was very distressed and upset, the radiographer spent time with her, listening to the patient's problems and reassuring her."

Observation 11/8/08, Main Department.

This particular radiographer took quite a lot of time to sit with the patient, despite the department being busy.

A radiographer was observed reassuring a nervous patient in CT;

"there was a nervous patient who needed reassurance from the staff and some gentle persuasion to go through with the scan. The radiographers demonstrated empathy, good patient care and communication skills."

Observation 11/11/08, CT.

In this situation it was apparent that the radiographers felt it to be worthwhile to spend some time reassuring this patient, so that they were able to go through with the investigation. They evidently felt that this patient needed care and attention.

Radiographers also spoke in their interviews about the need to reassure patients;

> *"you try your best with them and you try and get them in and reassure them and talk to them, explain what you're doing."*
>
> ***Interview with radiographer.***

> *"you've got to try and sympathise with them and try and reassure them. As long as you explain to them what you're going to do then they're usually fine."*
>
> ***Interview with student.***

and being caring to those who are unwell;

> *"if they're really ill I change my tone of voice, I change the words that I use, I'm quieter."*
>
> ***Interview with radiographer.***

The radiographers appeared to typify their patients based on their initial impressions and previous experiences [41].

The typifying of patients can often affect practice and the way in which patients are treated. It appeared that patients who were seen to be more deserving appeared to be treated in a more caring way by radiographers, and those interviewed felt that it was important to reassure and care for these patients. However, if a patient was seen to be less deserving then radiographers said that they found it hard to show empathy to these patients. No patient was poorly treated or treated without dignity and respect, and it was not obvious from their interactions with the patients that the radiographers found some of their patients challenging. These feelings were only expressed in the staff only areas of the department, and it was interesting to notice that the radiographers appeared to agree on which patients were considered to be

deserving based on their judgement of the patient's circumstances and the information that they had been given. Other authors describe this notion of the unpopular or challenging patient in nursing [41, 46, 47]. These authors all speak about how some patients, due to their healthcare problems, attitude or circumstances are more challenging to care for and may therefore be labelled as 'difficult' or 'unpopular'.

From this study it seems to be the norm for radiographers to label their patients. This is often done in order that they can work out how long the examination might take and what might be required which can assist with work flow. This may also be linked to the radiographers not wishing to become involved with or close to their patients by identifying them as an examination, rather than as a person [48]. Using the examination name is another way of categorising the person and trying to predict how they will behave [2].

Conclusion.

It appears that diagnostic radiographers make a rapid assessment of their patient and categorise them into a particular patient type which allows them to make judgements about the patient. Along with this patient categorisation, radiographers may also refer to the patient by the name of the examination for which they have attended.

Categorising the patient in this way then appears to assist the radiographer in their decision-making processes about the examination to be carried out and about the patient that they are about to deal with. The radiographers use the information that

they have from the request card to typify their patient. However, an error in judgement could lead to poor communication, something which a radiographer may experience if they make an incorrect judgment.

The concept of popular/deserving and unpopular/undeserving patients is not a popular one, however there is evidence that this occurs in practice. This could prove to be a problem in terms of caring for patients in an imaging department if the radiographer's judgement or labelling of such patients had an effect on the care provided to patients.

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