Ohio Communication Journal
Volume 55 – February 2017, pp. 29-42

Crafting a Culture of Patient Safety: Structuring Physicians' Medical Error Disclosure and Apology

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Hospitals across the country are embracing a new medical culture that privileges patient safety. Part of this ideological shift is an imperative for physicians to offer explanation and apology when a medical error occurs. Relying on structuration theory and organizational culture, this article examines a hospital's medical error disclosure and apology program, exploring how the program ultimately structures not only how doctors and the hospital communicate about medical errors, but also creates an organizational culture of patient safety. Specifically, the disclosure and apology program structures a culture of patient safety by crafting a shared discourse, establishing order and control, and legitimizing organizational ideologies.

Keywords: medical errors, structuration, organizational culture, disclosure, apology

Physicians practice medicine in the space between two statements in the Hippocratic Oath: "Do no harm" and "Whatever I see and hear, professionally or privately, which ought not to be divulged, I will keep secret and tell no one" (Strathern, 2005, p. 11). Medical errors are examples of instances which physicians may see, hear, or be involved in that often demand silence. Practicing medicine in the space between those two statements has led to a medical culture of "naming, shaming, and blaming" (Nordenberg, 2000, para. 28), where physicians are often too concerned about malpractice litigation and being labeled "bad" doctors to talk about their mistakes. In their landmark study on medical errors, the Institute of Medicine proposed that health practitioners and hospitals move away from a culture of secrecy to a culture of patient safety (Kohn, Corrigen, & Donaldson, 1999). In a culture of secrecy, physicians and hospital administrators offered patients and their families "cheap grace," where they ask for forgiveness without disclosing, apologizing, or making amends for their error (Berlinger & Wu, 2005). Conversely, a culture of patient safety strives for "true grace" by moving toward a culture that openly communicates errors. By openly communicating about errors, hospitals may be able to reduce medical error instances (The Joint Commission, 2005).

Over the past twenty years, communication scholars have slowly explored the communicative nature of medical error experiences, with research becoming more abundant over the past decade. This line of research focuses on how physicians construct and enact responses to mistakes (Mizrahi, 1984), how they disclose medical errors (Allman, 1998; Hannawa, 2009; Petronio, 2006), how physicians negotiate the aftermath of errors (Carmack, 2010, 2014; Noland & Carl, 2006), and how practitioners are socialized to communicate errors (Noland & Carmack, 2015a, 2015b; Noland & Rickles, 2009). This line of research emphasizes informally disclosing medical mistakes, but has yet to explore how health providers and administration make sense of and talk about disclosing and apologizing for medical errors as a result of organizational policy and hospital culture. The study of organizational culture is not a new phenomenon (e.g., Eisenberg & Riley, 2001; Schein, 2010; Schrodt, 2002; Witmer, 1997), although its use in studying communication in health care settings is almost non-existent (Apker, 2011, Groves, Meisenbach, & Scott-Cawiezell, 2011). Scholars have studied how, theoretically and practically, organizational culture is created and maintained in organizations, focusing on emotion management (Carmack, 2008; Scott & Meyers, 2005; Waldron & Krone, 1991), organizational change (Scott, 1997), and customer interactions (Larkin, 1990), but these investigations primarily focused on non-health based organizations. Scholars have yet to explore the communicative micropractices in large bureaucratic health organizations that must balance the business and care elements of health and healing.

This study spotlights one hospital, known as MidSouth Hospital, which crafts a culture of patient safety through the hospital's disclosure and apology program. I begin with a theoretical discussion of how organizational policies structure, create, shift, and maintain organizational culture, theoretically tying together organizational culture and structuration theory. This marriage of organizational culture and structuration theory allows scholars to focus on how the micropractices of the organization impact the macropractices of care (Groves et al., 2011). After

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an explanation of my research practices, I explore how MidSouth Hospital providers and administrators make sense of the program. Finally, I discuss the theoretical and practical implications of this program.

Structuring Patient Safety through Organizational Policy

Organizational realities and actions are crucial to understand because they "draw attention to webs of interwoven social forces—market patterns, institutional practices, lived experiences of individuals—the locus of observation expands to include the hegemonic and material constraints that often lie beyond the awareness of the individual" (Harter, 2005, p. 191). These organizational realities must be constituted and maintained by the organization in order to create rules and resources for organizational members (Giddens, 1984). To understand the MidSouth Hospital disclosure and apology program, we must investigate how organizational policies shape, enable, and constrain the construction of organizational discourses.

Organizational policies, procedures, and other organizational discourses communicate organizational rules to organizational members (Yates & Orlikowski, 1992). Organizational discourses are used specifically for the purpose of perpetuating hierarchies, structuring identities, and constructing identifications or divisions among individuals in an attempt to (re)create an organization's ideology. Not only do policies and procedures provide the rules of the system, they also provide the knowledge needed to negotiate resources (Kirby & Krone, 2002). Organizational structures, then, coincide with organizational policies, procedures, and documents, which serve the purpose of communicating organizational behaviors to individuals (Scott, Corman, & Cheney, 1998). Organizational discourses, often with the assistance of structures, display the patterned behavior required by the organization.

These organizational policies, procedures, and discourses culminate in the creation and maintenance of an organizational culture. Broadly, organizational culture is the process of patterning human behavior and meaning (Eisenberg & Riley, 2001). Organizational culture focuses on how the symbolic nature of communication is presented in organizations, providing organizational members scripts for how to enact the roles, rules, and values of the organization (Eisenberg & Riley, 2001; Trujillo, 1985). Rather than seen as a static concept, organizational culture is an interactive, socially constructed experience where multiple organizational stakeholders participate in the creation and maintenance of culture (Ford & Etienne, 1994). Culture is communicated through a variety of discourses and material symbols, with everything from logos and slogans to the physical layout of offices communicating an organization's culture (Pratt & Rafaeli, 1997). Scholars studying organizational culture focus on how organizational micropractices become ingrained in an individual as well as how the individual fosters the organization's culture through the performance of organizational roles and values (Trujillo, 1985).

For many hospitals, that translates into a "culture of patient safety." This specific organizational culture emphasizes:

> designing systems that prevent, detect, and minimize hazards and focus on system errors and remedies within a "blame-free" environment. Blame-free does not mean individuals are never subject to corrective action. The emphasis is on structuring programs so that jobs and working conditions are designed for safety, that processes, equipment, and supplies are standardized, and that reliance on memory is discouraged. (Cornett, 2006, p. 83)

In order to create and maintain a culture of patient safety in hospitals, practitioners and administrators must find a way to structure policies, procedures, rules, and rituals that encourage organizational members to practice medicine in a "blame-free" environment. Reduction of errors and increases in safety are important outcomes in this culture.

Structuration Theory

Knowing and understanding the structuring of a particular organization is central to understanding the ways in which discourses, norms, and power are (re)produced and negotiated. Giddens' (1979, 1984) structuration theory provided a theoretical vocabulary through which to understanding how the apology program bureaucratizes experiences. It is in the spaces where discourses, norms, and power relations intersect where we can begin to explore how the duality of structure, agency and structures, are (re)produced or challenged (Giddens, 1979, 1984).

Duality of structure is enacted and embodied differently depending on the structural form of an organization. By focusing on how individuals make sense of organizational meanings and normative sanctions, we can see duality of structure in action (Giddens, 1984).

Structuration theory negotiates the inherent tension between social structures and human agency, acknowledging the inter-relationship between them. Awareness of actions and structures is a crucial part of the duality of structure (Banks & Riley, 1993; Browning & Beyer, 1998). Humans are knowledgeable actors, aware in some form or fashion of their actions and the subsequent consequences, but, at the same time, are constrained by the structural conditions that control their actions (Giddens, 1979). This is one of the reasons structuration theory provides a useful vocabulary to understand organizational policies; the focus on awareness means that individuals not only monitor their own action, but also monitor contexts (Browning & Beyer, 1998), which highlights how structure is embedded in interactions as well as how it perpetuates or challenges a social world (Howard & Geist, 1995).

How patterned human behavior is enacted depends on interpretive schemes, "standardized elements of stocks of knowledge, applied by actors in the production of interaction" (Giddens, 1979, p. 83). Individuals' stocks of knowledge are based on the continuous (re)production of organizational rules and resources, allowing them to make sense of specific experiences, make decisions, take action, and justify those actions (Weick, 1995). Focusing on three key aspects of the organization-- signification, domination, and legitimation—helps to examine how organizational members make sense of issues of control, agency, and knowledge (re)production. These three elements create an institutional analysis specific for the organization by placing in suspension the skills and awareness of actors, treating institutions as chronically reproduced rules and resources (Giddens, 1984).

Structures of signification highlight the codes and discourses used in interaction. This is where mutual knowledge is central; individuals must understand the codes, rules, and discourses used in a particular structure in order to create shared meaning (Riley, 1983). Structures of domination depend on the mobilization and use of allocative and authoritative resources. These resources emphasize power over and within certain interactions. Domination is inherently connected to power in an interaction; however, power and domination do not simply mean control over individuals (Giddens, 1984). Rather, it is important to position domination as power relationships *among* individuals. Domination, then, exists in and through knowledge and the control of knowledge.

Finally, the structure of legitimation is concerned with normative regulation of individual value standards and organizational interests. This interplay could result in tension between the individual and the organization when the individual value standards and organizational interests do not complement each other. The structure of legitimation creates sectional norms, controlled by sanctions. Instrumental to legitimation is the notion that "legitimate orders must be embodied as structural conditions of action by some members for them to have binding force" (Riley, 1983, p. 417). Individual values and organizational or sectional interests do not need to agree, because in the structure, the sectional interests are considered universal.

Paramount to understanding the disclosure and apology program is exploring how the program came into being and how a culture of patient safety is reified in the program (Riley, 1983). Thus, the following research question guided this analysis:

RQ: How does the MidSouth Hospital disclosure and apology program craft a culture of patient safety?

Research Design

Settings and Participants

MidSouth Hospital is a fully accredited medical center that provides general medicine and surgical treatments to veterans. Located in a mid-sized Southern city, MidSouth Hospital consists of two different facilities: a facility that focuses on emergency care, medical-surgical care, acute psychiatry, intensive and progressive care, internal medicine, outpatient care, and ambulatory surgery and one for acute medical, neurological, surgical, and psychiatric inpatient services. I was on-site at both facilities, but primarily spent time at the first facility.

MidSouth Hospital is comprised of two divisions: the medical division, which includes all medical staff, and the administrative division of the hospital. The administrative division is comprised primarily of the Chief of Staff's office, billing, medical records, patient advocacy, and the in-house legal department. I observed members

of the Chief of Staff's office and the legal department. The administrative departments, especially the Chief of Staff's office and the legal department, play an integral role in negotiating the aftermath of medical errors by handling the medico-legal ramifications of medical malpractice and the disclosure and apology program.

In 1987, after dealing with two high-profile medical mistake cases, MidSouth Hospital created a disclosure and apology program. This program is a mandatory hospital policy that requires physicians disclose medical errors to patients and families as well as offer an organizational apology for the error (Kraman, Cranfill, Hamm, & Woodard, 2002). The program established a policy that allowed physicians, patients, and families to come together at a meeting and talk about mistake events. At the meeting, the hospital offers an apology, answers questions, and offers a monetary settlement. Since 1987, the MidSouth Hospital program has seen a decrease in lawsuits, settlement costs, and defense costs, with only three cases going to trial ("Why Sorry Works! works," 2005).

The disclosure and apology program involves several stages. When a potential error is identified, physicians perform a *clinical disclosure*, an informal process that provides factual information to patients and families. Physicians explain what has happened but do not acknowledge fault of the potential mistake. The case is then passed on to a group of legal and hospital administrators called the Clearinghouse, who use medical and legal standards to determine if an error has occurred. If the Clearinghouse determines that a mistake has not occurred or the event was a known complication, the Chief of Staff performs a *closure*, where patients and families are informed of the decision. If an error has occurred, the Chief of Staff performs an *institutional disclosure*, offering explanation, an apology, and compensation.

Data Collection

In order to understand how the disclosure and apology program came into being and how MidSouth Hospital stakeholders make sense of the program, I relied on two qualitative methods: (1) in-depth interviews and (2) organizational document analysis. Data collection began after I received university and hospital Institutional Review Board approvals.

In-depth interviews. Researchers that rely on in-depth interviewing techniques are often concerned with seeking "deep" information about personal matters such as an individual's self, lived experiences, values and decisions, or perspective (Johnson, 2002). A total of seven physicians and four administrative staff interviews were used for this study, with interviews ranging from 45 to 120 minutes.[1] These interviews were used because of the participants' involvement with the disclosure and apology program. Of the seven physicians interviewed, four physicians were attending physicians, practicing medicine for more than seven years, and three were residents, practicing medicine for less than seven years. The physicians' specialties included ambulatory care/outpatient care (n=2), anesthesiology (n=2), general surgery (n=1), ophthalmology (n=1), and urology (n=1). All the physicians were male. I interviewed all three of the disclosure and apology program co-creators and the MidSouth Hospital then-Chief of Staff (he has since retired). These four interviews comprise the administrative staff interviews.

The interview protocols were semi-structured to allow participants to talk about their individual experiences and insights, recognizing that the interview is a co-constructed event (Heyl, 2001). The tentative interview protocol used in these interviews focused on questions about medical error experiences, disclosing and apologizing for medical mistakes, and the enactment of medical error hospital policies and procedures. All of the interviews, with individual's consent, were audio-recorded on a digital voice recorder. All of the interviews were then transcribed in their entirety. The transcription resulted in 126 pages of physician interview text and 51 pages of administration interview text, resulting in a total of 177 pages of single-spaced typed interview text. To protect the anonymity of participants, pseudonyms were used.

Organizational documents. Additional materials are often needed to make sense of organizations. Organizational documents offer additional insight by using the language and expressions of the organization, highlighting the social rules of the organization (Hodder, 2000). Organizational documents allow researchers insight into how stakeholders talk about a topic, how past events (re)create organizational narratives, and the rationality and reasoning of organizational decision-making (Lindlof & Taylor, 2010). Documents for this particular analysis included, but were not limited to, MidSouth Hospital's original policy, the national roll-out

[1] A total of 30 physician interviews were originally conducted, resulting in 330 pages of interview text.

policy, additional MidSouth Hospital policies created in response to the disclosure and apology program, and MidSouth Hospital literature regarding patient safety.

Data Analysis

As I collected data, I was engaged in a constant comparative method of data analysis (Glaser & Strauss, 1967). A constant comparative method, as a part of grounded theory, requires researchers to "take control of their data collection and analysis, and in turn these methods give researchers more analytic control over their material" (Charmaz, 2002, p. 676). I made initial notes of theoretical and practical connections throughout the data collection process. I also transcribed in order to completely immerse myself in the data, enabling me to see potential connections as I worked through the data. I made note of emerging patterns in the data, paying particular attention to converging and diverging discourses.

Once data collection was complete, I began the "reduction" and "interpretation" stages of data, characteristic of the constant comparative method. After reading all the transcripts and documents and gaining a holistic sense of the discourses, analysis of all of the data began. The constant comparative method allows researchers to identify recurring patterns of behavior and meaning in the participants' accounts and performances. The analysis process begins by manually coding the data of the transcripts and documents. Constant comparison of these data was continued until "theoretical saturation" was achieved (Glaser & Strauss, 1967, p. 110). The themes presented emerged from the constant comparison of data. Structuration theory and organizational culture emerged during data analysis as salient ways to make sense of the themes.

Below is an analysis of the how the MidSouth Hospital's disclosure and apology program structures error experiences to create a culture of patient safety. This analysis highlights how hospital policy shapes and is shaped by medical mistake experiences. This analysis also shines a light on the ways in which personal action and organizational reaction become interwoven.

Analysis

MidSouth Hospital represents Weber's (1946) conceptualization of the modern day bureaucracy. The emphasis in bureaucracy is on categorization and clear organization. The rules and norms of bureaucracy are specific enough to apply to individual cases, but vague enough to leave room for some interpretation. Organizations structured in a bureaucratic fashion emphasize the rules and norms of the organization and use those rules and norms to control individuals in the organization (Weber, 1946). Discourses in a bureaucratic organization will also be structured in a bureaucratic fashion, highlighting the structuring of authority, rules, and responsibilities of all organizational members (Philips, 1987). Interestingly, the bureaucratization of organizations is designed to shine a light on the mystery associated with hierarchy, making "readily visible what was previously dim and obscure" about the organization and its actions (Merton, 1957, p. 104).

The MidSouth Hospital program is designed to break down the mystery traditionally associated with medical errors by creating a clear and organized policy with detailed rules and identifiable authority. The disclosure and apology program bureaucratizes medical mistake experiences by interlacing medical mistake, disclosure, and apology meaning and action, and normative elements of MidSouth Hospital and medical practice. Bureaucratization is accomplished through (1) the crafting of a shared program discourse, (2) establishing order and control, and (3) legitimizing organizational ideologies.

Crafting a Shared Program Discourse

In order for the MidSouth Hospital disclosure and apology program to be enacted, how MidSouth Hospital stakeholders make sense of the discourses and communicative meanings behind organizational actions is key. This sense-making serves as an attempt to justify maintenance or changes in the organization (Weick, 1995). The MidSouth Hospital stakeholders, particularly the co-creators and the Chief of Staff, use the program's genesis narratives and clearly defining medical mistakes to create a justificational discourse for the program. Storying the creation of the program and providing clear definitions highlights the bureaucratization of the program by identifying the reason for the policy.

In order to justify the creation of the program, the program co-creators turn to the stories of the first mistakes as a need for the program. All three program co-creators were involved with the first medical mistake case, and although their re-tellings provide different perspectives and layers of the story, each highlight the ways in which they see this case as the impetus for the program. Patricia, a program co-creator, recounts the error narrative which led to the program's creation:

> It looked like we had ordered an IV infusion of potassium for an alcoholic female who was here getting what we call rally packs. She was dehydrated, she was malnourished. What should happen is over the course of a few hours, you decrease the amount of IV fluids. That didn't happen. We went and pulled the telemetry record. …Those EKGs showed changes in her heart rhythm related to an overdose of potassium. We said, okay, ethically we have an obligation to notify the patient that a medical error has occurred…And that was the point where we had to figure out, okay, how do we do this?...Up the line people are going to get really pissed because we are going to admit liability for a medical error…But, we aren't asking permission to do it. We are going to do it because it's the right thing to do…So, there was never a discussion of not doing; only *how* would we do it.

Patricia's narrative points out how she, as a co-creator, begins the justification for a different way of thinking about medical errors. Her comment also highlights the need for accountability, not only for the mistake, but also for how the hospital negotiated the aftermath of the mistake. Accountability is an important part of making sense of organizational discourses (Giddens, 1984) and provides the normative grounds for justification. Accountability becomes an important part of MidSouth Hospital's discourse, and, as will be discussed later, serves as a unifying value for practitioners.

The genesis narrative is important because it provides all MidSouth Hospital practitioners a common justification discourse. Dr. Pope, another co-creator, uses the genesis narrative as a way to highlight how the potassium overdose case forced some of the hospital administrators to rethink the hospital's approach to medical mistakes.

> We said… how does a reasonable honest person deal with something like this… So, we just told them the whole thing that had happened. I apologized on behalf of the hospital because a situation like that, it seemed like the right thing to do.

Dr. Pope's comment calls attention to the ideological underpinning of the program: "the right thing to do." This ideological underpinning is the start of the bureaucratization of the medical mistake experience because the program attempts to highlight what was once invisible or silenced. Moreover, "it was the right thing to do" as a recurring justification associated with the genesis narrative also serves as a re-envisioning of traditional approaches to medical mistakes. Dr. Earhart, an ambulatory care attending, echoes Dr. Pope's evaluative positioning of the program: "When we make a mistake, there is no question about it. We made a mistake. We have the opportunity to tell people that we have and we get on with whatever needs to be done." "Doing the right thing" privileges a shared value to guide the MidSouth Hospital program discourse.

A second way in which the program crafts a shared discourse is by providing definitions of what counts as a medical mistake. How physicians and hospitals make sense of medical mistakes is often very different from how the general public defines medical mistakes (Leape, 1994). As Gina, a co-creator explains, what counts as a medical mistake and how stakeholders make sense of those definitions is key to making sense of the program. The disclosure and apology program policy bureaucratizes the terminology by clearly outlining the rules and responsibilities associated with the program's definition of the mistakes. Article 2, section F of the policy provides the definitions of the program. "An adverse event is any untoward incident, therapeutic misadventure, iatrogenic injury, or other undesirable occurrence directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic, or other [MidSouth] facility" (US Department of Veterans Affairs, 2005)." The defining of terminology serves as one of the first major ways in which the program is bureaucratized.

Although individuals in the medical profession may understand the nuanced difference between an "adverse event" (a medical mistake) and a "known complication," patients and their families often have a difficult time

understanding the difference. Dr. Lee, an anesthesiology resident, discusses the frustration associated with the difference between complications and mistakes.

> There is a difference between a bad outcome and a mistake. This patient had a bad outcome, but there wasn't an error. No medical error. It might look like there was. You can have a bad outcome. And one of the frustration[s] with medicine is that malpractice decisions are typically based on outcomes, not on whether or not there was an error.

In order to alleviate the uncertainty associated with definitions, the policy provides a clear definition of what adverse events warrant initial disclosures. Defining key terms bureaucratizes medical mistake experiences by shining a light on what actions physicians can expect to be involved in at MidSouth Hospital. The definitional aspects of the policy are so clear that the policy even explains the rules and responsibilities physicians have in the case of "close calls" or almost mistakes. This ensures that MidSouth physicians learn about and from *all* adverse events.

Establishing Order and Control

An important element of bureaucracy is that of control and authority. To implement and maintain a change to a system, individuals have to exert power in order to establish organizational control. Domination relies upon the mobilization of two different forms of power: allocative and authoritative resources (Giddens, 1984). Allocative resources refer to the ability of individuals to mobilize material and corporeal resources needed to make changes. Authoritative resources focus on how to convince individuals to make changes (Giddens, 1984). The MidSouth Hospital program bureaucratizes medical mistake experiences by ordering how physicians and administrators deal with the aftermath of mistakes. The program establishes order and control by "reallocating" who has control of medical mistake experiences.

The program bureaucratized medical mistake experiences by identifying who is responsible for types of disclosures and closures and by repositioning the fault of medical mistakes. As discussed earlier, the program openly outlines different types of closures and disclosures based on the clear definitions of medical mistakes and bad outcomes. The first step is the *clinical* disclosure, which takes places when potential mistakes happen. Dr. Sampson, a urology attending, explains how the clinical disclosure is enacted.

> An example, say you lacerate a bladder during a surgical procedure, which is a common thing. And it may indicate that there is an error and it may be one of those things that happen because of the patient's anatomy. So, per our policy, the physician goes in and saying, "M'am, we lacerated your bladder during this procedure. We are going to look into it and we will get back to you." We don't acknowledge that it is our fault or that it's not our fault.

The clinical disclosure begins to "pull back the veil" by including the patient and family in the medical mistake experience. Although clinical disclosure is meant to include the patient or family, Dr. Sampson's comment underscores an important tension in clinical discourse: the clinical disclosure does not acknowledge fault. MidSouth Hospital maintains control over the medical mistake experience by not acknowledging fault or admitting blame.

The Clearinghouse, as another element of the bureaucratization process, determines whether or not a mistake has been made or if the adverse event is the result of a known complication. The creation and use of the Clearinghouse points out an important element of the re-envisioned organizational medical mistake approach by identifying all potential sides of the mistake experience. The analysis, known as the Swiss cheese analysis, merges the medical and legal realms to determine if an adverse event is a mistake or a complication. If the "holes" match up, then a disclosure is in order. Gina explains how the Swiss cheese analysis works.

> When it comes down to deciding has there been a medical mistake that has impacted a patient, then the legal, it's sort of like a template, or a transparency. You lay the legal criteria over the medical criteria and if it adds up to a medical mistake, it requires disclosure.

The Swiss cheese analysis highlights the bureaucratic nature of the program because it provides clear rules and instances that require a disclosure, simultaneously highlighting how the program works and disciplining physicians and families by determining what counts as a mistake.

An important element of the disclosure and apology program is that, up to this point, the physician or the medical practitioner involved in the adverse event is part of the process. This, however, will be the last time that the physician or other medical personnel are actively involved in the disclosure process. A major part of bureaucracy is the use of management or administration to construct and enact important decisions in the organization. The systematic streamlining of individuals involved in the process stresses the role of control and domination the administration maintains in the process and further reinforces the control of the situation and of the information presented to patients and families. Gina reports how the intimate setting for disclosures and closures work to maintain control by following the rules set forth by the policy.

> It's not a bunch of shirts sitting around the table with these poor people. Dr. Wright [the Chief of Staff] will go through the clinical occurrence, give all the clinical facts. He tells what went wrong, he doesn't name names. We try not to point fingers. It's not because Dr. X screwed up. It's because [MidSouth] failed.

The physician or medical practitioner involved in the case is intentionally excluded from the actual disclosure and apology in order to frame the situation as an organizational failure, rather than an individual failure.

The program also controls medical mistake authority by passing on control to individuals who are on the frontlines of the medical mistake experience. In traditional approaches to medical mistakes, authority regarding medical mistakes is relegated to the hospital legal staff. The clinical disclosure places control of the process, initially, in the hands of practicing MidSouth physicians, giving authority to caregivers. Gina's earlier comment about how the point of the disclosure is to identify the organizational failure, rather than the individual's failure, is tied to the program's desire to place authority of the disclosure with the organization. The disclosure and apology program exerts domination by repositioning the authority and control of the program in the hands of the heads of the medical and legal departments, controlling medical mistake knowledge.

Legitimizing Organizational Ideologies

In order for a program to be enacted and embraced by organizational members, it must be legitimized. Legitimization centers on the relationship between the rights and the obligations "expected" of organizational members (Giddens, 1984). Not only do these norms aid individuals in the sense-making process, but they also serve to reinforce the authority and control promoted through the program. The program legitimizes MidSouth Hospital values as well as reinforces a "culture of patient safety", encouraging open communication about mistakes.

The MidSouth Hospital program attempts to foster the MidSouth Hospital values of trust, respect, excellence, commitment, and compassion. The MidSouth Hospital program directive demonstrates how the hospital's values underlie the program's approach to medical errors:

> Disclosure of adverse events to patients or their representatives is consistent with [MidSouth Hospital] core values of trust, respect, excellence, commitment, and compassion. Providers have an ethical obligation to be honest with their patients. Honestly discussing the difficult truth that an adverse event has occurred demonstrates respect for the patient, professionalism, and a commitment to improving care. Clinicians and organizational leaders must work together and ensure that appropriate disclosure to patients or their representatives is a routine part of the response to a harmful or potentially harmful adverse event. (US Department of Veterans Affairs, 2005)

All of these values are embodied in the program's desire "to do the right thing." Patricia reflects that the main goal of the program is to "do the right thing" for all parties involved in the medical mistake experience.

> To do the right thing for the patient. The right thing for the physician. The right thing for the family… One of the big goals of the program is to maintain the physician-patient relationship. We have gone away from blaming.

This desire to "do the right thing" is predicated on MidSouth Hospital's desire to foster and maintain healthy relationships between patients, physicians, and MidSouth Hospital. At MidSouth Hospital, the physician-patient relationship is paramount. As Dr. Ferris, an ambulatory care attending, stated: "It's every day, building and maintaining good relationships." In order to build and maintain good relationships, MidSouth Hospital, and by extension, the disclosure and apology program, must rely on that trusting relationship in the face of an adverse outcome or mistake. This de-shrouding of mistakes helps to build trust between physicians and patients, as Patricia elucidates. Trust is multifaceted in the medical mistake experience, and thus, is multifaceted in the disclosure and apology program. The hospital has an obligation to be open and honest with patients and, at the same time, created the right to do so. By appreciating both the obligation of "doing the right thing" and the right afforded to individuals through the program, the program is legitimized.

The desire to "do the right thing" also clearly embodies the hospital's ideological commitment to patient safety. This ideological commitment is unique to MidSouth Hospital because it was one of the first hospitals in the country to fully embrace the ideas of patient safety by implementing a facility -wide policy to address medical errors. "'Ideology' refers only those asymmetries of domination which connect signification to the legitimation of sectional interests" (Giddens, 1984, p. 33). Ideological beliefs rely on the organizational discourses and expressions of domination to legitimate the belief. The MidSouth Hospital disclosure and apology program serves as a way through which MidSouth Hospital stakeholders can further the culture of patient safety. As Dr. Wright, the Chief of Staff, succinctly states, "This is all about patient safety."

The desire to structure medical mistake experiences is equally about the practitioner and the patient. Dr. Xavier, an ophthalmology resident, clarifies that although patient safety is a patient-centered approach to health care, "one of the underlying assumptions of patient safety is that it is meant to benefit the physician by clarifying the practice of medicine." The disclosure and apology program is meant to not only de-shroud the mystery of mistakes to patients but also to help de-shroud the mystery of dealing with mistakes for physicians. As Gina asserts, "We wanted to be able to sleep at night. It's not a good idea to hide these things, stick them in the closet. They may come back years later and bite you." Gina's comment again draws attention to one of the aims of the program: to change the mentality associated with medical mistakes.

Discussion

This study explored the ways in which multiple MidSouth Hospital physicians and administrators were actively involved with the disclosure and apology program's creation, enactment, and legitimation. Appreciating how MidSouth Hospital structures and rationalizes the disclosure and apology program is central to understanding how MidSouth Hospital physicians and administrators create and maintain a culture of patient safety. As this study indicates, MidSouth Hospital stakeholders use the organizational structures provided in order to structure their own knowledge and discourses regarding medical errors.

The disclosure and apology program both enables and constrains physicians in their practice of medicine. First, the program enables physicians by creating opportunities for physicians to be open with patients. This openness is not relegated just to discussions of medical mistakes; rather, it includes being able to be open with patients about every aspect of their care. The program, through the crafting of a patient safety culture, reveals some of what was previously hidden about medical mistake experiences and how hospitals dealt with mistakes. The program created a clear policy that outlines a clear hierarchy and rules for stakeholders. This benefits patients and families as well, as they are able to have a well-defined set of guidelines for how the hospital will deal with their case. More importantly, patients and families know that communication about the potential mistake *will* happen.

Conversely, the program constrains physicians in their practice of medicine by determining *who* makes decisions in the practice of medicine. As mentioned above, the structuring of a culture of patient safety enables physicians by revealing information that was previously invisible. Interestingly, it is this structuring that constrains physicians, as well. The bureaucratic nature of the program dictates who gets to make decisions about medical

mistakes and how the hospital handles mistakes. Moreover, the program places all the decisions in the hands of a small number of administrators, not physicians. Finally, connected to the constraining elements of the program, the program ultimately takes the decision-making of medical mistakes and medicine out of the medical arena and places the control in the legal arena. Interestingly, it is the multi-disciplinary nature of the program, the connection between the medical and legal worlds, which creates this constraint for physicians.

Reframing MidSouth Hospital medical error experiences as an organizational failure rather than an individual physician's misdeed potentially controls physicians by taking away their ownership of the mistake. This disciplining raises an interesting question: Who has the right and obligation to apologize for errors? Moreover, who has the authority to make those decisions? Often, organizational or societal apologies are in response to a social legitimacy crisis (Hearit, 1995), and are designed to demonstrate that the organization and its organizational members are caring and decent (Rowland & Jerome, 2004). Social legitimacy cannot be controlled by law or government, and thus, must be regulated by organizations and the general public. In this case, the MidSouth Hospital program is responding to a larger medical error epidemic and seeks to affirm that all of its organizational members are dedicated to patient safety and care. This is inherent in the program's foundation to "do the right thing." However, because the program places the act of the apology in the hands of administration, not physicians, problematizes issues of physician emancipation and domination when dealing with medical errors. Moreover, it does not take into account physicians' interpretation of the policy and the experience. It is possible that physicians do not agree that disclosure and apology is the "right thing" to do in medical error situations.

The heavy involvement of the administration in the disclosure and apology process underscores the importance of questioning a top-down policy approach as an attempt to change organizational culture. At the heart of this question is bureaucratic and ideological control (Apker, 2011), where organizations attempt to control action, identity, and values through policies, rules, and structures. Although these forms of control create pathways for productive organizational practice, they also can be oppressive to organizational members, especially if it asks them to change practice *and* belief (Mumby, 2013). The disclosure and apology program, created and implemented by the hospital's administration, seeks to mandate not only communicative action, but also providers' systems of values and beliefs about the practice of medicine. At its core, the disclosure and apology policy assumes that providers and administrators hold the same ideological beliefs about medical practice and error; errors are inevitable and providers are fallible. But what if providers do not believe this? As Carmack (2014) previously argued, disclosure and apology programs serve as a way to seek redemption and assume that everyone involved with an error wants redemption. By mandating disclosure and apology, MidSouth administrators control organizational practice, but complete by-in to the program requires providers to hold the same ideological beliefs about error, apology, and redemption. Or is it possible that health providers could ideologically disagree with a policy and still practice medicine under the gaze of the administrative policy?

Limitations and Future Research

The in-depth interviews and observations I conducted at MidSouth Hospital were fruitful in terms of understanding how the multiple stakeholders in the facility make sense of the medical error, disclosure, and apology experience. This article relies primarily on the co-creators of the program and the then-current Chief of Staff as the gatekeepers to structuring the experience. Of the 30 physicians who were interviewed, only seven openly discussed their personal knowledge and experience with the disclosure and apology program. Thus, this analysis showcases the difficulty in exploring organizational decision-making when only one group of stakeholders is actively or constantly involved in the process. More research is needed, however, on how physicians make sense of policies related to medical error disclosure and apology. Additionally, it is unclear if providers at MidSouth Hospital have competing ideological beliefs about error and believe the program is successful. Future researchers must examine complementary and competing providers' ideological beliefs about disclosure, apology, and medical error and how that impacts how organizational members view the success of a top-down program which mandates organizational action and belief.

Finally, this analysis focuses on the individuals who create and enact organizational policy, be it practitioner or administrator. Missing from this analysis is the voice and experience of patients. Exploring patients' views regarding medical errors, their understanding of the program, and how these policies impacts patients'

communication with providers are important elements of the complex medical error experience. Future research is needed on patients' understanding of medical mistakes, disclosure, and apology.

Understanding the structure of a disclosure and apology program is beneficial for applied health and organizational communication scholars and practitioners interested in creating and implementing organizational policies regarding errors. Although other hospitals will have different justifications for disclosure and apology programs, the MidSouth Hospital program underscores the hospital's commitment to changing the nature of health care and enacting a culture of patient safety.

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