Unconscious bias: the hidden culture underpinning preoperative pain planning and day surgery practices

INTRODUCTION

Due to the nature of surgery and the potential for tissue injury and the initiation of nociceptive pain responses, perioperative analgesia should be arranged preoperatively, using pain planning which encompasses individualised and comprehensive pain screening (Chow *et al.,* 2012). However, while contemporary practice acknowledges this, comprehensive preoperative assessments within day-case surgery are often inadequate (D'Arcy, 2012). The reasons for this are complex due to the competing forces of agency (the extent to which one is free to make a choice) and structure (the external social, political and economic influences that may limit choice) (Bourdieu, 1977). Consequently, perioperative care does not take place in a vacuum, and preoperative practices may vary considerably depending upon clinical culture (Stomberg, Brattwall and Jakobsson, 2013).

Cultural research studies attempt to explore the shared practice of a specific group of individuals and try to explain human behaviour and the social interactions which are often deemed as the norm. However, the 'cultural portrait' of a specific sphere of practice can often be mispresented, as the surface image is only the tip of the iceberg and it is the invisible internal culture, found beneath the surface, which represents the greatest influence on clinical practice.

METHODS

To examine how culture influences and shapes preoperative pain planning practices; a critical ethnographic methodological approach was adopted, utilising Carspecken's five stage analytical enquiry. This approach, which utilised a structured framework, also enabled and encouraged the use of a variety of methods for collecting, analysing and interpreting the data, in order to capture multiple perspectives (Carspecken, 1996).

Qualitative and quantitative data including observations, field notes, staff interviews and timings of interactions between patients and staff were then analysed using reconstructive analysis and triangulated with the numerical data that was statistically analysed.

RESULTS

Over 9 months 124 patients and 33 healthcare professionals took part in the study, 130 hours of practice were observed, and 20 in-depth interviews with healthcare professionals took place. The hidden finding that emerged from this study was the concept of unconscious bias. Essentially how the partialities (of which the participants were sometimes unaware) towards "surgery type" and "gender" influenced pain planning and management decisions and interactions with day case surgical patients.

1. Day surgery and its position and status within the organisational hierarchy was often subject to unconscious bias. This was witnessed not only during the interactions between staff members but also between staff and patients. These conversations often devalued day surgery with the use of minimising language and sometimes comparing the time taken for the surgery or level of invasiveness, to surgical procedures which required patients to be admitted

2. Anaesthetic staff (who view their knowledge as superior to patients), make a value judgement on pain expectations associated with the surgery type, and this can be used as a way on imposing an expectation of minimal behaviour from the patient. The minimisation of day surgery was also found in staff interview responses when asked about pain preparation for day surgery patients.

3. There was an additional layer of bias related to more specific surgical specialities with orthopaedics being perceived as superior and gynaecology inferior in terms of specialism, income generation and also in relation to the levels of postoperative pain that can result from the procedure.

4. Differences in language and tone were also noticed when some staff discussed pain with male and female patients undergoing similar surgeries, which was often minimising, in particular when referring to the postoperative pain in female gynaecology surgery.

5. Gender inequalities were evident in the timings of the consultations with less time being spent discussing pain with female patients, especially those undergoing gynaecology procedures. This inequality is further reinforced when isolating the visits that can be directly compared in terms of surgery types, surgical list, surgeon and anaesthetist.

6. Gender bias was also illustrated in the language that was often used to describe female staff during the preoperative visits and also during the interviews, as female nurses were labelled using words which were are infantilising, and which negatively reflected on their professional status and worth.

CONCLUSION

Unconscious and intuitive processes can serve to protect; however, biases can also be harmful, and can negatively influence clinical decisions and interactions. Minimising and trivialising language can act in a coercive capacity, instilling a prior expectation of how patients should behave postoperatively. For the status quo to be changed, healthcare professionals need to be made aware of how unconscious biases, from both an organisational and internal perspective, can impact on their interactions with patients, and how the use of language can reinforce stereotypical attitudes and unequal power relationships between staff and between healthcare professionals and patients.

REFERENCES

Bourdieu, P. (1977) Outline of a theory of practice. Cambridge: Cambridge University Press.
Carspecken, P. F. (1996) Critical ethnography in education research: A theoretical and practical guide. New York: Routledge.
Chow, W. B. et al. (2012) 'Optimal preoperative assessment of the geriatric surgical patient: A best practices guideline from the American College of Surgeons national surgical quality improvement program and the American Geriatrics Society', J Am Coll Surg, 215(4), pp. 453-466.
D'Arcy, Y. (2012) 'Treating Acute Pain in the Hospitalised Patient', Nurse Practitioner, 37(8), pp. 22-31.
Stomberg, M. W., Brattwall, M. and Jakobsson, J. G. (2013) 'Day surgery, variations in routines and practices a questionnaire survey', International Journal of Surgery, 11(1), pp. 178-182.

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