Empowerment of whom? The gap between what the system provides and patient needs in hip fracture management: A healthcare professionals' lifeworld perspective

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Abstract

Aims and objectives: To use a Habermasian lifeworld theoretical perspective to illuminate a treatment gap for hip fracture patients in a Danish university hospital to guide future healthcare services.

Background: Most healthcare systems focus on systematised guidelines to help reduce hospital length of stay in response to increasing demand because of the ageing of the global population. For patients with hip fractures, a previous study demonstrated that there is a lack of patient
empowerment and a gap between patients' needs and wishes and what was provided by the healthcare system.

**Design**: In this follow-up study, the previous findings were introduced to a mixed group of health professionals (HPs) who participated in focus group discussions (n = 3, with a total of 18 HPs).

**Methods**: Data were analysed using qualitative content analysis. By analysing the discourse of the discussions using Habermas’ perspective, the lack of patient-empowerment was illuminated and facilitated, describing it in terms of the gap it creates in communicative actions between HPs and patients.

**Results**: Information and education of patients in systematised pathways, such as those for patients with hip fractures, are dominated by a biomedical discourse. Patients are overwhelmed by the psycho-social implications of the hip fracture for their lives, leaving them in a shock-like state of mind.

**Conclusion**: Empowerment of patients should involve empowerment of HPs by providing them with skills to support patients in a shock-like state of mind. There is also a need to provide HPs with a more individually targeted means of informing and educating patients.

**Keywords**: Empowerment; Hip fracture; Habermas; Lifeworld; System; Content analysis; Focus groups; Healthcare professionals; Self-care

**Introduction**

Hip fractures are the most common reason for admission to acute orthopaedic wards (Palm, 2008; Parker and Johansen, 2006). Although there is evidence of declining hip fracture incidence in some developed nations, the total number of patients with hip fracture is expected to increase globally (Dhanwal et al., 2011; Johnell and Kanis, 2006; Stoen et al., 2012) due to continued ageing of the population (Ahlborg et al., 2010; Stoen et al., 2012). In 2015, the World Health Organisation (Global Health and Aging, 2018; WHO, 2010) estimated that the percentage of the world's population over 60 years will increase from 12% to 22% by 2050. Hip fractures will continue to represent, therefore, an important health problem worldwide - not only for the patient and family in the form of functional decline and pain, but also for society from a health economics perspective (Hansen et al., 2013; Metcalfe, 2008; Schiller et al., 2015). (see Fig. 1)
This growing number of older adults is increasing the pressure on healthcare systems and is driving demand for optimum health initiatives. This is also generating demand for greater efficiency in patient pathways, interpreted by many government-funded health care organisations as a need to decrease length of (hospital) stay (LOS). Systematised and standardised guidelines, aiming to improve peri-operative programmes, have become increasingly common tools for care quality improvement and for facilitating efficiency in the hospital setting (Husted, 2012; Kehlet and Dahl, 2003; Walter et al., 2006). In future healthcare systems, individuals will increasingly be expected to be more involved in managing their own health and preventing disease, as is reflected in the design of joint healthcare systems (Clemensen et al., 2016; Ministry, 2017). Programmes focused on reducing LOS will increase pressure on health practitioners, who are central in preparing patients for hospital discharge. Spending less time in hospital will also add to the demand on patients and their relatives.

**Background**

Collaborative healthcare systems require empowered healthcare users. Empowerment is a concept that focuses on the processes through which people can be enabled to improve their ability to develop, control and manage their own resources (Anderson and Funnell, 2010). The operationalisation of the concept of empowerment involves creating processes through which individuals are able to counteract deprivation and dependence. Patient empowerment is described as: “...a process through which people gain greater control over decisions and actions affecting their health” (WHO, 1998). A growing body of qualitative research concerning hip fracture management (Gesar et al., 2017a,b; Langford et al., 2018; Sims-Gould et al., 2017) has addressed gaps and needs in the rehabilitation process.

According to report from the National Research and Analysis Center for Welfare in Denmark (VIVE), the Danish healthcare system is in the midst of unprecedented development (VIVE, 2017). Five trends will challenge this system in the next few decades and drive its development: 1) the aging population; 2) increasing...
incidence of chronic disease; 3) the information revolution; 4) clinical-technological development and 5) future citizens as new health care consumers. More diseases can now be treated or managed, often more safely and more effectively than in the past. Such developments are beneficial for many, and have given the whole population greater security. The most serious side effect of this positive development, however, is that healthcare costs are continuing to rise. The Danish government focus, therefore, is on reducing hospital costs through, among other things, interventions aimed at efficiency and prevention. Such drivers for change are also evident in other countries with sophisticated healthcare systems. Systematised programmes have become increasingly common, not only in Denmark, but worldwide, as essential tools for improving efficiency in the hospital setting (Husted, 2012; Kehlet and Dahl, 2003; Walter et al., 2006).

A Danish study considering the patient's perspective of hip fracture management and short LOS found that the empowerment of patients was not adequately achieved (Jensen et al., 2017). The study found that, although patients were given oral and written information during hospital admission, they could not recall the information later. Patients recovering from hip fractures, who had been independent prior to the injury, had a strong desire to be in control of their own lives and to remain autonomous. They did not, however, feel in control of their hip fracture management and rehabilitation. Patients seemed to accept systematised pathways with a short LOS. They wished to be treated as individuals, but this did not seem to be achieved during hospitalisation. Acquiring a hip fracture and recovering from the injury is a traumatic experience both physiologically and from a psycho-social perspective, placing individuals in a shock-like state of mind not unlike neurogenic shock. A gap between patients' needs and wishes and what was provided by the healthcare system was identified by the study, indicating a need to change healthcare practice. This lack of empowerment in a society with a healthcare system where individuals are, conversely, expected to be involved in maintaining their own health, indicated a need to explore this issue using Habermas (1984b) perspective of ‘system’ and ‘lifeworld’ as the theoretical framework. Application of Habermas' theoretical perspective has previously been a useful tool in effecting change in medical and healthcare practice, or interpretation of social ramifications caused by diagnosis or illnesses, by giving voice to patients' lifeworld. It was anticipated that this approach could guide development of future healthcare services involving the management of hip fracture within the context of short LOS.

**Methods**

**Study aim**

The aim of the study was to use a Habermasian lens to illuminate the Health Professionals' perspective of the gap between what the system provides and patients' needs and wishes, with a view to supporting patient-empowerment.

**Study design**

This study was the second sub-study in a sequence of four planned sub-studies within a participatory design approach with the collective aim of improving the pathway for future patients with a hip fracture in a distinct hospital in southern Denmark. Participatory design (PD) is a research methodology that derives from action research (AR) and is a research methodology located within an interpretative and critical worldview (
Simonsen and Robertson, 2015). AR aims to create a new understanding of peoples’ practices by becoming part of the practice and to bring about change by action that is informed and shaped by this collaborative understanding. PD shares many fundamental values and objectives with AR, such as empowerment and democratisation (Foth and Axup, 2006) and, consequently, some of its methodology. As Foth and Axup describe (2006), the main differences lie in the intent and purpose: while AR might be characterised as seeking to act, change, understand and reflect; PD is also concerned with involving and designing. PD is about the direct involvement of people in the co-design of the information technology they use (Simonsen and Robertson, 2015).

In the first sub-study, patients’ needs and wishes were identified through field studies and interviews with patients, their relatives and health professionals. (For further information about this study see Jensen et al., 2017). The purpose of the second sub-study reported in the present paper was to enable the patients' lifeworld to be illuminated for health professionals (HPs) by exploring the findings from the first sub-study with them using focus group discussions (FGs). The findings relating to patients' needs and wishes were discussed in the FGs to initiate the generation of ideas towards creating a solution to bridge the gap between patients’ needs and wishes and actual practice.

**Setting and participants**

The characteristics of the participants in the FGs are summarised in Table 1. They were all HPs from various healthcare professions working at the same hospital and with a professional connection and collaboration through the patient pathway of focus: patients with a hip fracture treated at a university hospital in southern Denmark.

<table>
<thead>
<tr>
<th>Focus group number</th>
<th>Participants</th>
<th>Duration</th>
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<tbody>
<tr>
<td>1</td>
<td>1 doctor in chief</td>
<td>120 min</td>
</tr>
<tr>
<td></td>
<td>1 leading orthopaedic doctor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 head nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 endocrinologist</td>
<td></td>
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<tr>
<td></td>
<td>1 geriatrician</td>
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Illustrates, who participated in the three focus groups.
Purposive sampling was conducted based on the participants’ involvement in the patient pathway of interest. Initial contact with participants was made by the first author, either face-to-face and/or by email. They were given written information about the study and their voluntary participation was sought.

**Data collection**

Three FG discussions took place in the last three months of 2016. FG discussions were chosen as they create a dynamic and idea-generating dialogue, ideal for discussing experiences (Freeman, 2006; Spradley, 1979). Each FG commenced with a short presentation of the aim: i.e. to discuss findings relating to patients’ needs and wishes compared to what is provided by the healthcare system (Jensen et al., 2017) and to generate ideas about how to improve the patient pathway. The findings of the first sub-study were presented to the FGs as three overall points of interest along the patient pathway as follows:

1. Acquiring a hip fracture is a life-breaking event - not only a break in a physiological way but the break also causes social and existential cracks and worries about the future. These worries mask patient’s states of mind and leave them in a situation similar to neurogenic shock after trauma (a ‘shock-like state’).

2. Mean LOS was 5.6 days. Patients were aged between 67 and 92 years. Patients were given written and oral information along the pathway and at discharge. Nevertheless, they had little or

<table>
<thead>
<tr>
<th>2 researchers</th>
<th>1 extern observer</th>
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<tr>
<td>1 geriatrician</td>
<td></td>
</tr>
<tr>
<td>2 nurses (1 with 10–15 years of experience; 1 with 1 year of experience)</td>
<td></td>
</tr>
<tr>
<td>1 Social and Healthcare assistant (with &gt;30 years of experience with patients with hip fractures)</td>
<td></td>
</tr>
<tr>
<td>1 physiotherapist</td>
<td></td>
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<tr>
<td>2 researchers</td>
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<tr>
<td>1 extern observer</td>
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| 2 nurses with 5–10 years of experience |
| 1 Social and Healthcare assistant (with 20–25 years of experience with patients with hip fractures) |
| 1 geriatrician |
| 1 physiotherapist |
| 2 researchers |
| 1 extern observer |

| 3 nurses |
| 1 Social and Healthcare assistant (with 20–25 years of experience with patients with hip fractures) |
| 1 geriatrician |
| 1 physiotherapist |
| 2 researchers |
| 1 extern observer |
no recollections of this after discharge. Patients accepted the short LOS, but many felt that they had been treated as “a hip fracture” and not an individual person. Patients wished to “be masters of their own destiny” and have autonomy, but they did not feel supported in this.

3. When patients received letters summoning them for osteoporosis assessment or fall prevention programmes, they often chose not to attend as they had no recollection of having the importance of these explained to them.

After presenting each of these points, discussions were initiated using open questions such as “What do you think of this?”. This allowed the participants to freely discuss their thoughts, perceptions and ideas and generated follow-up questions. When the subject of the discussion progressed to a different issue, an immediate first validation of the content was conducted by summarising the contents of the discussion.

As recommended by Morgan (1993), each FG was planned to involve 6 to 10 participants, enabling constructive group interactions. An additional observer was also present at all FGs who took notes and posed questions designed to illuminate implicit statements made by the participants using their own professional terminology. Some of the discussion used common language or tacit knowledge known only to the HPs and this needed to be interpreted and checked with them. Undisturbed meeting facilities at the hospital were used to conduct the FGs. Each lasted for 90–120 min and was facilitated by the first author (CMJ) in the presence of the last author (JC) as an experienced moderator. Data saturation was reached when no new ideas or comments emerged in the discussions. The FGs were audio recorded and transcribed verbatim by the first author (CMJ).

**Theoretical framework**

Drawing on Habermas' theoretical framework enabled us to analytically and theoretically distinguish lifeworld from system aspects of the patient pathway. Habermas (1989) describes the healthcare system, including its actors such as hospital physicians and other healthcare providers, as a subsystem. The actors' roles are to assess and provide care and treatment to patients using evidence-based guidelines. For communicative rationality or actions to occur, decisions must be rooted in the participants' lifeworld. Lifeworld is the background to ordinary life, representing individuals' everyday lives. Habermas elaborates on this in the description of three dimensions of lifeworld (Habermas, 1984b);

1) The objective world; containing knowledge that can be judged “objectively”. Empirically based medical knowledge belongs to this world.

2) The social world; concerning the way people relate to others, the rules and norms that govern social interactions. Patients' expectations of other persons and health-related decisions belong to this category.

3) The subjective world; made up of intentions, thoughts, emotions and wishes. For medical decisions to be rooted in the subjective world, the criterion is that the patient perceives them as congruent with his or her intentions, emotions and wishes.

In practice, the three worlds are heavily intertwined (Habermas, 1984b). Lifeworld is based on a tacit fund of shared meanings and understandings that enable us to perform actions that we know others will comprehend.
A central part of Habermas' theory is that lifeworld can only be reproduced in and by the means of the lifeworld, namely, through a common understanding based on what he calls “communicative action” (Habermas, 1984b). Habermas' theory of communicative action theorises that there is a tension between human communications in “lifeworld” and “the system”. In lifeworld, communications constitute true “communicative actions” that are sensitive to context, oriented toward mutual understanding, and result in planned actions through consensus and coordination. Habermas’ theory of communicative action is also based on the assumption that we reach a greater insight into matters concerning individuals by using language - asking and answering questions - thus enabling reproducing lifeworld.

In contrast, the system (in this case, the patient pathway) communicates through a pattern of “strategic actions”, which are governed by abstract and decontextualised rules. The system pursues goals that are defined in technical and instrumental terms. These goals are oriented toward producing a desired outcome instead of achieving mutual consensus. Thereby actions are made through instrumental trading (Habermas, 1984a, 1984b). In the context of the present study, binary codes are used as inclusion/exclusion criteria for treatment of a biomedical condition.

When the system intrudes in an inappropriate and unaccountable way into the lifeworld, the problem is that instrumental trading overrules and, to some extent, replaces the communicative action. Thereby, lifeworld is colonised by the system. This colonisation can lead to psychological and social problems such as identity loss and a reduced feeling of social belonging (Habermas, 1984a) - a lack of empowerment. The first sub-study had exhibited a gap between what the system provides and patients' needs and wishes – demonstrating a need to bridge the gap by illuminating the patients’ life world for HPs so that the pathway could be adapted to meet unmet needs.

**Data handling and analysis**

Since the aim of the FGs was primarily to enable participants to understand patients' expressed needs and wishes and to generate ideas about improving the patient pathway, illuminating the discourse in the transcribed data from the FGs enabled an awareness of an imbalance between the patients' lifeworld and the HPs' lifeworld. Using a Habermasian lens in analysing the data, therefore, enabled the discourse to be examined from “lifeworld” and “system” perspectives.

As we wished to analyse the data from the discourse of the FGs, we used conventional content analysis (Graneheim and Lundman, 2004; Hsieh and Shannon, 2005). This enabled a focus on the characteristics of language as communication with attention to the content or contextual meaning of the text using an approach to analysis inspired by Fairclough's critical approach (Fairclough, 2010) who describes content analysis as a critical analysis of the discourse for communication of need for change. This corresponded with the aim of the study being to inform a change in future healthcare practice. The manifest content of the transcribed material was analysed. Transcripts from all three focus groups were read and re-read several times so that the researcher became immersed in the data. The initial analysis highlighted meaningful utterances, which could be as short as a few words in a sentence or as long as a whole speech. A matrix was constructed to organise the objective, the subjective and the social life-world perspectives in three overall categories concerning the patient pathway. Each utterance made by the different HPs was coded according to the categorising matrix by the first author.
Then, analysis concerning the Habermasian perspective of system and lifeworld aspects was discussed and described by two of the authors (CMJ, PRJ). The first and last author (CMJ, JC) discussed the findings and agreed on the final themes. Finally, findings and the themes were discussed by all authors in relation to the socio-political/socio-cultural context.

The interviews were conducted, recorded and transcribed in Danish. For the purposes of this paper, the quotations from participants, chosen to illuminate the themes, have been translated into English. The first author speaks English as a second language and was present at all interviews so conducted the first draft of translations. The translations were then cross checked for grammatical accuracy by two native English-speaking authors (JST and AS).

**Ethical considerations**

All participants gave their informed, written consent. Approval was obtained from the Regional Health Service and University Research Ethics Committee and the Danish Data Agency (S-20110171; § 14.1; 2008-58-0035) (case approval no. 15/11860). Data were semi-anonymised in that no names have been identified but individual professions are identified to enable the reader to understand the professional context. Where quotations are provided in the findings, each participant gave their permission for this and for the context of their presentation to be discussed.

**Findings**

Sixteen HPs from one Danish university hospital orthopaedic trauma unit participated in the FGs (see Table 1). Nineteen HPs were invited to participate, but three declined due to other obligations: a physiotherapist in the first group, and an orthopaedic surgeon in each of the second and third groups.

Analysis indicated that the language the HPs used in connection with the patient pathway originated from a biomedical discourse. Two main themes emerged; “representing the objective, the subjective and the social life-world perspectives:

1) Systematised pathways and clinical guidelines are inevitable
2) How to counteract patients' lack of information.

In the following section these two overall themes will be presented in turn using data extracts to illustrate each theme.

**Systematised pathways and clinical guidelines are inevitable.**

A systematised guideline with physical foci, including rapid mobilisation, was used as a tool for quality development and improvement of efficiency in the hip fracture pathway in which the study participants were involved. The discourse in the discussions was predominantly biomedical and concerned the objective world. Actions were articulated as instrumental using words such as: baseline; control; instruct; plan; standard and flow as illustrated in the following quotations:
“...according to the plan, the patient has to be mobilised within 24 hours...this is our task...to mobilise with a walker...and then help the patient to walk to the toilet .... and then we instruct in getting in and out of bed .... getting in and out of a chair...and lower limb venous pumping exercises”...[Physiotherapist]

“I receive the patient after the operation ... and order the blood samples.... they are in a standard programme...so we always know that they need to have this and that on day 1, 2 and 3 .... and then I write a progress plan to the municipality...we have to do this within 48 hours” [Nurse]

In discussing and describing their role in the patient pathway the HPs focused on objective aspects. They spoke of the “patient with a hip fracture” or simply “hip fractures” and commented on time-consuming or time-saving processes. They expressed the patient pathway as limited and specific tasks. Their role was focused on instrumental functions; either operatively restoring or caretaking or rehabilitating. They explained that the systematised programmes involving short LOS demanded this stringency in order to meet the goal of rapid discharge:

“...In the accelerated pathways we have to think about discharge on admission... otherwise we cannot maintain the flow needed...... My focus is on the physical things like measuring their temperature and that .... we have such a hard time keeping up with the flow of the patients that we have no time to concentrate on the psychological part.....” [Social and Healthcare Assistant]

In relation to psycho-social aspects, the HPs were aware that patients were worried about discharge and insecure about the future, illustrated in the following:

“... the fracture is part of the process of getting old. It is a step on the road of decline...and we, as orthopaedic surgeons, have the craftsmanship to fix this... easily...but it [the fracture] is just a symptom of age weakness...this is just a fact... of course they are afraid of going home...this is where they acquired the hip fracture” [Orthopaedic Surgeon]

Doctors often expressed the need for a focus on following clinical guidelines centred on physical factors. This was stressed as important in being able to conduct research on the efficacy of treatment and its clinical quality according to the national standard hip fracture programme. They stressed the necessity of the local clinical guidelines which were prepared in accordance with the national programme. Accordingly, all actions were to be documented meticulously in the electronic patient record. The caregivers explained that this need for feeding the system with biomedical and objective data prevented the focus from being on communicating with the individual patient. This documentation of data and clinical actions were seen as time consuming processes, stealing time from patient-directed actions:

“... we spend a lot of time on nursing the system – instead of nursing the patients...” [Nurse]
“...we stand with our hand on the door knob instead of on the patients' hearts...”

[Social and Healthcare Assistant].

Nevertheless, they reflected that a change in practice should not only meet the need for more time, but also a need for cultural and behavioural change: “...we have this fixed way of doing things...”. Nursing issues concerning the patients’ subjective and social lifeworld were articulated as “soft values”. An awareness of the need to focus on the inclusion of “soft values”, and not mainly on documentation of objective measures, was evident during the FG discussions and was connected with the information and education of patients. This information and education of patients, preparing them for discharge, was verbalised as a task connected with nursing i.e. not with the doctors and not with the physiotherapists.

**Lack of information**

There was consensus among the HPs that all patients should be individually informed. That is that HPs should assess patient needs and, accordingly, provide them with written information. However, there was also an awareness of a need to focus on information/education for the individual patient. This was not as a means of involving patients’ subjective and/or social world - more for an objective measurement of the dissemination of information:

"We have approximately 700 patients admitted a year, so a hip fracture is a standard everyday patient...and we are actually good at repairing the fracture operatively...but it may well be that we as staff just communicate with each other and we set a frame for how the process should be - and I think this in very logistical terms ..... it may well be that we do not get our knowledge disseminated to the patients" [Orthopaedic surgeon]

Findings concerning the lack of information puzzled the HPs and were seen as “an eye-opener”:

“....I actually see an eye opener here ... I compare what you're saying to ... if we took a meeting room upstairs with a lot of oncologists.....if you tell them (patients) all these things about how they should do, but they do not hear it...because a cancer patient does not .... and if it is the same for a hip fracture patient ... I think that's interesting.... "[Geriatrician]

On one hand, HPs understood patients' stressful situations and the need to accommodate their shock-like state of mind. On the other hand, the doctors also expressed a wish to place a tape-recorder with each patient to detect if information was, actually, given to them. The discourse in favour of knowing exactly what information was given also involved a wish for measuring patients' needs and wishes:

“...we think we know what they want to know .... but we don't actually know now... do we?” [Geriatrician]

In this sense, there was an expressed need for “thinking out of the box” and finding new ways of disseminating knowledge to future patients on rehabilitation and how to manage life after a hip fracture.
Discussion

The overall purpose of patients' recovery after a hip fracture is to restore their physical, mental and social capabilities to those prior to the injury. In this study, the findings indicate that the focus and actions in the hospital care and management were mainly targeted towards physical aims.

Communicative action or the system colonising lifeworld

When individuals are admitted to hospital, their lifeworld will, to some extent inevitably, be colonised by the system (Habermas, 1984a,b). Findings from the first sub-study of patients' perspectives (Jensen et al., 2017), illuminated a gap between patients' needs and wishes and what was provided by the healthcare system along with a lack of patient-empowerment. From a Habermasian perspective, this suggests that patients' lifeworlds were not only partly colonised by the system during hospitalisation, but that this colonisation was influenced by the HPs' strategic actions related to assessment, management/treatment and care where the biomedical discourse dominates. In this study, we found that the overall impression from discussing the patient pathway and findings from the study on patients' perspectives with HPs was characterised by emphasis on the importance of structure, measurability and clarity in patient records as well as in the overall healthcare. Traditionally, many of these “systems perspective” features are highly valued by healthcare professionals and organisations. Standardised treatment processes, terminologies and other approaches to care are seen as important contributions to patient safety, for instance, by reducing the risk of medical errors (Biostatistik, 2016; Lauritzen, 2016; Rozich et al., 2004).

Several studies (Falaschi, 2017; Liu et al., 2014) show that optimisation of the hip fracture pathway, employing standards including short or reduced LOS, is of benefit to positive outcomes and mortality rates. According to the healthcare staff participating in our study, existing documentation standards foster a biomedical framework for treatment and care which was seen as detrimental to individual and holistic care. This echoes a study by Hyde et al. (2005), where a gap was found between nursing ideals and the biomedical-technical system dominance in the patient records. In our study this was illuminated by the following phrase; “we spend a lot of time nursing the system instead of nursing the patients”. Care staff declared that accommodating and maintaining a holistic approach, including so-called “soft values”, in the care pathway was challenging. From a Habermasian perspective, holistic nursing should involve all three dimensions of the lifeworld perspective; the objective, the subjective and the social. Patients who have sustained a hip fracture are in a unique situation that they have not usually previously experienced. The first sub-study of patient perspectives also suggested that patients are in a shock-like state of mind (Jensen et al., 2017). This is in contrast to staff perceptions that being a patient with a hip fracture in an orthopaedic ward is being a: “standard everyday patient”. Our findings suggest that HPs were not aware of patients' shock-like state of mind and that this was not taken into consideration in care giving. Although HPs articulated a wish to consider patients' psycho-social perspectives, their discourse indicated that they were in favour of these ‘measurable’ values.

Rehabilitation is essential for people having experienced a hip fracture (Archibald, 2003; De Rui et al., 2013; Falaschi, 2017; Lofgren et al., 2015). Research shows that psycho-social support is of utmost importance from the time of the injury and throughout rehabilitation in the patient regaining pre-fracture function and
independence (Gesar et al., 2017a,b; Healee et al., 2011; Jensen et al., 2017). Pathways with short LOS and with patients in a shock-like state of mind challenges HPs in issues such as having adequate time for supporting patients in rehabilitative activities and facilitating motivation for these. Likewise, education of patients in matters such as prevention of future falls, the continued management of bone fragility and secondary/tertiary fracture prevention is challenging. Succeeding with this, in a Habermasian view, demands that HPs consider patients’ lifeworld perspectives.

HPs must often balance different rationalities; on one hand, they have to accommodate the system where they have to answer to standards and political strategies and economy, but on the other hand, they have to make sure that the interests and personal preferences of individual patients are pursued. A study of HP’s behaviour in fast-track treatment programmes (Berthelsen et al., 2014), showed that HPs appreciate treatment programmes, but they declared a lack of opportunity or time to meet the patients' individual needs. Findings from our study indicated a need for change in the common cultural understanding of how the available time is spent in hip fracture pathways during a short stay in hospital. The HPs in our study stressed the importance of documentation in measuring outcomes. They declared that it would require a change of mind-set not to be absorbed by the systematised documentation of care and treatment actions in favour of seeing or containing individual patients’ needs. That is, HPs do not operate in a ‘Lifeworld’ perspective but are governed by strategic actions defined by ‘the system’. From this perspective, we found that having to engage in strategic actions towards systems goals were perceived as a barrier to engaging in communicative actions with the individual patient. Patients were informed according to guidelines aimed at achieving desired outcomes instead of being sensitive to patients' states of mind. Nevertheless, when HPs became aware of this practice, they realised that practice was changeable and a wish for “thinking new” and a future-oriented way of informing and educating patients was expressed. They found it possible to create means of combining communicative and strategic actions. In reality, any communication is a mixture of the two, where we shift back and forth simultaneously between the two concepts (Habermas, 1984a). For a positive and dynamic process to take place, the HPs involved in the patient pathway must have an open attitude and seek to understand the other. Habermas describes this as being moved by the “force of the better argument” (Habermas, 1984b).

Individuals' independence and autonomy, as well as the ability to control decisions and actions affecting their own health, are important factors in understanding the perspective of the patient and in their empowerment (WHO, 1998). Hence, individually targeted communicative actions aimed at communicating health information and encouraging patient empowerment are required. This need for information and knowledge is echoed in other studies of patients' power and ability to participate in decisions concerning, for example, their rehabilitation (Joseph-Williams et al., 2014). We found that HPs' biomedical practice, led by systematised guidelines, produce discourse practices and instrumental trading that promote the interest of the system rather than the patient. Actions were often insensitive to context and were not always oriented towards creating mutual understanding through consensus and coordination. When HPs avoid considering the individual patient's lifeworld and solely follow systematised guidelines, from a Habermasian perspective, this can result in patients feeling disempowered and as though they are being treated as a biomedical condition rather than a human being. In our study, this was demonstrated by the HPs and their cultural traditions of communicative actions towards a discourse governed by guidelines and effectiveness. Thus, a biomedical power-perspective is imposed in the patient pathway. Our first sub-study of patient perspectives showed that a lack of patient
empowerment (Jensen et al., 2017) increased patients’ concerns about the impact of a hip fracture on their future lives and that it did not seem to be a priority for HPs during the hospital admission. Patients felt that they were classified as “a standard hip fracture”, giving them a feeling of being invisible as individuals. They also felt that information or education was targeted towards physical measures and not at them as individuals. This supports other studies about patients’ perspectives of care, showing that patients feel that HPs are more interested in their physical condition than them as human beings and that this affects their recovery negatively (Baillie and Ilott, 2010; Rasmussen and Delmar, 2014).

Future healthcare services providing treatment for patients with a hip fracture must give voice to patients' social and subjective worlds to support their empowerment. Empowerment is a process which enables individuals to act. It could be argued that HPs also need to be empowered; both with knowledge of patient perspectives and with new means targeted towards more individualised information or education of patients in pathways with a short LOS. This means replacing or supplementing strategic actions with communication towards constituting true communicative actions to enable the support and empowerment of patients. Habermas' theory of communicative action is based on the assumption that we reach a greater insight in matters concerning ourselves and the world around us by using language, presenting arguments, justifying statements and asking and answering questions. In our study we found that HPs gained greater insight by discussing the findings from the first sub-study of patients' perspectives; their needs and wishes. Using this insight in communicative actions towards future patients, asking and answering questions, provides an opportunity to promote patient empowerment and could be a means of enabling patients to gain greater control over decisions and actions affecting their health and would support bridging the gap between what the system provides and what patients’ need in hip fracture management pathway with a short LOS.

Identifying constraints to communicative action does not necessarily result in immediate change in systems that are dominated by economics, politics and cultural traditions. However, critically examining constraints and working around them to promote communication offers the potential for change through interaction and discourse. Based on what has been learned from the study reported here, further work is needed that involves patients and HPs in collaboratively proposing a solution to bridge the gap between patients’ needs and wishes and what the system provides.

Strengths and limitations

The study was performed according to accepted principles for focus groups and reported according to the COREQ guidelines (Tong et al., 2007), see Supplementary File 1. We included HPs from different professions in the focus groups to create appropriate group dynamics. This can be seen as both a strength and a limitation as findings could have been different with other group constructions. The chief orthopaedic surgeon participated in one of the FGs. His presence may have influenced the discussion.

By providing a clear description of the context, selection and characteristics of the participants we have helped the reader to appraise the study's possible transferability to similar contexts.

Conclusion
We found that the gap between what the healthcare system provides and patients' needs and wishes primarily exists because HPs’ informing and education of patients originate from a biomedical discourse. Systematised pathways demand biomedical stringency and HPs’ behaviour and care is primarily guided by the tasks contained in the pathway. Patients, on the other hand, are overwhelmed by the psycho-social implications of the hip fracture. Empowerment of patients should involve empowerment of HPs by providing them with skills to support patients in a shock-like state of mind. We also found a need for providing HPs with a more individually targeted means of informing and educating patients.

Relevance to clinical practice

With an increased life expectancy in humans and a subsequent increase in the number of the elderly population, the frequency of hip fractures is also expected to rise. In future healthcare systems, individuals will play a much more central role in their own treatment and, in particular, there will be high expectations for the individuals who are consuming health care resources to take an active part in their own health. The healthcare service is meant to be proactive rather than reactive; so there will be focus on health rather than treatment. A way of proactively improving quality, efficiency and health outcomes is by empowering individuals through patient engagement and collaboration. Collaborative healthcare systems require empowered healthcare users. In this study, we found that HPs information and education of patients originates from a biomedical discourse. Patients, on the contrary, are overwhelmed by the psycho-social implications of the hip fracture on their lives. Identifying and discussing central factors of importance along the patient pathway was found to facilitate understanding and promote communicative action in favour of patients’ lifeworld. Thus, our findings indicated that a focus on improved methods of communicating health information and encouraging patient empowerment was needed.

The results of this study contribute to better insight concerning factors of importance in hip fracture pathways. Future healthcare service needs to consider these factors when aiming to support patient empowerment.

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Author contribution

This study was conceptualised and drafted by CMJ, SO, UKW, PRJ and JC. CMJ conducted the interviews. CMJ and JC conducted the FG’s. CMJ, PRJ, JS-T and JC drafted the manuscript. All authors revised the manuscript critically and approved the final manuscript.

Declaration of competing interest

The authors declare no conflicts of interest with respect to the authorship and/or the publication of this article.

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References

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