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HOW TO SAY I’M SORRY: A STUDY OF THE VETERANS ADMINISTRATION
HOSPITAL ASSOCIATION’S APOLOGY AND DISCLOSURE PROGRAM

by

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ABSTRACT

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HOW TO SAY I'M SORRY: A STUDY OF THE VETERANS ADMINISTRATION HOSPITAL ASSOCIATION’S APOLOGY AND DISCLOSURE PROGRAM (402 pp.)

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Medical mistakes are the “hidden epidemic” of medical care. The number of medical mistakes continues to rise, but patients, medical providers, and hospitals remain silent about mistakes. I join the scholarly and practical discussion about medical mistakes through a case study of the Veterans Administration Hospital Association’s Apology and Disclosure Program. This program, created 21 years ago at the VAMC in Lexington, Kentucky, was the first program in the country to remove the secrecy and silence surrounding medical mistake experiences. At the VAMC, physicians openly disclose bad outcomes and potential mistakes to patients, and the hospital issues an apology and offers compensation when a mistake does happen. In this dissertation, I provide the first in-depth communicative analysis of the program and offer an interpretation of how multiple medical and hospital stakeholders make sense of organizational policies and external exigencies that enable and constrain the practice of medicine. Using narrative and structuration frameworks, I employ three methodologies to collect discourse related to the VAMC program and medical mistakes: in-depth interviews, participant observation, and document analysis.

The results are encapsulated in five themes which include discussions of issues related to the bureaucratic organizational structuring of hospital policy, narrative expressions of mistakes, the discursive and material consequences of mistakes, the
emotional redemptive journey through mistakes, and the question of ethical action in health care. Woven throughout these five major themes are issues of co-ownership of mistake experiences, control and authority, and ideological and ontological questioning about the role of professionalism in medicine.

The results of the data collection and interpretation are used to answer four research questions. Ultimately, I argue that the VAMC disclosure and apology program attempts to re-envision medical mistake narratives, providing multiple stakeholders new scripts through which to interact with patients and practice medicine. The analysis attempts to enlarge the societal scripts about medical mistakes and the cultural practice of medicine. I underscore the complexity of practicing “socially responsible” medicine in the face of inevitable mistakes, managed care, and the bureaucratic organizing of medicine. Theoretical and practical implications for the VAMC program, limitations of the study, and directions for future research are also discussed.

Approved: ________________________________

Lynn M. Harter

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When the giving of consolation is taken to be the paradigm of generosity, our imagination of what might be a generous relationship moves beyond material gifts and the economy exchange that material gifts instigate. Generosity transcends any expectation for what the gift may bring back in reciprocity. Generosity implies the host’s trust in the renewable capacity to give; the generous person feels no need to measure what is given against what is received. Generosity does not plan for the giver’s own future. It responds to the guest’s need. (Frank, 2004, p. 2)

This dissertation is the work of many different individuals, who provided consolation and generosity. I would be remiss if I did not take the time and space to recognize many of the individuals who gave me intellectual gifts throughout my journey in graduate school and helped to shape me as a scholar, teacher, and human being.

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CHAPTER ONE

Problem Statement

Hank Goodman was at the hospital—a tentacled, modern, floodlit complex, with a towering red-brick building in the middle and many smaller facilities fanning out from it, all fed by an extensive network of outlying clinics and a nearby medical school. Situated off a long corridor on the ground floor of the main building were the operating rooms, with their white-tiled, wide-open spaces, the patients laid out, each under a canopy of lights, and teams of blue-clad people going about their business. In one of these rooms, Goodman finished an operation, pulled off his gown, and went over to a wall phone to respond to his messages while waiting for the room to be cleaned. One was from his physician assistant, at the office, half a block away. He wanted to talk to Goodman about Mrs. D.

Mrs. D was twenty-eight years old, a mother of two, and the wife of the business manager of a local auto-body shop. She had originally come to Goodman about a painless yet persistent fluid swelling on her knee. He had advised surgery, and she had agreed to it. The week before, he had done an operation to remove the fluid. But now, the assistant reported, she was back; she felt feverish and ill, and her knee was intolerably painful. On examination, he told Goodman, the knee was red, hot, and tender. When he put a needle into the joint, foul-smelling pus came out. What should he do?
It was clear from this description that the woman was suffering from a disastrous infection, that she had to have the knee opened and drained as soon as possible. But Goodman was busy, and he never considered the idea. He didn’t bring her into the hospital. He didn’t go to see her. He didn’t even have a colleague see her. Send her out on oral antibiotics, he said. The assistant expressed some doubt, to which Goodman responded, “Ah, she’s just a whiner.”

A week later, the patient came back, and Goodman finally drained her knee. But it was too late. The infection had consumed the cartilage. Her entire joint was destroyed. Later, she saw another orthopedist, but all he could do was fuse her knee solid to stop the constant pain of bone rubbing against bone.

When I spoke to her, she sounded remarkably philosophical. “I’ve adapted,” she told me. With a solid knee, though, she said she can’t run, can’t bend down to pick up a child. She took several falls down the stairs of her split-level home, and she and her family had to move to a ranch-style house for safety’s sake. She cannot sit on airplanes. In movie theaters, she has to sit on an aisle. Not long ago, she went to see a doctor about getting an artificial knee, but she was told that, because of the previous damage, it couldn’t safely be done...Sitting with him [Hank Goodman] over breakfast in a corner of a downtown restaurant, I asked him how all this could have happened. Words seemed to elude him. “I don’t know,” he said faintly. (Gawande, 2002, pp. 89-91)

To error is human. The practice of medicine is no exception—health care providers engage in interpretative and ambiguous work as they adjust scientific abstractions to individual cases, engage in diagnostic reasoning, and offer up treatment
protocols. Indeed, Hunter (1991) identified medicine as “the exercise of practical wisdom in the face of uncertainty” (p. xix). Even so, providers and patients alike remain bound by what Lupton (2004) described as “certainty scripts” and “god-like” expectations for providers. The belief that physicians are omniscient is supported by a long tradition in which doctors are socialized to understand themselves as infallible. Physicians’ expectations for their own careers and abilities are often distorted by unrealistic and narrow understandings of medicine as a realm of knowledge that is or can be as certain as chemistry or physics (see critiques by Hunter, 1991; Montgomery, 2006). Health care contexts must be re-envisioned as uncertain arenas—contexts characterized by medical mishaps woven through role performances among characters who act toward others with the best of intentions. Just as medical mistakes have been linked to vulnerable communication processes (see Allman, 1998; Eisenberg, Murphy, Sutcliffe, Wears, Schenkel, Perry, & Vanderhoef, 2005), the (mis)management of medical mistakes is a communication accomplishment.

Meanwhile, the general public remains relatively unaware of mistakes in medicine. In 1999 the Institute of Medicine (IOM) released its landmark report, *To err is human: Building a safer health system* (Kohn, Corrigen, & Donaldson, 1999). This report shared staggering statistics and stories of medical mistakes that had, up to this point, been silenced within hospital walls. The explosive statistics, including the shocking conclusion that between 44,000 and 98,000 people die annually from medical mistakes, sparked a nationwide debate in the medical community concerning how to begin to rebuild a safer health care system (McLaughlin, 2005).
I begin this chapter with a discussion of medical mistakes and a culture of patient safety followed by brief description of the setting of my dissertation fieldwork: the Veterans Administration (VA) Disclosure and Apology Program. Next, I articulate my theoretical standpoints, highlighting their salience in understanding the process of medical mistakes and their aftermath at the VA. Finally, I conclude the chapter with a brief summary.

Medical Mistakes and a “Culture of Patient Safety”

Part of the controversy associated with the IOM report was the suggestion of new hospital policy about physicians’ and administrators’ responses to medical mistakes. Covering up mistakes, not informing the patients, altering medical charts, denying mistakes, or simply keeping the mistakes secret are typical hospital practices (Duff, 2002; Green, 2003; Kalra, Massey, & Mulla, 2004). The IOM report called for alternative approaches to handling medical mistakes and encouraging open and honest communication about mistakes and patient safety. These ideas were further prompted in the Joint Commission on Accreditation of Healthcare Organization’s (2005) report and recommendations and the U.S. Agency for Healthcare Research and Quality. Specifically, JCAHO called for health care facilities to pursue patient safety initiatives that prevent medical injury, to foster open communication between patients and providers, and to create an injury compensation program that is patient-centered. Likewise, the U.S. Agency for Healthcare Research and Quality placed a special emphasis on medical mistakes (Lammers, Barbour, & Duggan, 2003). Inherent in these recommendations is the disclosure of medical mistakes. In order to foster open
communication, pursue patient safety initiatives, and create patient-centered programs, the disclosure of medical errors is essential.

Since the 1999 IOM report, the medical community has tackled the medical mistake epidemic with rigor, emphasizing diverse approaches when dealing with mistakes. Deciding whether to disclose a medical mistake to patients, families, and hospital administration can be a daunting task. Disclosing error means exposure, embarrassment, fault, and blame for the physician and the hospital (Dickens, 2003). Medical practitioners find themselves in a struggle to choose between self-preservation and telling the truth. While the medical community tackles the issue of dealing with medical mistakes, the general public is trying to determine what a medical mistake really is; is it a mistake if you are able to change the outcome to prevent injury? Is the medical practitioner who actually commits the mistake the only one responsible?

Rowe (2004), in an attempt to provide a definition for the general public, suggested that a medical error is an error or almost error committed by a medical practitioner or witnessed by a medical practitioner who does nothing to stop the error from occurring. This definition, while inclusive, positions medical mistakes as an outcome. Instead, Paget (2004) argued that we need to break down the preconceived notion that “an act is not a mistake in itself—the end product is a mistake” (p. 45). She explained further:

Like the common phrase “everyone makes mistakes,” “mistakes are inevitable” is a surface expression of a far more complex and disturbing actuality, that irreparable errors are inevitable. Such errors violate the spirit of the work in an absolute way. They are for this reason immensely undermining of the efficacy of
the conduct of physicians. There is no adequate language here, no way to code good intentions and deadly acts, nor even entirely understandable inattentions and deadly acts. The language of tragic experience is in disuse. (Paget, 2004, p. 94)

Medical mistakes are part of the process of medicine; and like any process, mistakes and errors are likely to occur. This does not mean, however, that medical mistakes should be simply labeled as a part of the process and ignored; instead, by positioning mistakes as a part of the larger medical process, we can begin to understand why mistakes continue to be part of medicine.

Even within the medical community there is debate about how to handle the disclosure of medical mistakes and what actions the medical practitioner and hospital should take in the instance of a medical error (Brown, Donohue, Bobb, & Goodwin, 2003; Dauer, 2003; Furrow, 2003; Lamb, 2004; Runciman, Merry, & Tito, 2003). The “gold standard” of disclosure of mistakes provides anonymity, nondiscoversability of victims’ identities, and immunity from legal action (Andrus et al, 2003). The medical community generally accepts that disclosure is an ethical responsibility of the medical practitioner (Bernstein & Brown, 2004); however, the tension lies with the discussion of whether medical practitioners should be held legally responsible for the mistake or if, by admitting guilt, they get a “get out of jail free card.” Although medical practitioners are inclined to be honest, if they feel that disclosure of a mistake will mean legal action, “their instinct for self-preservation may prevail over their desire and professional obligation to tell the truth” (Bernstein & Brown, 2004, p. 106).

Because most hospitals do not have a clear disclosure policy, medical practitioners are not put in the position to choose between honest disclosure and legal
action. In fact, most medical practitioners do not have to disclose or apologize for an error at all (Brown et al., 2003). Although contemporary voluntary disclosure policy provides medical practitioners and patients anonymity, they are criticized for not promoting immunity from legal action. This is the crux of the IOM suggestion and the medical community has yet to conceive of a way to have both anonymity and immunity. By positioning medical mistakes as a process of healthcare rather than an outcome, we can explore how the current environment of medical mistakes is situated and embodied in a recursive system. Re-envisioning medical mistakes are a process of medical practice, then, means that they cannot completely be eliminated from the healthcare system. In turn, by acknowledging the presence of mistakes, alternative approaches to how physicians and hospitals make sense of mistakes can move to the forefront of creating a culture of patient safety. For purposes of my dissertation, I was granted access to once such alternative program at the Veterans Administration Medical Center in Lexington, KY.

Veterans Administration Apology and Disclosure Program

The push for an ideological shift from a culture of secrecy to a culture of patient safety started in the late 1990s (Wachter & Shojania, 2004). One hospital system, however, has been fostering that culture since the late 1980s. In 1987, the Lexington, Kentucky Veterans Administration Medical Center (VAMC) created a disclosure and apology program. This program is a mandatory hospital policy that requires physicians disclose medical error to patients and families as well as offers an organizational apology for the error. The VAMC program began after the hospital lost two high-profile malpractice cases (Kraman, Cranfill, Hamm, & Woodard, 2002). The program, created
by VA attorney Ginny Hamm and Dr. Steve Kraman, then Chief of Staff, wanted a policy in place that allowed physicians, patients, and families to reflect and talk about the medical mistake event (Gebhart, 2005). Apology and disclosure advocate Doug Wojcieszak explained the logic behind providing a space for reflection and discussion:

The majority of people who file medical lawsuits file out of anger, not greed. That anger is driven by lack of communication, being abandoned by doctors, and no one taking responsibility for his mistakes. Apologizing and offering some up-front compensation reduces this anger. Also, if doctors learn from their mistakes, they have a better chance of fixing them and not repeating them. (as cited in Murdock, 2005, ¶ 20)

The program brings together patients, families, and hospital administrators to an apology and disclosure meeting. At the meeting, the hospital offers an apology, answers questions, and offers a monetary settlement (Gebhart, 2005). Since its inception in 1987, the VAMC program has seen a decrease in lawsuits, settlement costs, and defense costs. Since 1987, only three cases have gone to trial in the 17-year period (“Why Sorry Works! works,” 2005). Other hospital systems have taken their lead from the VAMC disclosure and apology program, with legislation proposed from Illinois to Vermont (Tanner, 2004). In October, 2005, the VA National Center for Patient Safety instituted a national directive, mandating the implementation of the apology and disclosure program in all VA hospital systems (VHA Directive, 2005). Not all VA hospital systems waited until the national directive to implement the apology program. The VA hospital system in Michigan put the apology program into practice in 2002 (Hall, n.d.).
Through a case study of the Veterans Administration Hospital Disclosure and Apology Program, this dissertation was my attempt to bring medical mistakes to the forefront of health communication theory and practice. In the remainder of this chapter, I briefly outline my theoretical standpoint drawing on narrative and structuration theories, and articulate how that standpoint provided a theoretically sensible place from which to make sense of failure and answerability in health care contexts.

Narrative Standpoint

Human beings are homo-narans, natural storytellers, and we use stories as a way to understand and create our worlds (Fisher, 1984, 1985). Life, then, is itself a storied experience (Somers, 1994). Narratives are both social ontology and social epistemology, as Somers (1994) argued, approaches through which “we come to know, understand, and make sense of the social world” (p. 606), a way of being in these worlds. As such, narratives serve as a way for people to communicate knowledge, feelings, values, and beliefs on a particular subject (Burke, 1969), or what Burke described as “the element of self expression in all human activities” (1931/1968, p. 52). The task of communicating these values, beliefs, and knowledge is not always an easy one; with a constant ebb and flow of permanence and change (Burke, 1954), we inevitably have to come to terms with changing beliefs, knowledge, and experience. Telling stories is how we make sense of these changes (Bruner, 2002). Moreover, how we negotiate these changes is influenced by our orientation(s) to reality (Polkinghorne, 1988). How we approach the world will inherently affect what narratives we tell and how we tell them. We use narratives not only to make sense of experiences and change, but also to claim, express, and enact our multiple and sometimes divergent identities (Langellier & Peterson, 2004). These
elements make up problematics narrative scholars face when we attempt to make sense of other (and sometimes our own) stories (Harter, Japp, & Beck, 2005a).

Responding to the emergence of the use of scientific and psychological explanation to understand human action that centered on a final product, Burke (1954) proposed a more humanistic approach that focused on the process of human action. This process oriented approach, known as the poetic perspective, explores both human action and the motivation behind the action. For Burke, as symbol (mis)using creatures, humans create a social world through their action and do this in a poetic manner. Moreover, these symbolic actions are situated in an already established world, which can be molded and changed based on the crisis in which we are confronted. “Some decisions merely apply ways of thinking in which the person is already familiar. Others, in time of crisis, involve anything unsettling, and require an attempt to think differently about the situation” (Burke, 1954, p. xlvii). These moments of crisis in which we must react are moments of Trouble with a capital T.

To understand human behavior, we have to understand how humans construct and use symbols in a time of crisis. Although humans have the opportunity to make changes and respond differently in different situations, they do so in a symbolic social structure already constructed. This structure has recurrent patterns that are developed and reified by the people that live in the structure. However, that does not mean we discern situational patterns by means of the particular vocabulary of the cultural group into which we are born. Our minds, as linguistic products, are composed of concepts (verbally molded) which select certain relationships as meaningful. These relationships are not realities, they are re-interpretations of
reality—hence different frameworks of interpretation will lead to different conclusions as to what reality is. (Burke, 1954, p. 35)

Although patterns exist which guide our lives and actions, we cannot exist without change. Burke saw humans living in a state of constant flux and change, and continuously striving to maintain some stability in this chaos. Although humans are not ever able to have complete stability, they can develop communicative strategies that help them negotiate change. Uncertainty goes hand in hand with change, and humans are driven to reduce that uncertainty.

Burke offered narrative as a way to make sense of and communicate moments of tension and uncertainty. We tell stories in attempt to come to terms with uncertainty and (re)create stability. Narrative, then, is a way to think beyond “rational” scientific interpretations of the world (Fisher, 1985). Rational approaches tend to privilege science and logic over human experience, often failing to grant authority to people’s storied experiences. Conversely, narrative privileges human experience as a way to understand the storying of multi-dimensional experiences. Burke (1954) explained

Life itself is a poem in the sense that, in the course of living, we gradually erect a structure of relationships about us in conformity with our interests…all acts are “synthetic,” each being a new way of putting thing together, quite as each line of a drama is. (p. 254)

Narrative and the art of storytelling become ways of not only communicating human experience to others but also as a way to make sense of ourselves.

Narrative, as the storied expression of the human experience, recognizes the multiple tellings and retellings of events. A single, unified story does not exist. Rather,
narratives of experiences are constellations of experiences. Humans, over the course of a lifetime, encounter life events that become storied. Humans, however, do not experience these events separate or in a vacuum—multiple and sometimes divergent tellings of an event exist as stories converge and collide with each other (Boje, 2001). By recognizing this multiplicity, we recognize that lived experiences do not end with the completion of a telling of a story. Narratives are always partial and indeterminate, bounded and unfinished (Harter, Japp, Beck, 2005b, p. 25). Storytelling, then, is a collective and iterative enterprise; in order to understand an event, multiple stories and ongoing reflexivity are needed. Multiplicity situates narrative experiences as an ontology of possibility, a way to “be” in and make sense of our worlds. Narrative is no longer a persuasive tool to impose perspectives on others, but rather a way to “acknowledge the diversity of storied lives and told and develop constructive ways of weaving the diversity of stories together to create new ones” (Barge, 2004, p. 109). By positioning life itself as storied, narrative constitutes an “ontological condition of social life” (Somers, 1994, p. 614): the human condition.

For this dissertation, I focused on several key concerns that undergird narrative theorizing. These key concerns provided a lens through which to understand how selves, organizations, and communal life are storied experiences. Finally, I explored how some stories are silenced and the liberating potential of disrupting silenced narratives.

*Key Concerns of Narrative Theorizing*

There are several key characteristics of narrative theorizing. These characteristics are particularly important for this study as they not only help to make sense of the apology, disclosure, and medical mistake experiences, but also as a way to make sense of
the role of structuration in the narrative process, which will be discussed in depth at a later point. The key characteristics are continuity and disruption, the role of time and space in narrativizing, relationships between narrators and audiences, and intertextuality. There are certainly other concerns present in narrative theorizing; however, these three points are crucial to this particular study.

Inherent to narrative is a concern for disorder and coherence. As noted above, one of the primary reasons for narrative is to make sense of the disruptions intrinsic in human life. The tension of disruption and continuity is at the heart of narrative theorizing. “Narrativity involves characters embedded in the complexities of lived moments of struggle, heroes or victims who resist or accept the intrusions of disruption and chaos, preserve or restore continuity, and re-story meaning in their lives in the face of unexpected blows of fate” (Harter, Japp, & Beck, 2005b, p. 14). These disruptions are Trouble with a capital T. In these disruptions, humans struggle with the lived experiences of self and others, to make sense of change and uncertainty (Bruner, 2002).

We create orders, or hierarchies, as ways through which to make sense of uncertainty and create stability. These hierarchies are communicated through the telling and retelling of narratives, and over time, create fossilized institutions of behavior (Burke, 1954). Importantly, Burke argued that when we disrupt those fossilized institutions of behavior, when we disrupt the mystery of social order, guilt or embarrassment is experienced. We feel guilt or embarrassment because we have broken the order, and are behaving or acting “the way it should be.” Cleansing of guilt or embarrassment is needed to maintain social order. This can be accomplished through either mortification of self or scapegoating of an other. The mortification of self is to
admit the fault is one’s own, to take the blame and responsibility of the disruption. More common, argued Scheibel (1999), is to place blame on another. Scapegoating, then, positions the other as a villain for disrupting the order. Regardless of whether purification is accomplished through mortification or scapegoating, catharsis is achieved and the order is maintained. This cycle is never-ending, as disruption and redemption are constantly needed to maintain order (Burke, 1954).

The unique nature of narratives and self are situated in time and space. Narrative is, in essence, the “temporalizing of human beings” and their experiences (Polkinghorne, 1988, p. 127). The act of temporalizing humans and their experiences narrativizes human experiences. Narrativity, embedding characters in the complexities of lived moments of tension, aids individuals in the preservation and restoration of continuity in the face of unexpected turns in our lives. Narrativity calls individuals into a state of awareness about the stories in their lives. Mattingly (1998) suggested that this awareness, emplotment, encourages individuals to become aware of what story they are enacting or are in at the particular moment in time. Importantly, she argued that we live stories before we tell them. Emplotment, then, translates acts into episodes that eventually translate into meaningful narrations. Emplotment makes connections between narratives, identifying the tensions and showing how they work together.

Emplotment not only allows individuals to make sense of the stories in which they are present, but also allows individuals to make sense of past stories and potential future stories. “A story is made out of events, to the extent that plot makes events into a story. To be temporal, an event must be more than a singular occurrence; it must be located in relation to other events that have preceded it or will come after it”
Taking into account the past and the future helps to continually situate the narrative in time and space (Carr, 1986). Moreover, by situating narratives in a present time, and in a larger historical time, we make events meaningful, giving purpose for telling the story and giving purpose to the storyteller. Situating narratives in time and space in relation to and with other narratives helps scholars to make sense of the connections between the narratives.

Moreover, the space of the narrative experience is also essential to how individuals tell and situate narratives. Here, we are referring to the actual context or scene in which the narrative takes place. Burke (1969) explained, “It is a principle of drama that the nature of acts and agents should be consistent with the nature of the scene” (p. 3). The space of the narrative acts as a container that situates the act, making those telling the narrative to ask, “What kind of scene did he say it was, that called for such an act” (Burke, 1969, p. 12). In some cases, the space is more than just the relational container; it is the catalyst for the events of the narrative (Harter, Deardorff, Kenniston, Carmack, & Rattine-Flaherty, 2008). In the case of medical narratives, the scene is associated with the medical encounter: the clinic, the doctor’s office, the operating room. The context of the narrative event will partially determine what is told in the narrative and how it is expressed.

The recognition of time and space in narrative theorizing allows us to make sense of another key characteristic of narrative, the art of reflexivity. Narratives help individuals make sense of multiple colliding narratives by connecting parts of reality within a social network composed of relationships among symbolic, political, institutional, and material practices (Brockmeier & Carbaugh, 2001). In order to
construct, share, and change stories, we engage our own personal experiences and the socio-cultural contexts in which our stories are located. This process calls for individuals to continually reflect on the narratives they tell and the narratives they hear, making sense of all of the external exigencies that influence those narratives (Lieblich, Tuval-Mashiach, & Zilber, 1998).

Narrative reflexivity is central to individuals, especially when change is experienced by the individual. Reflexivity, as part of a postmodern turn away from absolutism, calls individuals to make sense of the inherent temporality and spatiality of narratives (Beck, 2005). Because narratives are situated in time and space, choice is a central part of the narrating process. Narrative, and as discussed later, structuration, is an ontological and epistemological *process of possibility*, meaning that we have to make choices. Choice asks that we reflect on the decisions we make; especially important are the intended and unintended consequences of choices (Giddens, 1991). Emplotment also asks individuals to reflect on their narratives by making sense of how present and past moments collide and impact future moments. We have to figure out “what story we are in” (Sharf, 2005) so that we can make sense of that story.

In narrative sense making, however, the self does not tell and listen to stories in isolation; rather, storytelling and story listening are inherently influenced by others. This influence, known as intertextuality, suggests that narratives do not exist as one story told by one person. Instead, narratives include multiple voices (Bakhtin, 1981) and are often co-articulations of an event. Reflexivity, then, asks a narrator to appreciate how his or her “participation in a conversation shapes the way others coordinate their actions in conversation and the kinds of emotions, feelings, and attitudes that get constructed”
Likewise, narrators must appreciate the other voices and texts that participate in the co-construction of their narrative. When discussing medical mistakes and apology, physicians, as self-reflexive narrators, must consider not only their experiences with medical mistakes and apology, but also the narratives of other physicians, patients, literature they have read, and the hospital policy that influences how they make sense of medical mistakes and apology.

The act of narrativizing experiences, as discussed above, means that narratives are intrinsically co-constructed by the narrators and others. Since, as Somers (1994) articulated, life and the experiences that make up life is storied, we ontologically position ourselves as authors, storying ourselves into being. Like many of the other characteristics discussed above, this storying of self does not happen in isolation. Instead, others, through audience members, readers, or other narrators help to construct our narratives. Likewise, we influence others’ co-constructions of narratives. These tellings and retellings from different perspectives mean that we enter into narratives from different places with different purposes. How we tell our narrative event is influenced by how we enter the narrative, make sense of the narrative, and how others have entered and made sense of the narrative event. Meaning, then, lies between narrators and readers, between the storyteller and story listener.

**Storying Self, Organizational, and Communal Life**

A key problematic of narrative theory is that of self-identity, of knowing and being (Harter, Japp, & Beck, 2005b). Knowing and being position narrative theorizing as an ontological act. By positioning stories as an ontological act, we construct our sense of self in and through stories; narratives, then, communicate who we are to ourselves and
others. This particular approach to narrative theorizing emphasizes the symbolic and corporeal nature of narratives. Not only are narratives symbolic, communicating our experiences to ourselves and others, but they are also material, embodied in our actions and behaviors. The symbolic and corporeal nature of narratives means that they are both lived in the moment and retold, making narratives emergent (Mattingly, 2000). A potential danger of situating narratives as simply “told” to others prevents us from asking, “How do we see narrative in terms of life and in terms of narrative without loss of richness and complexity, without neglecting the phenomenological complexities of lived experience and the creative artifice of narrative” (Mattingly, 2000, p. 188)?

Understanding the symbolic and corporeal exigencies of narratives help to make sense of the role of the body in narrating about experiences. Experience is participated in, not just observed (Bakhtin, 1981). This is why storytelling is sometimes seen as a performative event. Especially in the expression of health narratives, the role of the body is an essential part of narratives. Frank (1995) emphasized the importance of the body in health and illness. Illness is an inherent call for stories, and the body is what experiences illness. Speaking for and through the emergent body is how life and narratives can be expressed without losing the complexities of life.

Narratives also function in a strategic form in which we come to understand our being. Narratives articulate “the relation we have to ourselves in the form of a narrative or memorization of how we think we have come to be the person we are, and, second, by reference to the relation we have with the spatial dimension of being” (Venn, 2002, p. 31). To understand the self, the body and the self must be situated in time and space (Polkinghorne, 1988). Situating the self in time and space means that there is the
opportunity for alternative presentations and interpretations of narrative; the self is unique, and a unique presentation of self will offer unique presentations and interpretations. The narratives may be about the same topic and use the same language, but each is a unique expression of a unique experience (Wittgenstein, 1958).

It is important to understand and appreciate the different ways narratives are presented and how those different presentations work in tandem to constitute knowledge and life, and how those different narratives can collide and rest in tension with each other. Grand narratives, also know as meta-narratives, are culturally constructed narratives that represent social understanding (Lindemann-Nelson, 2001). Grand narratives are meant to be archetypal in nature, the historical stories of societies or institutions. These grand narratives guide our lives by providing principles through which to make sense of our multiple identities. Without the grand narratives, we would be unable to make sense of and enact our multiple and sometimes conflicting identities. For example, grand narratives tell us what it means to be a mother or a wife. For the medical community, a grand narrative may be what it means to be a patient (obedient and passive) and a physician (dominant, certain, infallible, knowledgeable, machine-like). Multiple grand narratives exist, and sometimes clash with difference. For physicians, the grand narrative that explains what it means to be a physician may conflict with the grand narrative of what it means to be human because the emphasis in the traditional physician grand narrative is that of man-as-machine. These narratives provide the guidelines for how to maintain and negotiate aspects of communal life, like how to be a patient.

Grand narratives are meta-narratives that are situated as larger institutional or historical narratives. For example, the “health” narrative is a grand narrative that shapes
how health narratives are supposed to be told and, to an extent, experienced. They are seen as the “official” way to tell the narrative (Boje, 2001). Of course, one limitation of the grand narrative is that it privileges certain ways of telling narratives, which means that other ways to story experiences are silenced. Grand narratives can be both enabling by allowing us to live in our worlds, and constraining in that not all narratives get to be told. Moreover, there is not always space to contradict or counter the grand narrative. Boje (2001) and Lindemann-Nelson (2001) suggested that rather than reject all grand narratives, we can restory them, retelling them by including the voices once lost. We restory by juxtaposing little stories and big stories in order to get a broader understanding (Boje, 2001). This means, then, that scholars must be open to multiple and sometimes divergent stories in order to make sense of a situation.

Distinguishing between different levels of narratives is key to understanding and using a narrative lens because the restorying process invites multiple, sometimes divergent, narratives (Phelan, 1996). Restorying grand narratives also means that grand narratives are open for alternative readings and interpretations of narratives (Garro & Mattingly, 2000). Moreover, this distinction is important when analyzing narratives because not all narratives are equal (Frank, 1995) and some stories are more important to tell than others (Mattingly, 1998). When we restory grand narratives, counter-narratives designed to aid in the healing of damaged identities silenced by grand narratives emerge (Lindemann-Nelson, 2001), continually forcing individuals to reevaluate the grand narratives that constitute their lives.

Communication scholars studying organizational settings are drawn to organizational and institutional narratives because the narratives are “those stories
constructed within and constrained by the collective consciousness of the individuals and
groups within their domain” (Japp, Harter, & Beck, 2005b, p. 2). Organizational
narratives, like individual narratives, are multi-vocal stories, what Bakhtin (1981) calls
heteroglossia. Because there are multiple and potentially divergent stories constituting the
organization, it is imperative to understand how organizational discourses and narratives
influence how and what individuals tell in their narratives (Czarniawska, 1998). These
stories, known as stories from the field, help to identify the sense-making processes of
individuals in the organization, as well as aid in exploring how these stories make up the
organizational narrative.

Organizational narratives, like individual narratives, are meant to be legitimizing
forces of realities (Mumby, 1987). In this case, the organizational reality needs to be
legitimized to maintain the organization. This reality must be constituted and maintained
by the organization in order to create a “mode of rationality,” rules and resources that
enable and constrain organizational members as they negotiate the organizational terrain.
Organizations create policies and procedures to help with this negotiation (Kirby &
Krone, 2002). The documental discourses are used specifically for the purpose of
perpetuating hierarchies, structuring identities, and constructing identifications or
divisions among individuals in an attempt to create a convincing organizational
ideological narrative.

Organizational and individual realities are crucial to understand because “when
narrative theorists 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). If, as this study attempts to do, we want to understand how multiple stakeholders make sense of changes in the organization and institutional narratives, then we have to consider more than just the personal narrative; we have to understand what contributes to the construction of those narratives. Stories have limits in what they can and do tell (Lindemann-Nelson, 1997), so we have to consider the multiple narratives that make up a particular event in order to make sense of the narratives told about the event. To understand medical mistakes, we have to understand how the apology program restories organizational and institutional narratives in order to make sense of how and what is told by physicians.

Grand narratives help to construct organizational narratives, constituting how organizational narratives are storied and what those narratives tell (Mumby, 1987). In terms of medical mistakes, the traditional narrative of silence and denial is situated in the larger institutional medical narrative of how medicine is performed in society. Hospitals tell their own narratives of medical mistakes because of their own unique experiences; however, these narratives are informed by many grand medical narratives. Organizational policies, procedures, and other organizational discourses communicate to organizational members the organizational narrative. Finally, organizational members use the policies and procedures, organizational narratives, and grand narratives to create their stories and how they tell stories. This distinction highlights how narratives work together and how they might resist each other.

This is not to say that organizational narratives should be situated as more important than individual narratives; conversely, organizational narratives should not be
positioned as secondary to personal narratives. Rather, they rely on each other for their constitution:

Although it is evident that personal narratives energize public narratives, it is often less obvious that the cumulative force of public narratives shape and constrains personal narratives. Personal stories can never be constituted independently from public narratives, those pervasive patterns that provide the language, structure, and formulas that shape our ways of thinking and our collective understandings. (Japp, Harter, & Beck, 2005, p. 4)

This is why understanding the structure of the organization, and the larger historical institution in which the organization is situated is crucial to understanding personal stories. Moreover, narrative organizing helps to weave together the inter-relationships between the personal, institutional, and communal narratives by highlighting the places of connection and divergence. Physicians’ tellings and retellings of personal stories of medical mistakes are informed by the organization. Even so, the organization provides the vocabulary to talk about the experience. Ignoring the organizational impact on these personal stories prevents scholars from truly understanding those stories. Likewise, to ignore the individual stories in organizational stories is to ignore how those stories were formed. Ultimately, it is the subjective nature of narratives that make them so appealing (Riessman, 1993); their subjectivity, their intimate nature and vulnerability, their humaneness is why we are drawn to narratives.

Disrupting Silence: The Liberating Potential of Narrative Activity

Not every person wants or is able to tell his or her story. Individuals may be silenced or not have the vocabulary through which to express their stories. Stories are
then sequestered, or silenced (see Clair, 1993). The telling of these stories can even become forbidden (see Carabas & Harter, 2005). Silenced stories are those which are hidden from the mainstream. These silenced narratives may very well be told, but they are not told in a forum that is open for public consumption. Individual stories which are sequestered create an organizational narrative of silence, which further inculcates narrative silence into the organization. When we give space for the voices of silenced narratives, we give the narratives a chance to be told and heard. Essential to the silencing of narratives is the recognition of who tells it, with whom the narrative is shared, where the narrative is shared, and how the individuals tell their stories (Clair, 1993).

There are multiple ways in which narratives can be silenced. An important distinction in the sequestering of experience is who is doing the silencing. A person can not want to tell his or her story; this is an act of self-silencing. This could be done as an act of self-preservation. By self-silencing a narrative, an individual may be attempting to remain silent about an event or refraining from experiencing emotions, such as guilt, shame, anger, loss, or rage (Giddens, 1991; Kurzon, 1997). Conversely, a person may want to tell his or her narrative, but be unable to do so. Clair (1993), in her exploration on the sequestering of sexual harassment narratives, identified several reasons behind the sequestering of narratives; however, only five of the sequestering devices are relevant to this study. The first device is accepting dominant interests. Here, dominant organizational interests supersede the individual need; tension exists when the dominant organizational interests collide and resist individual interests. This tension evolves into the second device, simple misunderstandings. Here, contradictions exist between organizational ideological beliefs and practices, making it difficult to share narratives. These tensions
must be either justified or correct. Connected to dominant interests is the third device, reification. Reification is an extension of accepting dominant interests; as dominant interests continually take precedent over individual interests, the dominant interest eventually becomes fossilized. The dominant interests become representative of reified organizational ideologies (Clair, 1993).

With evolution occurring throughout the first three devices, finding a vocabulary through which to make sense of and express a narrative can be difficult. Denotative hesitancy is when narratives are sequestered because a vocabulary does not exist through which to tell the narrative. If the vocabulary is controlled by the organization, “then it is possible that the subordinate group may be without the means of expression necessary to convey their own narrative or define their own experience” (Clair, 1993, p. 120). New experiences, especially, are prone to denotative hesitancy because a dominant group is controlling the vocabulary. Silence may occur through denotative hesitancy when a vocabulary does not exist or has never been used. The final sequestering device is the positioning of private/public expression in a private/public domain. Here, “traditional” expressions are relegated to a particular domain. For example, the expression of emotion is thought to be a private expression, so it is consigned to the private domain. By relegating certain expressions to certain domains, narratives can continually be sequestered because they may not be seen as appropriate for particular realms. These devices can be used solely to silence narratives or used in tandem to maintain silence. The distinction between why narratives are silenced is an important one; tensions may exist when someone who wishes to silence his or her narrative is forced to give it or if he or she is silenced.
When individuals are denied the ability or lack the vocabulary to share their stories, experiences are silenced. This silencing of experience (Giddens, 1991) separates day-to-day life and prevent individuals from experiencing existential questions (p. 244). Silencing of experiences conceals potentially disturbing or provocative aspects of life. Silencing of experiences represses human life by preventing individuals from wrestling with the connection of values, beliefs, and identity. Narrative expression is both how the self is presented and how the self exists. By denying individuals the opportunity to wrestle with existential tensions, then, we are not able to express the self nor is the self allowed to exist (Giddens, 1991).

The silencing of experiences can be both symbolic and corporeal. For example, we do not talk about sexuality (symbolic) and we sometimes segregate individuals with disabilities in sheltered workshops (corporeal). Sickness and death are the ultimate sequestered experiences (Giddens, 1991) because sickness and death are moments where human control over existence no longer exists.

The point is not just that, today, death is routinely hidden from view. In addition, death has become a technical matter, its assessment removed into the hands of the medical profession; what death is becomes a matter of deciding at what point a person should be treated as having died, in respect of the cessation of various types of bodily function. Death remains the great extrinsic factor of human existence; it cannot as such be brought within the internally referential systems of modernity. (Giddens, 1991, pp. 161-162)

For physicians and other medical personnel in healthcare, sickness and death are not silenced experiences; however, the stories they tell about sickness and death often remain
disciplined and regulated narratives. This is especially true in the instance of medical mistakes. Legally, physicians are bound to silence about mistakes because of the legal malpractice repercussions that often are associated with the mistake (Paget, 2004).

Narrative, and by extension, experience, can be liberated by providing space for storied expression. Eliminating the constraints of liberation creates space for individuals to share previously silenced experiences. This, in turn, creates an opportunity for grand narratives to be restoried (Carabas & Harter, 2005), and gives a chance for muted voices to be heard. However, this may not be an entirely liberating activity. By challenging the aforementioned silencing devices, individuals could be placing new forms of silence on the narratives to replace the previous ones. By providing a vocabulary for a previously muted experience, we constrain how an experience can be narrated. The tension of liberating can easily be seen in the device of relegating public/private expression to public/private domains. By relieving the binary positioning of expression and domain, and situating private expression in a public domain, we may be disciplining the emotional expression of experience by placing it a public space.

The liberation of experience through narratives has the potential to be both therapeutic and uncomfortable. The “success” of narrative as a therapeutic activity depends on the individual’s ability to construct a narrative of healing and coping (Launer, 1999). Narrative acts cannot be simply about telling a story that could not be told before. For narratives to be therapeutic, narratives must also provide space for moving past the experience. To be therapeutic, narratives cannot simply seek out “hidden truths;” they must also create “previously unformulated truths” (Launer, 1999, p. 117). By positioning narratives as a therapeutic act, individuals have opportunities to tell those hidden truths,
as well as cope with previously silenced experiences. This does not mean that liberating previously silenced narratives will also be a therapeutic activity. The liberation of narratives can be a potentially dramatic, and sometimes traumatic experience (Mattingly, 1994). Narratives provide a therapeutic lens through which individuals make sense of “inner hurt, despair, hope, grief, and moral pain” (Greenhalgh & Hurwitz, 1999, p. 48). Expressing these emotions can be difficult when individuals were not able to do so before. Likewise, telling and retelling narratives means that individuals relive emotional experiences. Individuals may not want to continually relive these experiences, making the narrative process not therapeutic.

Moreover, positioning narratives as potentially therapeutic underscores a moral dimension of narratives specific to issues of health and healing. As Mattingly (1994) wisely noted, moral negotiations in health and healing worlds are traditionally hidden. The silencing of health and healing narratives means that ethical dimensions of medicine are silenced. In the medical realm, the primary narrative is the patient’s narrative, with the recognition of other voices and stories (Jones, 1999). By situating the patient’s story as the primary story, the physician’s story has the potential of being silenced. To understand the moral dimension of medical mistake narratives, the physician’s story has to be equally privileged in order to understand the experience.

Coupling Narrative and Structuration Theory

Narrative theory provided an excellent theoretical lens through which to understand how physicians make sense of a disclosure and apology program. Yet, as argued by Mumby (1987) nearly twenty years ago, the robustness of narrative theory is more fully realized when coupled with a structuration lens. From a structuration
perspective, “narratives not only evolve as a product of certain power structures, but also function ideologically to produce, maintain, and reproduce those power structures” (p. 113). To understand apology and disclosure programs, we must also understand the material policies and procedures that shape, enable, and constrain the construction and telling of these narratives. Giddens’ (1979, 1984) structuration theory provided a theoretical vocabulary through which to understanding the role of structures in the symbolic telling of stories.

Structuration theory emerged as a way for social action theorists to negotiate the inherent tension between social structures and human agency (Wallace & Wolf, 1999). Before structuration theory, the sociological research world largely positioned itself into one of two camps: the voluntarism camp and the determinism camp. Voluntaristic approaches, such as phenomenology, which privilege agency over structure, divorce the agent and their action from societal, organizational, and environmental contexts. Action exists because of complete free will and voluntary decisions (Giddens, 1979, 1993). Organizations, thus, become treated as self-contained, self-regulated entities, separate from human involvement. The object almost vanishes as the subject is situated in a place of supreme importance. Conversely, functionalist approaches emphasize a more deterministic approach, acknowledging the actor, but emphasizing the structures that guide and dictate behavior. This deterministic approach argues from a “fixed” pattern to social life, one that stresses the object over the subject (Giddens, 1993). In a sense, deterministic approaches, by virtue of ignoring the human agent, attempt to humanize systems and structures as a way to explain why systems function as they do. If we attach human features to systems then we do not need to include humans in discussions of
organizations. However, “social systems have no purpose, reason, or needs; only human individuals do so” (Giddens, 1979, p. 4). To make sense of the world, determinism and voluntarism need what the other has to holistically study individual, organizational, and societal behavior.

Rather than privilege structure over agency or agency over structure, structuration theory strives to acknowledge agency and structure and their inter-relationship. Giddens’ duality of structure situates agency and structure as cyclical: agency produces, reproduces, and transforms structure; it is only because of structural traditions, however, that humans can change or maintain the structure (Giddens, 1979, 1984). Structuration theory, then, is the structuring of social relations across time and space, evolving and changing because of the duality of structure. The duality of structure is a direct response to the tension between functionalism and phenomenology, which tend to position agency and structure as dualisms, emphasizing one over the other (Conrad & Haynes, 2001). Both camps constrain either the individual or the structure, making investigations from these perspectives incomplete. Structuration theory attempts to bring together both theoretical camps. Giddens (1993) challenges the idea of dualism. He questions the false binary created by positioning the individual as the subject, confronting the structure, the object. The duality of structure reconnects the subject and the object through the “de-centering of the subject” (Giddens, 1979, p. 38). Although the de-centering of the subject connects the agent and structure, the subject is still privileged. This is needed to enact transformation, an agent driven activity.

As a methodological lens, Giddens (1984) sees structuration as an ontological approach, a way of understanding how humans “be” or exist in the world. Instead of
isolating the self in a separate time and space from society, an ontological approach positions the individual in the social world, acknowledging not only how the individual influences the social world, but also how the social world influences the individual (Gadamer, 1989). Giddens (1993) relied heavily on Gadamer (1989) in his beginning introduction of structuration theory, particularly in his discussion of hermeneutics as an ontological lens to understand human and social world behavior. Hermeneutics is an “ontological process of human discourse in operation” (Giddens, 1993, p. 63). Through discourse, we come to understand and produce or reproduce shared meanings. This, then, creates traditions in the social world. Hermeneutics is a lens in which we make sense of those traditions (Gadamer, 1989). These traditions produce stocks of knowledge, knowledge that individuals are often unable to articulate but can enact. These traditions and stocks of knowledge are important to know and recognize when individuals attempt to enact transformation because before we can challenge parts of our social worlds, we have to understand the traditions of our social worlds.

Moreover, an ontological approach appreciates the positioning of the individual and their social world in a larger historical world, often referred to as the long durée (Giddens, 1993) or “great time” (Bakhtin, 1981). Giddens (1979) situated individuals and their social world within the long durée; it is this situation that helps individuals make sense of the social world. This, for Giddens, is “being in the process of becoming” (p. 130). Existence is not solely about the individual, but the individual and the social world. An ontological approach highlights the diversity of human action and the social institutions that are shaped through that diversity. Structuration as an ontological approach is one of possibilities (Banks & Riley, 1993; Conrad, 1993). Possibilities exist
because human action is not completely determined, some free will does exist. That free
will, however, is constrained by the structures already in place. Action is then determined
based on the choices provided by the structure. Structuration then, is about choice—the
choice to produce and reproduce the social world or the choice to transform it.

*Key Assumptions of Structuration Theory*

There are several key assumptions of structuration theory that need to be explored
in order to understand how structuration theory functions as a theoretical lens for looking
at the world. Many of these assumptions operate as dialectics, tensions between the
individual and structures. Because this particular study is concerned with both individuals
and structures, understanding how these dialectics exist in the structuration realm is
paramount.

*Duality of structure.* The central tenet of structuration theory is duality of
structure. As discussed above, duality of structure engages the inter-relationship between
structure and agency. However, there is more to the duality of structure than simple
structure, agency, and their reciprocal nature. Awareness of actions and structures is a
crucial part of the duality of structure (Banks & Riley, 1993; Browning & Beyer, 1998).
This awareness, or consciousness, does not always need to be able to be articulated; as
mentioned above, some stocks of knowledge are known but individuals are unable to
articulate them. The duality of structure, then, is both enabling and constraining. 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). Because of this, social worlds, and
the human activities in those social worlds, are produced, reproduced, and transformed.
Structuration theory, as a high or late modernity theory, relies on the reflexive monitoring of action (Bryant & Jary, 1991). This is one of the reasons structuration theory provides a useful vocabulary to understand individual and organizational narratives; the focus on reflexivity means that individuals not only monitor their own action, but also monitor contexts (Browning & Beyer, 1998; Giddens, 1984). A focus on reflexivity highlights how structure is embedded in interactions as well as how it perpetuates or challenges a social world (Browning & Beyer, 1998; Howard & Geist, 1995).

Structuration theory is composed of four different levels. The first level is interaction, the human-to-human interaction influenced by the social world. Although Giddens does not focus primarily on individual interactions, the stocks of knowledge that constitute the social world are embodied through individual interactions. The second level is structures. Structures are “recursively organized sets of rules and resources” (Giddens, 1984, p. 25). Structures exist as stocks of knowledge, appearing in the social world through human action. A key element of structure is its recursive nature. Deeply connected to the reciprocal nature of the duality of structure, structures are both enabling and constraining. Structures embody the simultaneous flow of action and the entrenched traditions that enable and constrain that action (Barley, 1986). The third level of the duality of structure is systems. Systems are the regular, patterned social practices created through the production, reproduction, and transformation of structures. Important to the level of systems is the connection between the individual and the collective. Systems are the equivalent of organizations; organizational narratives present the patterned practices of the organization (Mumby, 1987). The final level of the duality of structure is structuration, the “structuring of social relations across time and space” (Giddens, 1984,
Structuration represents the long durée, or for the purposes of this study, the institutional and historical discourses of social worlds. It is important to recognize, then, that structuration includes multiple institutional discourses that can collide and resist each other.

These levels exist in a hierarchical-like system, one building on the other, influencing how communicative practices are enacted and embodied in discourse. As the patterned practices and activities are continually produced and reproduced, practices become institutionalized. Important to structuration theory is the routinization of human activity. Routinization not only helps to institutionalize stocks of knowledge, making that knowledge mutual, but also helps to create ontological security in the social world in which individuals reside (Conrad, 1993). These levels are extremely important in the connection between narrative and structuration theories, and will be explained in a later section.

Dimensions of structuration. The duality of structure is more than the cyclical nature between the active agent and the social world. Within this duality lies structural features, or dimensions (see Table 1). These dimensions are not meant to be representative of structures or the human interaction than takes place in and between them. Rather they are used in combination to make sense of different social practices (Giddens, 1979). How structural elements are embodied and enacted in interaction depend on interpretive schemes, “standardized elements of stocks of knowledge, applied by actors in the production of interaction” (Giddens, 1979, p. 83). As Giddens (1984) explains,
Human actors are not only able to monitor their activities and those of others in the regularity of day-to-day conduct; they are also able to ‘monitor that monitoring’ in discursive consciousness. ‘Interpretative schemes’ are the modes of typification incorporated within actors’ stocks of knowledge, applied reflexively in the sustaining of communication. The stocks of knowledge which actors draw upon in the production and reproduction of interaction are the same as those whereby they are able to make accounts, offer reasons, etc. (p. 29)

Interpretative schemes act as the foundation for mutual knowledge, and provide universal meaning to interactions.

Three different structural dimensions of social systems exist that influence those interpretative schemes: signification, domination, and legitimation. Structures of signification highlight the codes and discourses used in interaction. This is where mutual stocks of knowledge are central; understanding the codes and discourses used in a particular structure assumes an element of mutuality (Riley, 1983). Signification allows communication to occur in interactions. Structures of domination depend on the mobilization and use of allocative and authoritative resources. These resources, discussed in more depth in a later section, emphasize power over and with 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. 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, but this does not have to extend to a majority of the members, nor is stability determined by the existence of these common values. (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.

Conflict and contradictions. The constant collision and possible resistance of structures, systems, and institutional structuration creates space for conflict and contradictions that must be resolved through human action. Giddens (1979) passionately urged scholars to focus on contradiction, arguing, “Don’t look for the functions social practices fulfill, look for the contradictions they embody!” (p. 131). Like the different levels of the duality of structure, conflict and contradiction represent tension on those different levels. Conflict is the struggle between individual or collectives on the level of social practices (Giddens, 1979, p. 131). Individuals or collectives may have trouble making sense of rules and resources in their daily activities if they oppose how they see and experience social worlds (Stohl & Cheney, 2001).

Furthermore, contradiction arises when the patterned activities of the structures, created and maintained through and for sectional interests, rest in tension with individual value standards (Fairhurst, Cooren, & Cahill, 2002). Contradiction is a structural concept, as opposed to conflict, which emphasizes the individual. Contradiction, being a structural concept, can occur on the structurational level, when institutional discourses collide with
each other (Giddens, 1979). Moreover, contradiction arises in the midst of reproduction and transformation of systems; conflict does not require reproduction or transformation. Regardless of their position in the hierarchical-like levels of structuration, conflict and contradiction are connected but do not necessarily need each other to exist. Conflict needs a preexisting contradiction in place for it to exist (i.e. - individual value standards must diverge from sectional interest). Conversely, contradiction can occur without the individual feeling a conflict with the system (Giddens, 1984, p. 198).

Tied directly to the discussion of conflict and contradiction is power. Power is another central tenet of structuration theory, especially in understanding how structures, systems, and institutional/historical discourses are produced, reproduced, and transformed. Power is mostly prominent in the structural dimension of domination and, by connection, legitimation. Power, for Giddens (1979), is a dialectic of autonomy and dependence on the structure. This is what Giddens often refers to as the dialectic of control. Agency is essential to the dialectic of control, as “an agent who does not participate in the dialectic of control, in a minimal fashion, ceases to be an agent” (Giddens, 1979, p. 149). Power in structuration theory is relational, similar to Foucault’s (1982) positioning of power as a relational activity. Power is the individual’s ability to gain access to and use resources provided by the system, to achieve an outcome (Giddens, 1984).

Giddens’ (1984) definition of power as simply the achievement of an outcome is a crucial element of this study. Traditionally, issues of power are relegated to the realm of critical theorists, thus often situating structuration theory as a critical theory. Giddens, however, resists this classification, arguing throughout his work that structuration exists
as a late or high modern lens, not a critical or postmodern lens. In regards to power, Giddens (1984) continues to emphasize this distinction:

Power is the capacity to achieve outcomes; whether or not these are connected to purely sectional interests in not germaine to its definition. Power is not, as such, an obstacle to freedom or emancipation but is their very medium—although it would be foolish, of course, to ignore its constraining properties. (p. 257)

It is not that power cannot be seen as a constraining property, keeping individuals in oppression; it is just that power does not have to be seen as such. Rather, power is the ability by individuals to recognize dueling systems of meanings and how individuals select meanings to make sense of and govern their world (Huspek, 1993). This is central to this particular study as I use structuration theory coupled with narrative theory from an interpretative lens, not a critical one.

Like narrative theory, there are many important elements of structuration theory. For this dissertation, however, the elements important for this study were (1) the identification of the meso structure, (2) rules and resources, (3) ideological positioning and ontological security, and (4) crises and fateful moments.

Finding the “Meso” and “Meta” Structures

Giddens (1993) found fault with deterministic and voluntaristic approaches to the individual and social worlds because these approaches separate macro-structures (structures) and micro-structures (individual), emphasizing one over the other. This emphasis makes any analysis lacking, creating spaces for unanswered questions. Structuration theory, even in its earliest stages, attempts to break down the dichotomy of the macro and micro. Macro- and micro-structures are not mutually exclusive; on the
contrary, they require each other even though they must be kept apart. Rather than
viewing the macro and micro as separate structures, Giddens (1984) suggests that they be
reconceptualized as concerning how “interaction in contexts of co-presence is structurally
implicated in systems of broad time-space distanciation—in other words, how systems
span large sectors of time-space” (p. xxvi). Important in this reconceptualization is that
systems and institutional or historical discourses are separate; systems are situated in the
institutional or historical discourses. Structures, then, operate as a meso-structure,
connecting the macro-structure of systems and the micro-structure of human interaction.
In structuration, then, the institutional and historical discourses serve as meta-structures.

In its application in empirical research, however, structures often are lumped
together with systems; the meta- and meso-structures often becomes a synonym for
macro-structure (Stones, 2005), clustering structures and systems together to set in
opposition to the individual. Moreover, institutional and historical discourses are also
combined with systems in macro-structures. The problem with this is that the nuances of
the structures, systems, and the institutional discourses are lost in the analysis process.
Institutional and historical discourses are situated in the long durée, influencing the
discourses of systems. Meso-structures are important to emphasize separately because
they are often time-space bounded (Giddens, 1984). The structures used in particular
systems are particular to those systems. More importantly, structures are the ways in
which patterned behaviors are embodied; they are how individuals know the behaviors of
the systems. Structures are the discourses or material representations of the system
(Giddens, 1979). In organizations, policies and procedures serve as the representations of
the meso-level. Not only do policies and procedures provide the rules of the system, they
also provide the knowledge needed to negotiate resources (Kirby & Krone, 2002; Yates & Orlikowski, 1992). Policies and procedures represent the material manifestation of the reciprocal relationship between institutional practices and human action (Yates & Orlikowski, 1992). Although Giddens does not ultimately spend time on the importance of meta-structures, he does emphasize the importance of situating analysis in the larger long durée, which is in effect, the meta-structure.

The distinction between micro, meso, and macro levels of analysis is essential not only for understanding the nuances of organizational systems, but also as an essential way to connect narrative and structuration theories. As indicated by Table 2, the distinction between levels of analysis is needed to make sense of the storying of organizational life. The interaction level corresponds with the act of storytelling. Here, agency is extremely important and this level offers individuals space for voice and for individuals to tell their stories to others. The act of storytelling would be a human-to-human activity since interpretation is part of making sense of the entire structuration process (Giddens, 1973).

The next three levels focus more on the discourses and narratives of organizational and societal life. Structures, as established earlier act as the meso-level, are the connections between patterned behaviors and how they are enacted by individuals in interactions. Structures coincide with organizational policies, procedures, and documents, which serve the purpose of communicating organizational behaviors to individuals (Scott, Corman, & Cheney, 1998). Moreover, structures provide the vocabulary through which to communicate in the interactions; without the language of the policies and procedures, individuals might not have the language through which to
tell their story. Policies and procedures serve as the discursive manifestation of the symbolic act of storytelling by giving words to practical consciousness, or what we know but cannot articulate (Giddens, 1984). System works in tandem with organizational discourses. This particular match is obvious since organizations act as spaces of patterned behavior. Organizational discourses, often with the assistance of structures, display the patterned behavior required of the organization. Finally, the meta-level of structuration is positioned within institutional or historical narratives. Structuration and institutional and historical narratives both emphasize the importance of the long durée. A particular organization may be its own separate system with its own separate structures; however, it is still influenced by multiple institutional and historical discourses, such as the type of organization, the service they provide, and the evolution of organizations in society. Structuration helps to make sense of the often colliding institutional and historical narratives by exploring the potential contradictions they create.

**Rules and Resources**

Rules and resources are the symbolic and material expressions of structures. Rules and resources cannot be separated from each other, as each provides an essential element to understanding structure (Giddens, 1984). Rules enforce procedures of social interactions, often creating boundaries around human behavior. Because structure is both enabling and constraining, these boundaries are often how power is facilitated by individuals. This particular aspect of rules means that all social rules are thus transformational, evolving as the system evolves (Giddens, 1979). Rules play a key role in the production and reproduction of systems by creating, enforcing, and norming behavior. Organizational policies and procedures are an example of structure rules
because they dictate organizational rules and scripts of behavior to organizational members.

Resources, like power, are capabilities to make change. They are not meant to be seen as barriers to freedom or arms of oppression (Giddens, 1979). Two different types of resources exist: allocative and authoritative resources. Allocative resources are “material resources involved in the generation of power” (Giddens, 1984, p. 373). These resources are material in nature; the use of the physical environment, money, technology, and artifacts that can be used in interactions. Authoritative resources are the “non-material resources” used in the attempt to gain power (Giddens, 1984, p. 373). Authoritative resources are derived from the ability to harness the power and action of others. Both forms of resources may exist in an organization setting as the reasoning and motivation behind transformation in an organization. Rules attempt to maintain stability in the organization, while resources serve to help make change. They work in tandem, however, as once the change is enacted, rules are needed to maintain the change in the organization. When transformation is a goal of an organization, both the organization and the individuals in the organization are charged with the transformation, either through the creation of change or the maintenance of that change (Witmer, 1997).

Ideological Positioning and Ontological Security

Although change in a social system is inevitable, individuals in the system still have to make sense of the system. This negotiation of sense making is known as ontological security, “the confidence or trust that the natural and social worlds are as they appear to be, including the basic existential parameters of self and social identity” (Giddens, 1984, p. 375). Trust is a key component of ontological security, but this trust
can be misleading. If we fail to question, or even challenge, the routines of the social world, then the ontological security we experience is a façade. Day to day activities requires ontological security, an expression of control and routine known to the individual (Giddens, 1984, p. 50). This expression of control and routine not only provides the individual with the ability to make sense of the systems in which they exist, they also help individuals make sense of their purpose in the world (Giddens, 1991).

Purpose and meaning are essential to human existence. As Giddens (1984) explained,

The feeling of autonomy of action that individuals have in the ordinary routines of day-to-day life in orthodox social setting was almost completely dissolved. The ‘futural’ sense in which the durée of social life ordinarily occurs was destroyed by the manifestly contingent character of even the hope that the next day would arrive. The prisoners, in other words, lived in circumstances of radical ontological insecurity: ‘it was the senseless tasks, the lack of lost time to oneself, the inability to plan ahead because of sudden changes in camp policies, that was so deeply destructive.’ (p. 62)

Distrust or lost trust in the social system leads to the loss of trust in the self, and although the prison example is extreme, it serves a purpose. Without direction or purpose in human action, there is no meaning behind the action. Humans need some sense of stability and security in their lives if they want to have purpose in their lives.

Ontological security occurs in different spheres of life, where the routines of a particular self-identity are laid out and followed. For physicians, in their medical self, ontological security can be found in knowing the procedures and protocol for medical mistakes. Knowing that silence is part of medical mistakes, along with potential
malpractice cases, provides ontological security because it follows the traditions of the medical community. This may rest in tension with the non-medical self, the self that has learned that admitting guilt and apologizing for mistakes is the appropriate course of action. Disclosure and apology programs disrupt the ontological security of medical mistakes, because now, physicians are asked to not only admit the mistake, but also to apologize for it. This represents ontological insecurity, a disruption in tradition.

Context is an important part of ontological security since

All social interaction is situated interaction—situated in space and time. It can be understood as the fitful yet routinized occurrence of encounters, fading away in time and space, yet constantly reconstituted within different areas of time-space. The regular or routine feature of encounters, in time as well as in space, represent institutionalized feature of social systems. Routine is founded in tradition, custom or habit, but it is a major error to suppose that these phenomena need no explanation, that they are simple repetitive forms of behaviour carried out ‘mindlessly.’ (emphasis in original, Giddens, 1984, p. 86)

Routine in social activity has to be “worked at” to maintain itself. Moreover, this illustrates why we must develop distinct levels of analysis when examining narratives; without the different levels, scholars are unable to make sense of interaction, routines, and traditions, which all work together to make up ontological security.

Ontological security is necessarily married to routine; it is through the situated actions over time that has created tradition. Tradition creates routine, which provides humans with guidelines to follow in those situations, thus creating ontological security. To maintain that routine, and that ontological security, the routine has to be constantly
“worked at.” Situated within the long durée, the routine becomes part of a fossilized institution. In the case of medical mistakes, the routines associated with how to handle a medical mistake have become routinized; the silence and anonymity have become part of the tradition (Wachter & Shojania, 2004). Likewise, the routinized activity of medical mistakes is situated in the larger institution of medical practice.

Because we know that change in systems is inevitable, how we rationalize choice is also critical in understanding ontological security. Organizational change creates stability and ambiguity, weakening individuals’ ontological security. Contradiction appears if the organizational change rests in tension with the individual’s own values. In order to maintain ontological security, individuals must rationalize the change and their position on the change. Ideological positioning is way in which organizational members “attempt to rationalize and explain the choices they make” in response to organizational change (Howard & Geist, 1995, pp. 112-113). Ideological positioning not only helps individuals make rationalized choices, but also aids in the definition and clarification of their position. Ideological positioning is a key element to understanding ontological security because ontological security is needed to maintain life purpose. Understanding positions on change help to carry individuals’ ontological security through traditions, ambiguity, and crisis (Giddens, 1991).

Individuals are constantly exposed to uncertainty, which lead to life crises (Giddens, 1991). “A ‘crisis’ exists whenever activities concerned with important goals in the life of an individual or a collectivity suddenly appear inadequate. Crises in this sense become a ‘normal’ part of life, but by definition they cannot be routinized” (Giddens, 1991, p. 184). All crises are going to be different, making it impossible to routinize the
experience of a crisis; the only consistency is that we know they will happen. Medical mistakes serve as the crises of everyday life of physicians; the grand medical narrative has presented medicine and those who practice it as infallible. Medical mistakes place the spotlight on an individual’s inadequacy. At the same time, however, medical mistakes as a crisis become part of the “normal” medical life since they are inevitable (Paget, 2004). The medical narratives told from this new place of medical mistakes as an inevitable process of medicine inherently calls for the inclusion of the stories which were not told or heard before.

Because humans are attempting to find and maintain meaning in their lives, individuals and collectives have to make decisions about how to handle each crisis. These decisions are known as fateful moments, moments in which “consequential decisions have to be taken or courses of action initiated” (Giddens, 1991, p. 243). Fateful moments are climatic moments in both system and individual stories. Decisions move the story forward in order to alleviate the inadequacy causing the crisis. Moreover, fateful moments are moments meant for self-reflection. Crises provide the opportunity for individuals to reflect on their life meaning by exposing an inadequacy; fateful moments are spaces for reflection and decision (Giddens, 1991). Fateful moments propel a narrative forward, providing meaning to the uncertainty and messiness of issues of health and healing (Frank, 1995).

Summary

Disclosure and apology of medical mistakes are the fateful moments in which the institutional stories of medical mistakes move forward and changes. At the same time, the VAMC disclosure and apology program serves as a way to (re)tell the storied
experience of the physician involved in the medical mistake because, before, his or her story was silenced. Woven together, narrative and structuration theories allow people to make sense of the symbolic nature of experience and the ways in which policies and procedures are embodied (Harter, Berquist, Titsworth, Novak, & Brokaw, 2005). Both are needed in order to understand a phenomenon; each provides a piece of the health puzzle that is needed to make sense of the process of medical mistakes and the practice of medicine and humanity.

In this chapter, I articulated my theoretical standpoint, informed by narrative and structuration frameworks. I focused primarily on the foundations of these sensibilities as well as highlighted how narrative and structuration were wedded to explore the unique nature of the VAMC disclosure and apology program. Narrative and structuration lens allowed me to focus my attention on the individual stories of physicians and their encounters with medical mistakes as well as the larger institutional stories of medical mistakes and the practice of medicine. This dissertation reveals how VAMC physicians enact and embody the organizational restorying of medical mistake experiences that take place in the VAMC as well as the symbolic and material consequences of such changes to how they practice medicine. This exploration into a new world of medicine privileges the voices of physicians yet remains sensitive to the structures of the hospital and the institution of medicine.

Chapter Two continues the exploration of medical mistakes in light of personal and institutional narratives that continue to structure the practice of medicine. I review literature concerning the nuances of medical mistakes, focusing on the medical discourses of mistakes as well as the ideological shift to a culture of patient safety. I also review
communication scholarship on apologia and apology. In particular, I pay attention to personal, organizational, and societal apologies since the apology programs are a blending of these different types of apologies. Ultimately, I argue that the discourses of medical mistakes continue to be a misunderstood and understudied societal epidemic. Additionally, communication scholars have yet to explore the role of apology in issues of health and healing. In Chapter Two, I argue that the VAMC disclosure and apology program represents a discursive turn to bring social responsibility and citizenship back to the practice of medicine. In Chapter Three, I discuss the methods of ethnographic fieldwork I used to explore the VAMC program and multiple stakeholders’ perceptions of the program, focusing on the importance of interviews in narrative expression.
CHATPER TWO

Review of Literature

Joan Morris was asleep. A no-frills, high school educated woman of sixty-seven years, she was exhausted from yesterday’s procedure and ready to go home. She had been well until a few months earlier, when she passed out without warning. A brain CAT scan revealed not one, but two brain aneurysms, each a small outpouching in a cerebral blood vessel. Left untreated, these marble-sized aneurysms are time bombs that can burst without warning. Although they are often clipped off surgically, her daughter, a physician as it happens, had recommended that she have a newer procedure, called embolization, in which tiny platinum coils are injected into the aneurysm through a thin catheter to starve it of blood.

The procedure had gone without a hitch. Although the neurosurgeon told Joan she’d need a second procedure on her other aneurysm, the success of the embolization left her feeling very reassured. Still, she felt drained by the experience and told the doctor she preferred to recuperate for a month before Round Two, and he agreed.

Her daughter told her what to expect on the morning of checkout. She would wake up, have a breakfast of cool hospital eggs and limp toast, be read some discharge instructions by a doctor “with one foot out the door—these guys are really busy!” and be on her way home by noon. Before going to sleep, Joan mentally reviewed the list of things she’d do the next day: get her cat back from
the neighbor, water the plants, and make a dozen phone calls to worried friends
to tell them all was well and that her prognosis was excellent.

One floor below, Jane Morrison was also asleep. Morrison, a seventy-
seven-year-old grandmother of eight, had been transferred to the Big House from
a rural community hospital after passing out from an erratic heartbeat.
Medications hadn’t controlled the runaway rhythm, and she had been referred for
a cardiac electrophysiology study (EPS). She had been waiting for two days, as
her semielective procedure had been bumped from the schedule a few times by
emergency cases. But she was set to be the first case this morning. All night, she
tossed and turned in her creaky hospital bed, anxious to get it over with.

At 6:15 a.m., the first nurse arrived in the EPS lab to check the morning
schedule. She saw a “Jane Morrison” listed in the informal schedule kept at the
EPS laboratory. The EPS nurse telephoned the floor where Ms. Morrison, the
patient scheduled for the EPS procedure, was sleeping, but was told—
incorrectly—that she had been moved from the cardiac ward to the cancer ward.

This was one of those crazy, overflow days. When the hospital is full, it is
common practice to admit new patients to the first available bed, even if it is not
on the floor that specializes in the patient’s condition. Conversely, stable
patients—like Jane Morrison—may leave their “correct” floor to give a room for
sicker or more specialized patients. So—given the semiorganized chaos of patient
flow—it didn’t surprise the EPS nurse to hear that her patient had been moved
from the cardiac floor to another. At 6:20 a.m., she called the cancer ward, and
quickly explained that she needed “Morrison” for her EPS, without giving a first name or hospital number.

Dutifully, the ward clerk—typically a high school graduate with one or two years of health care training, in a tough job that is usually underpaid and overworked—pivoted in her chair, glanced at the whiteboard, saw “Morris” and told Joan Morris’s nurse that the EPS lab was ready for her patient. Joan Morris’s nurse picked up the chart and started toward her room, then paused. Her notes said that Morris was recovering from a cerebral aneurysm procedure and would be discharged later in the day. No one had mentioned an EPS procedure, and there was no written order for one in the chart. Another snafu, she thought. But she was used to this—patients were always being carted off the floor for procedures she or fellow nurses hadn’t been told about.

So Joan Morris’s nurse woke her patient from a deep sleep and, instead of the cold eggs and toast she’d been promised, told her in a gentle but authoritative voice that it was time to go for her procedure. The nurse later recalled that Morris said that she didn’t know anything about an EPS procedure. Joan Morris later recalled, “Yeah, it was about halfway through, I think, the doctor said... ‘How do you spell your name?’ And so then I told him what my name was and I told him how to spell it, you know. And that was about it. But then I was glad to go back to my room.”

Thankfully, Joan Morris emerged from her ordeal undamaged, expect for a little scar on her groin where the catheter was inserted. In fact, a few months
later she charitably allowed, “I’m glad that my heart checked out OK.” (Wachter & Shojania, 2005, pp.29-41)

Physicians practice medicine under the auspices of the Hippocratic Oath, which has served as a governing medical treatise since Ancient Greece (Strathern, 2005). The Hippocratic Oath, often sworn by physicians at the time of their medical school graduation, asks physicians to practice ethical medicine. The Hippocratic Oath offers a variety of statements of ethical medicine, many of which are considered out of date, such as refusing to practice surgery or perform an abortion. The banner statement of the Hippocratic Oath, “First, do no harm” is the one often touted by the media in stories of medical mistakes. This statement is used to remind society that physicians are not supposed to harm patients, but are supposed to heal patients. There is, however, a second statement that governs the practice of medicine as strongly as the “do not harm” mantra: “All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal” (Strathern, 2005, p. 11). Just as much as physicians should not harm patients, they should also maintain professional secrecy about the medicine they practice, and the mistakes that might be a result of this practice.

Physicians practice medicine in the space between these statements, balancing between doing no harm and keeping their mistakes a secret. This, in turn, creates a culture of “naming, shaming, and blaming” (Nordenberg, 2000, ¶ 28), where physicians are often too scared of litigation and being labeled “bad” doctors to talk about their mistakes. This “culture of secrecy” is the driving ideological force of the practice of medicine. In their landmark study, the Institute of Medicine (IOM) proposed a culture
change, suggesting that physicians and hospitals move from away from a culture of secrecy to a culture of patient safety. Inherent in this change was the suggestion that the underlying ideology of medicine as a profession of secrecy be replaced with one that focused on the patient. Moreover, a culture of patient safety provides avenues for patients when they feel they have not received the best care possible. As Cornett (2006) argued

The “culture of safety” means 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. (p. 83)

The important emphasis here is on the shift from the physician as the primary character in the medical narrative to the patient as the protagonist.

Hidden within the ideological shift to a culture of patient safety is a concern for physicians to offer penance to patients and their families when a medical error occurs. In the 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, 2007, p. 106). The culture of patient safety strives for “true grace” by moving toward a culture that openly communicates errors. Through the open communication of errors, hospitals can reduce the instances of medical mistakes (JCAHO, 2005). These recommendations also assume that patients will see the disclosure of mistakes as an opportunity to offer forgiveness to physicians who have erred (Prtilo, 2005).
Interestingly, since the landmark IOM study came out in 1999, hospitals have not seen a reduction in the reporting of medical mistakes. Unfortunately, the most recent reports suggest that the modern medical system has become even more dangerous for patients. Currently, an estimated 195,000 patients die every year from hospital errors (Adams, 2004), and this estimate only includes those that are labeled as hospital error. Moreover, another 140,000 people die because of errors in medication prescription and dispensation (Adams, 2004). In total, an estimated 350,000 people die from a medical mistake during a health care experience.

Clearly, medical errors continue to be a medical epidemic and the expectations of physicians to disclose and apologize for mistakes continues to be contested terrain. This chapter explores the multiple discourses of the medical error landscape. This chapter explores the discourses of medical errors, focusing on the ways in which medical errors have been defined and debated, the causes of medical errors, and the current legal and medical recourses for patients and physicians. The chapter also delves into the scholarly discourse of apologia and apologies, highlighting the purposes of apologies as well as the unique landscape of organizational apologies.

Discourses of Medical Mistakes

The story of Joan Morris’s medical mix-up is not an uncommon story, and the mix-up is not just one medical error. In fact, Wachter and Shojania (2005) argued that seventeen different errors occurred in the Joan Morris’s case. From failing to identify the patient’s identity to performing an invasive procedure on the wrong patient, the Joan Morris case illustrates that there is a wide variety and range of what counts as a medical
error. If almost everything in the Joan Morris story was a medical error, then what is a medical error?

*The Discursive Definition of Medical Mistakes*

Medical scholars in multiple fields have wrestled with finding an appropriate definition of medical mistakes and errors (see critiques in Banja, 2005; Bogner, 1994; Books & Fido, 2002; Inlander, Levin, & Weiner, 1988). The generally accepted definition of a medical error is as an “unintended act (either of omission or commission) or one that does not achieve its intended outcome” (Leape, 1994, p. 1851). This definition is broad enough to encompass the two major types of medical errors, errors caused by not doing a treatment or procedure (omission) and errors caused by performing an incorrect procedure or prescribing an incorrect treatment (commission). Mistakes are often the result of insufficient knowledge, lack of experience or training, insufficient information, or applying the wrong criteria to decision-making. Errors, then, are the result of *incorrect choices* (Barry, Murcko, & Brubaker, 2002). More importantly, mistakes and errors imply that someone is at fault and worthy of blame (Bogner, 1994; Paget, 2004).

Leape’s (1994) definition of a medical mistake is the accepted medical definition. However, it is important to note that this definition includes more than just mistakes. The definition identifies an error as one of omission or commission as well as “one that does not achieve its intended outcome.” Leape’s definition includes mistakes (omission and commission) and bad outcomes in medicine, which include known complications. Known complications are bad outcomes of a procedure that were known to potentially happen. Complications are not mistakes because they are potential outcomes. For example, a collapsed lung is a known complication of many medical procedures. Leape’s definition
includes both mistakes and complications, grouping them together as mistakes. Including both mistakes and complications in the definition makes it difficult for physicians, patients, and hospital administrators to deal with these two different bad outcomes because they are considered to be the same.

Criticism has been leveled at this definition of medical mistakes and errors, focusing mainly on language choice and interpretation. The problem with the generally accepted definition, as Banja (2005) argued, is that it assumes that the physician, as the primary provider of medicine, always has control over the medical situation. The definition ignores the possibility that there are forces outside of the physician’s control and that an error may occur as a result of an unforeseen or uncontrollable factor. The definition places action purely in the hands of physicians. This further contributes to the belief that physicians are “god-like” in their ability to practice medicine. Moreover, the definition assumes that there is a level of intentionality associated with medicine. This harkens back to the question that I posed in Chapter One about who must apologize in the wake of a medial mistake. Who really is at fault and who is responsible for apologizing for the mistake?

Intentionality in the medical mistakes literature focuses on whether the mistake or error was a “genuine error” (Quick, 2006). “Genuine errors” are errors which are the result of poor reasoning or judgment rather than malfeasance or recklessness. Intentionality is a central component of the medical community’s discussions about apologizing for mistakes and ties directly to issues of accountability, fault, and responsibility for apologizing. The presence of accountability and fault also problematize the accepted definition of medical mistakes. Issues of accountability lay at the center of
what kind of legal action patients and families take when a medical mistake occurs (Gallagher, Garbutt, Waterman, & Flum, 2006; Gray, 2006). Paget (2004) clearly articulated the tension caused by blame and fault in medical practice:

A “mistake” denotes something wrong rather than right, something incorrect rather than correct, for example, a wrong act. Furthermore, a mistake is connected with someone who has made it, with someone, therefore, who is wrong. It refers to a person’s misunderstanding or misinterpreting something. The term connotes being blameworthy and at fault. (p. 6).

Although the definition of errors assumes that the act and consequences were unintentional, blame and fault are still at the forefront of the definition. The use of language such as “right” and “wrong” prevents medical mistakes from being viewed as a part of the process of medicine, and firmly positions mistakes as a product of poor medicine.

Moreover, the discursive positioning of medical mistakes as “wrong” medicine has material consequences on the practice of medicine, mainly in the recourse of mistakes. The discursive positioning of medical mistakes as “wrong” medicine constructs stocks of knowledge that reify medicine as a certain, infallible science. The use of “right” and “wrong” language means that medical practitioners are reflexively monitoring their actions to ensure that they practice “right” medicine and to prevent others from seeing instances of “wrong” medicine. This reflexive self-monitoring further fossilizes what counts as right and wrong in the institutional medical grand narrative. However, when medical mistakes do happen, physicians are forced to make decisions about what action to take and to reflect on that action (Giddens, 1991). The current ideological practice of
secrecy and silence, in a sense, takes away agency from physicians because they practice medicine in a reified system. Physicians have a constrained choice of maintaining secrecy, and thus, practicing “good” medicine, or attempting blame and practicing “bad” medicine.

Unfortunately, a clear definition of medical mistakes and errors still eludes scholars and continues to contribute to the public and professional confusion about medical mistakes. Part of this uncertainty about the definition of medical mistakes and errors is that there are a variety of different kinds of medical mistakes and levels of severity associated with the different kinds of mistakes. The next section explores these different kinds of medical mistakes and errors.

*Types of Medical Mistakes and Errors*

At the heart of the definition of medical mistakes is failure. Failure typically denotes a breakdown, defeat, or mistake in the communication process. However, failure can be seen as a productive part of the communicative process, one that provides space for opportunity and change (Eisenberg et al., 2006). Failure is a lived communicative experience because humans tend to fail more than succeed (St. John, 2006). If we are to understand human communication, then we have to explore the failures as well as the successes.

There must be a limit to communication that functions simultaneously, and paradoxically, as a permit for its possibility. This limit is by no means a mystical negativity. Rather, it is the difference between what can be expressed and what remains inexpressible—the distance that succeeds all that has been said. (Chang & Butchart, 2007, p. 1)
Possibility lies in the in-between spaces between success and failure. In the medical arena, the highest echelon of failure is the medical mistake. Discourses about medical mistakes reside in the in-between space of possibility; the ability to take action to make amends for the mistake and try to prevent it from happening again highlight the space between success and failure. Additionally, medical mistakes reside in the in-between space of possibility because of the rawness and vulnerability associated with admitting fault and the success of preventing a mistake. Moreover, understanding the failures in communicating about medical mistakes may provide a window to understanding the changes hospitals are implementing to reduce failure and enact a culture of patient safety.

As evidenced by Joan Morris’s story, there are a variety of different ways in which medical mistakes can occur in a given health care encounter. The medical mistakes literature suggests there are four major types of medical mistakes. There are, of course, more than just four types of medical mistakes; however, many of the mistakes are included under one of these major types. The first major type of medical mistake is wrong-side/wrong-site surgery. This medical mistake consists of performing a procedure on the wrong side of a patient (e.g.- removing the wrong leg) or performing a procedure on the wrong site of the body (e.g.- performing heart surgery on a patient who needs a brain aneurysm removed). Although wrong-side/wrong-site mistakes are the rarest of the medical mistakes (Bann & Dazri, 2004) and are easily preventable (Seiden & Barach, 2006), they still occur. The origin of this mistake lies in the misleading markings made on a limb or the body. Bann and Dazri (2004) explain that a smiley face, often used to denote a limb that is to be operated on, can easily be confused to mean that the limb is fine. Mistaking patients because of name is also a common occurrence in this type of
medical mistake, even when the patients do not have the same name (Wachter & Shojania, 2005). The main reason behind this mistake is that physicians often feel that they are too skilled or too experienced to make such a simple mistake (Graling, 2006).

The second major type of medical mistake is that of misdiagnosis of a patient. This type of medical mistake occurs when physicians provide the wrong diagnosis, prescribe the wrong medication, or suggest the wrong treatment for a patient. This particular mistake is one of the most common of the medical mistakes and is often the result of a physician’s faulty judgment or technique (Wachter & Shojania, 2005). Moreover, the physician’s experience, expertise in a certain area of medicine, and time they have been working all influence their judgment and ability to correctly diagnosis a patient (Wachter, 2004). These mistakes are the most readily identified and corrected because the patient is often referred to another physician who catches the mistakes (Wilson & McCaffrey, 2005).

The third major type of medical mistake is that of the misinterpretation of physicians’ handwriting on prescription and treatment orders. Physicians notoriously have illegible handwriting, and misinterpretation of their orders is common (Studdert, Mello, Gawande, & Gandhi, 2006; Sage, 2006). Additionally, misinterpretation is compounded by the fact that many of the drugs have similar names, such as Cerebyx, an anticonvulsant drug, and Celebrex, an anti-inflammatory drug. There is also a lack of communication between physicians and nurses and pharmacists, who are often the individuals who actually commit the mistake because of their inability to read a physician’s order (Hoffman & Proulx, 2003).
The final major type of medical mistake is when surgical paraphernalia are left inadvertently in patients during a surgery. This phenomenon, known as the “retained sponge” effect (Wachter & Shojania, 2005) includes all forms of equipment and instruments, including towels, needles, retractors, and sponges. These types of mistakes are reported more than any other mistake in the media because of the sensational tragedy associated with leaving instruments and equipment inside a patient. Even though it is reported in the news more than any other mistake, “retained sponge” mistakes occur only approximately once over ten thousand surgeries (Gawande, Studdert, Orav, Brennan, & Zinner, 2003), making it an extremely rare mistake.

All of the types of medical mistakes discussed in this section represent narratively compelling instances of Trouble with a capital T (Burke, 1954). The tellings and retellings of narratives where individuals lose limbs, have foreign objects in their bodies, or receive the wrong dosage of medication represent “bad” medicine. As illustrated here, instances of medical mistakes are fraught with drama and crisis, calling on the individual narratives of physicians, patients, and medical practitioners, and the larger institutional grand narrative of medicine to be propelled forward. Although an integral and inevitable part of the practice of medicine, medical mistakes represent disruptions in individual physician and institutional medical narratives. Each of these mistakes calls for action to make sense of the uncertainty they cause in individuals’ lives.

*Rituals in the Culture of Blame and Shame*

When a mistake occurs, patients and physicians are often forced to engage in two different rituals: malpractice litigation and morbidity and mortality conferences. These rituals serve two very distinct and opposing purposes. Malpractice litigation serves as the
legal recourse for wronged patients and their families, usually through monetary
compensation. Conversely, morbidity and mortality conferences are the vehicles through
which the medical system internally disciplines physicians for mistakes. Both, however,
contribute to the reification of the culture of blame and shame. Critical to the reification
of a culture of blame and shame is an emphasis on the individual (the physician) and their
failure rather than recognizing the relational nature of medicine. The rituals that reinforce
a culture of blame and shame narratively communicate the accepted values and behaviors
of the institution of medicine. Medical mistakes disrupt the mystery of the precise
practice of medicine by showing that medicine is not as precise as we would like to
believe. Moreover, the rituals of a culture of shame and blame reify the guilt and
embarrassment associated with violating the hierarchical norms and behaviors. These
rituals act as a means of cleansing the individual and the hospital of guilt and
embarrassment.

The first ritual of a medical culture of shame and blame is the presence of
malpractice litigation. Most of the medical literature on medical mistakes focuses on
malpractice litigation, offering practical solutions and remedies to make the litigation as
painless as possible for the physician and the hospital system (see for example, Bernard,
2006; Boyle, O’Connell, Platt, & Albert, 2006; Hyman & Schechter, 2006; Lesnewski,
2006; Liang, 2002; Nguyen & Nguyen, 2005). Malpractice litigation is not a surprise in
what Nguyen and Nguyen (2005) say is a “litigation crazy society.” They argued that this
craze has been brought on by two changes in mindsets: an erosion of professional
privilege that questions what counts as “expert” and an increased emphasis in ethical
responsibility.
Malpractice litigation serves as the ultimate reification of a culture of shame and blame because of the emphasis on not discussing the mistake and the pending litigation with anyone but the hospital legal team. Moreover, physicians are prohibited from admitting a mistake happened or expressing remorse, both of which suggest guilt (Bernsten, 2005). As Gawande (2002) articulated, “At most, a doctor might say, ‘I’m sorry that things didn’t go as well as we had hoped’” (p. 57). The inability to express remorse or admit a mistake happened creates a practice of “defensive medicine” (Nguyen & Nguyen, 2005), where physicians start to view patients as potential litigants rather than people who need care (May & Aulisio, 2001). This, in turn, drives honesty of mistakes “underground” in the medical system, making it difficult for physicians to talk to each other openly about errors and how to correct them (Pinkus, 2001). Because malpractice focuses on the individual physician as being at fault, the current malpractice system creates a climate of deterring reporting for fear of individual blame and reprisals.

The dominant narrative of silence is structured through the process of malpractice litigation. Malpractice litigation serves as a structural constraint or sanction that legitimizes the silence narrative (Giddens, 1984; Riley, 1983). These sanctions are used to maintain a sense of order by limiting individual agency. The institution of medicine uses malpractice litigation as a sanction to limit the reflexive actions of physicians; these sanctions are meant to be acts of self-perseveration for the physician and the hospital. A potential tension exists, however, between the individual physician’s values and the organizational interests of the hospital. Malpractice litigation privileges the organizational interests of the hospital over the physician’s interests. Moreover, malpractice litigation serves as a ritual to maintain social order through a veil of
maintaining social responsibility. Although the physician does not and is encouraged not to attempt fault or guilt, the act of litigation is an attempt to show social responsibility for the mistake (Naitove, 1982). Because physicians cannot express guilt or fault in malpractice proceedings, the narrative of silence is maintained.

Malpractice litigation is a mainly patient-driven ritual of medical mistake recourse. The medical institutional ritual of morbidity and mortality (M & M) conferences also reify a culture of blame and shame. M & M conferences differ from malpractice litigation because the blame and shame physicians feel come from the medical system itself.

In its way, the M & M is an impressively sophisticated and human institution. Unlike the courts or the media, it recognizes that human error is generally not something that can be deterred by punishment. The M & M sees avoiding error as largely a matter of will—of staying sufficiently informed and alert to anticipate the myriad ways that things can go wrong and then trying to head off each potential problem before it happened. It isn’t damnable that it occurs, but there is some shame to it. In fact, the M & M’s ethos can seem paradoxical. On the one hand, it reinforces the very American idea that error is intolerable. On the other hand, the very existence of the M & M, its place on the weekly schedule, amounts to an acknowledgement that mistakes are an inevitable part of medicine.

(Gawande, 2002, p. 62)

Gawande highlighted a key structural tension that exists in M & M conferences: the tension of mistakes being inevitable and mistakes being intolerable. This tension further positions mistakes as either a process or a product. The tension of mistakes being either a
process or a product is congruent with the tensions inherent in the duality of structure (Giddens, 1979, 1984). Seeing mistakes as an inevitable part of medicine suggests the possibility for choice in addressing mistakes and their consequences. Viewing mistakes as intolerable suggests that mistakes are the end product and part of the reified structure of medicine.

Although M & M conferences were originally the means through which physicians were disciplined for making mistakes, with the introduction of malpractice litigation (Wachter & Shojania, 2005), M & M conferences have now evolved to be an open forum through which physicians can reflect openly and honestly about a mistake and what needs to be done to prevent it from happening again (Mello, Studdert, Kachalia, & Brennan, 2006). Moreover, M & M conferences are a pedagogical tool where physicians can learn from one’s own mistake as well as the mistakes of others. Additionally, M & M conferences can even be therapeutic or cathartic for physicians because they are now given the opportunity to openly and honestly talk about the mistake (Gawande, 2002). These conferences are also therapeutic because physicians do not have to worry about making statements of guilt that can be used against them in a court case. Statements made in M & M conferences are not open to legal discovery, so statements made in the M & M cannot be used as admissions of guilt in a malpractice case (Gawande, 2002, p.57). Ultimately, M & M conferences show that doctors are “willing to take responsibility for their mistakes, share them, and learn from the experience” (Wachter & Shojania, 2005, p. 280).

The main problem is that, although good information is often exchanged at M & Ms, single-case war stories raise all of the usual issues about hindsight bias. Physicians
can only suggest ways in which they can try to prevent the same mistake from happening again (Wachter & Shojania, 2005). Moreover, even when the conference points the way to an important change in practice or system, there is no easy mechanism to make sure it finds its way into the day-to-day habits of the institution. Because M & M conferences only ask physicians to reflect on what has already happened, they are not able to focus on how to anticipate complications that could be a direct result of procedures (Wachter & Shojania, 2005). Moreover, M & M conferences, like malpractice litigation, position the mistake as an individual failure (Mello, Studdert, Kachalia, & Brennan, 2006), which does not lend itself to challenging the relational or organizational constraints present in the mistake. M & Ms, although giving space for physicians to talk about mistakes, are still sanctioning interactions. As Giddens (1979) rightfully noted, “The communication of meaning in interaction does not take place separately from the operation of relations of power, or outside the context of normative sanctions” (pp. 81-82). These in-house conferences still reinforce the ideological position of the hospital and the medical institution of keeping mistakes secret from everyone outside of medicine. By continuing to keep mistakes a secret, M & M conferences, as well as malpractice litigation, further solidifies an ideological culture of shame and blame.

**Challenges to the Culture of Blame and Shame**

Currently, two different legal changes influence the disclosure and apology of medical mistakes: state benevolence laws and proposed national legislation. Starting with the passage of the first benevolence law in Texas in 1999, health care benevolence laws mandate the expression of some kind of sympathy by the physician or the healthcare facility to the patient or the patient’s family. Currently only 18 states have benevolence
laws: Arizona, California, Colorado, Georgia, Illinois, Florida, Massachusetts, Michigan, Montana, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia, Washington, and Wyoming. These state-specific pieces of legislation are designed to enhance the voice of the practitioner and healthcare facility while simultaneously constraining the decision-making ability of the practitioner in order to enhance ethical and moral responsibility. As a tort reform law, benevolence laws also assess any and all negligence that may have occurred during the care and safety of others (Feldman, 1998).

Benevolence laws reflect the ideological shift in healthcare to a culture of patient safety. The disclosure of medical mistakes and the expression of apology serve as a primary way through which physicians and hospital administrators can enact the JACHO recommendations of open communication. Moreover, benevolence laws serve as a vehicle for enacting the underlying motive of patient safety: to be ethical guides in the community. The discussion of the intent behind many of these laws highlights the desire of legislators to bring ethical responsibility and morals back to the practice of medicine. However, this does not mean that physicians and facilities are immune to the same legal actions as before the shift. A tension exists between the desire to encourage ethical responsibility and decision-making and the desire for self-preservation.

Although benevolence laws are meant to provide a mandated outline for physicians and facilities to follow in the instance of a medical mistake, the ambiguity inherent in these laws makes them difficult to interpret and enact. The laws are constraining in that protocol and decision-making has been taken out of the hands of the medical care agents and dictated by the structure. Although the laws give medical practitioners space to express remorse and grief for the actions, those spaces are
determined by the structure (e.g.- the legislators) and are not always protected from consequence. Benevolence laws attempt to negotiate two different but overlapping social structures, the medical system and the legal system, because medical mistakes exist in both (Sparkman, 2005).

One piece of national legislation has been proposed that would enact nationwide adoption of apology and disclosure policies. Senate Bill 1784 (2005), jointly proposed by Senators Hillary Clinton (D-NY) and Barack Obama (D-IL), is a “bill to amend the Public Health Service Act to promote a culture of safety within the health care system through the establishment of a National Medical Error Disclosure and Compensation Program” (¶ 1). The bill’s purpose is to promote a culture of patient safety within all healthcare facilities through the establishment of a National Medical Error Disclosure and Compensation Program by (1) improving the quality of health care by encouraging open communication between patients and health care providers about medical errors and other patient safety events; (2) reducing rates of preventable medical errors; (3) ensuring patients have access to fair compensation for medical injury due to medical error, negligence, or malpractice; and (4) reducing the cost of medical liability insurance for doctors, hospitals, health systems, and other health care providers (Clinton & Obama, 2006). These goals mirror those of the IOM (1999) report and the Joint Commission on Accreditation of Healthcare Organization’s (2005) report on patient safety. These four goals represent the ideological shift in healthcare to patient safety, attempting to universalize the values associated with a culture of patient safety as well as reify a need for change in the current structure.
The National Medical Error Disclosure and Compensation Program, like state benevolence laws, provides a safe space for apology and disclosure, guaranteeing immunity from admission against interest, while constraining that space through procedures. Section 935, the declaration of the National Error Disclosure and Compensation Program, institutes the constraining structure of apology and disclosure programs. This procedure dictates the protocol for adverse events, which begins with negotiating compensation with patients based on the event, providing at the discretion of the healthcare provider, an apology or expression of remorse, and then the sharing of efforts to prevent reoccurrences of the event (S. 1784, 2005). Interestingly, the structure provides agency to medical practitioners by proposing that apology is not mandatory but decided based on the discretion of the health care provider. Moreover, the apology comes after compensation has been negotiated. Additionally, the medical practitioner’s apology or expression of remorse is kept confidential and is immune from statements of guilt if the negotiations end without resolution. This is meant to constrain the actions of the patients, while protecting the interests of the healthcare facility and practitioner.

These two legal approaches to medical mistakes reflect the ideological shift from a culture of blame to a culture of patient safety. Like the VA apology program, these laws and proposed legislation both enable and constrain the physician and the hospital administration. This does not mean that there are not still forces, such as definitions and rituals that continue to reify a medical culture of blame and shame. However, they are important because they highlight a shift to ethical responsibility and need for apologies. The next section explores the scholarly literature surrounding the communicative act of apologies and how apologies can be seen as acts of social legitimacy.
Apologies and the Discourse of Apologia

When a mistake does occur, we expect an apology. Western societies place great value on the expression of an apology as a way of addressing wrongdoing and showing remorse (Ministry of Attorney General, 2006). Moreover, apologies serve as a therapeutic means through which wronged parties make sense of the incident (Cohen, 2002; Shuman, 2000) and as a vehicle for mending relational breakdowns (Sparkman, 2005).

Communication scholars have explored issues of apology in multiple contexts, from sports (Kruse, 1981a) to political and religious scandals (Armstrong, Hallmark, & Williamson, 2005; Brown, 1991; Harter, Stephens, & Japp, 2000; Kramer & Olson, 2002; Simons, 2000) to organizational blunders (Benoit & Brinson, 1994; Hobbs, 1995; Ice, 1991). The apologia literature relies primarily on a typology of apologia refined by Ryan (1982) and Ware and Linkugel (1973). The study of apologia, traditionally relegated to rhetorical criticism, focuses on the ways in which individuals, and later organizations, use apologetic strategies to deny wrongdoing and defend attacks on their personal character.

The simple definition of apologia is the denial of wrongdoing. Two different elements, however, complicate this definition. The first element focuses on the type of wrongdoing (different actions will require different responses), while the second element focuses on how the accused responds. Both of these will be discussed in detail below. Regardless of the type of apologetic strategy used, every apology focuses on denial, deflection, or justification of actions to restore damaged character; responsibility is never truly accepted in an apologetic event (Koesten & Rowland, 2004).
Apologia Typology

Kruse (1981b) argued that unless someone is defending his or her character from an attack, statements of apology are not apologies; they are simply defensive statements. An apology is a response to *kategoria*, or an accusatory charge (Ryan, 1982). Accusations can be made against a policy and against an individual’s character. Likewise, two different types of apologia exist that require action by the accused: defense of character and defense of policy. Accusations against an individual’s character stress ethical imperatives. Here, the accusation emphasizes a break from what is ethically and morally accepted by society. Attacks on character are intimately tied to policies or practices; individuals act unethically because they are breaking policies and rules (Ryan, 1982, p. 257). When an individual’s reputation or character is damaged, it becomes difficult for them to engage in the interpersonal relationships required by their participation in society (Gold, 1978). In response, “the apologist is motivated to deny, to mitigate, or to purify the resultant image” (Ryan, 1982, p. 257). In order to address attacks on character, then, an individual must emphasize their moral and ethical character. Important here is the expression of “genuine remorse” to bolster an individual’s moral responsibility to the community and profession they represent (Simons, 2000). If an individual does not express some kind of remorse for making others question their character (they can still deny that they have done anything wrong), then the apology will not be deemed successful.

This differs from accusations made about policy. In accusations of policy, statements are made that accuse an individual of disregarding policies and rules, but they did so ethically. In apologizing for policy accusations, then, the individual “absolves
himself of the fact (I did not do it), he explains the definition (I did not do what is alleged), he justifies the quality (I had laudable intentions), and he vindicated the jurisdiction (I appeal to a different audience or judge)” (Ryan, 1982, p. 257). In an apology of policy, the individual focuses on the facts, rather than on ethics or morals. Although accusations of character and policy can occur simultaneously (Ryan, 1982), “the questioning of a man’s moral nature, motives, or reputation is qualitatively different from the challenging of his policy” (Ware & Linkugel, 1973, p. 274, emphasis in original).

In the case of medical mistakes, physicians have to negotiate between accusations of character and policy. They obviously have to discuss the facts of the case, during which they focus on what they did right, often stating that they followed protocol. Physicians also have to manage their character because medical mistakes ultimately ask patients, patients’ families, juries, and judges to question their moral compass. The practice of medicine is a decidedly moral task (Montgomery, 2006), because it seeks to “choose what is best to do in the world of action” (p. 41). Practical reasoning lies at the heart of the practice of medicine, and to divorce medicine and ethics is to separate a reliable moral agent and a good physician (Montgomery, 2006). Accusations of a physician’s character, then, are an attempt to discover if they are both a good clinical physician as well as a reliable moral agent.

Ware and Linkugel (1973) proposed four “modes of resolution” or strategies to an attack on character or policy: denial, bolstering, differentiation, and transcendence. Each of these strategies can be used as separate strategies or can be used in combination with each other, depending on the type of accusation (character or policy) and the suspected
wrongdoing. The first strategy, denial, is the denunciation of the alleged wrong or event (Ice, 1991). An individual who uses denial is simply disavowing participation in the event. Denial is the most likely of the self-defense strategies and is useful “only to the extent that such negations do not constitute a known distortion of reality or to the point that they conflict with other beliefs held by the audience” (Ware & Linkugel, 1973, p. 275). For example, it would not be wise for a physician to deny that a patient died from an overdose of medication if they did, in fact, die from an overdose. They might, however, say that they did not administer the drug which caused the overdose.

The second self-defense strategy is bolstering. When an individual uses bolstering, they are seeking to reinforce the existence of a fact or relationship (Ice, 1991). Bolstering is the obverse to denial in that the individual does not deny participation in an event. The key to bolstering, however, is to identify with something viewed favorably by the audience (Hobbs, 1995). In bolstering, the accused individual is limited to certain interpretations of reality with which the audience is already familiar (Ware & Linkugel, 1973). In the case of an overdose of medication, a physician using bolstering would say that they attempted lifesaving measures in order to prevent the death. Attempting to save a life could be seen as a favorable behavior by the audience.

The third self-defense strategy is differentiation. When an individual uses differentiation, they are attempting to separate facts, sentiments, and relationships from a larger context. Differentiation is used primarily to divide a context into two different contexts in order to change the audience’s interpretations of reality. Differentiation attempted to move away from the abstract by asking audiences to question definitions and knowledge (Hobbs, 1995). Differentiation often signals an individual’s attempt to
suspend judgment “until his actions can be viewed from a different perspective” (Ware & Linkugel, 1973, p. 278). A physician might use differentiation by asking the audience to question if the patient died from an overdose or if the patient died from multi-system organ failure (which might have been caused by an overdose). By separating the cause and effect, the physician is asking the audience to think about what really was the reason the patient died. By showing the difference between an individual caused death and a natural bodily death, the physician is attempting to reconstruct the reality of the audience.

The final self-defense strategy, transcendence, “cognitively joins some fact, sentiment, object, or relationship with some larger context within which the audience does not presently view that attribute” (Ware & Linkugel, 1973, p. 280). Transcendence attempts to move an audience away from particulars towards a larger abstract principle (Ice, 1991). Transcendence is the most “manipulative” of the self-defense strategies because they attempt to juxtapose seemingly incongruent ideas. The physician in the overdose case might attempt to transcend the death by talking about the fact that drug names are extremely similar and that labels often look identical to each other. This takes the emphasis off the patient’s death and focuses attention on a larger organizational problem.

The combination of different strategies provides postures, or outcomes, that the accused wishes of the audience. The first posture is absolution, which is a combination of denial and differentiation (Mueller, 2004). In absolution, the individual seeks acquittal from the audience (Ware & Linkugel, 1973). The second posture, vindication, involves denial and transcendence and attempts to preserve an individual’s reputation while recognizing their worth as a human being and appreciating what they offer to society.
(Hobbs, 1995). Explanation, the third posture, occurs when the accused combines bolstering and differentiation. In the explanation posture, the accused “assumes that if the audience understands his motives, actions, beliefs, or whatever, they will be unable to condemn him” (Ware & Linkugel, 1973, p. 283). The final posture is justification, which is a combination of bolstering and transcendence. An individual seeking justification looks for understanding and approval of the action taken (Mueller, 2004).

These four strategies are either reformative or transformative in nature. Reformative strategies only attempt to revise or amend realities, while transformative strategies attempt to change a part of a reality (Hobbs, 1995). Denial and bolstering are reformative in nature because they only attempt to re-envision their role in a particular incident; they do not deny that a particular event or wrongdoing happened. By contrast, differentiation and transcendence are transformative strategies because they attempt to change or alter the reality of audiences by asking them to question their previously held knowledge and beliefs. Central to determining whether a strategy is reformative or transformative is the intent of the accused individual to provide a defense in the case of wrongdoing. In reformative strategies, the intent is to distance the individual from the event, but not to deny that the wrongdoing occurred. In transformative strategies, the individual’s intent is to reconceptualize the wrongdoing altogether, to force the audience to question if wrongdoing even occurred.

The most substantial critique to Ware and Linkugel’s strategies and postures is image restoration theory. Benoit (1995) critiqued Ware and Linkugel’s typology, arguing that it is too simple and not coherent. Instead, Benoit (1995) and Benoit and Brinson (1994) propose different strategies that highlight the inconsistent nature of apologia and
emphasize the intent of the accused and the wrongdoing event. Image restoration theory focuses less on the wrongdoing and more on how the individual “saves face” in what Giddens (1991) would call fateful moments. Image restoration theory has explored a myriad of crisis moments from celebrity reputation (Benoit, 1997a; Benoit & Anderson, 1996; Benoit & Hancozor, 1994) to political crisis (Benoit, 1982, 1999; Benoit, Gullifor, & Panici, 1991; Benoit & Nill, 1998) and organizational catastrophe (Benoit & Brinson, 1994; Benoit & Czerwinski, 1997; Benoit & Lindsey, 1987; Blaney, Benoit, & Brazeal, 2002). Important to image restoration theory is that crisis moments are often discrete moments and events in time (Benoit, 1997b; Benoit & Drew, 1997).

In image restoration, the emphasis is on saving the reputation of the accused. Benoit and his colleagues have proposed five discursive strategies: denial, avoiding responsibility, minimization, mortification, and correction. Similar to the strategies and postures proposed by Ware and Linkugel (1973), these strategies can be used in combination depending on the wrongdoing event and the individual’s reputation. The strategies can be divided up into two different categories: denying the wrongdoing and attempting to minimize the wrongdoing (Benoit, 1995). The first image restoration strategy, denial, involves the accused simply denying the accusation of wrongdoing or placing the blame on someone else (Benoit & Brinson, 1994). This differs from the denial strategy proposed by Ware and Linkugel because the accused, in some instances, can deny wrongdoing even occurred. Similar to denial, avoiding responsibility, the second strategy, allows the accused to deny responsibility because of someone else’s misdeed, lack of information about the event, arguing the event was an accident, or by saying the
misdeed was committed with good intentions (Benoit, Gullifor, Panici, 1991). Denial and avoiding responsibility make up the first category of denying wrongdoing.

The second category of minimizing wrongdoing includes minimization, mortification, and correction. When an individual uses minimization, they are attempting to reduce the perceived offensiveness of the wrongdoing. They do this in a variety of ways. An individual can bolster their strengths, minimize the unpleasantness of the misdeed, attack the accuser, compare the act to a similar reprehensible act, situate the misdeed in a larger social context, and/or offer compensation to the wronged party (Brinson & Benoit, 1996). The fourth image restoration strategy is the process of mortification. Similar to Burke’s definition of mortification in his cycle of redemption (discussed in Chapter One), mortification in image restoration requires that the accused admit wrongdoing and ask for forgiveness (Benoit, 1995). Mortification is the only strategy of image restoration or of Ware and Linkugel’s strategies and postures that calls for the accused to admit guilt and fault. The final strategy is correction. When an accused uses correction, they vow to correct the problem and prevent it for occurring again (Benoit & Brinson, 1994).

Organizational Apologia

Benoit’s multiple discussions of image restoration, although providing a less ambiguous typology of apologia strategies, provide strategies that can be used by individuals and organizations. One of the critiques leveled against Ware and Linkugel’s strategies and postures is that they are only for individual use rather than organizational wrongdoing (Hearit, 1995, 1997; Rowland & Jermone, 2004). Hearit (1995) argued that organizational apologia is “a public response to a social legitimacy crisis, a response that
seeks to distance institutional actors from their wrongdoing and reaffirm adherence to key social values” (p. 1). Organizational wrongdoing is different than individual wrongdoing because implicit in the use of organizational apologia is allegations of individual and organizational wrongdoing. Similarly, the issuing of an apology is often seen as the automatic admittance of that wrongdoing (Rowland & Jerome, 2004). While individuals may be able to apologize without admitting guilt, organizational or societal wrongdoing is often too large to not admit guilt.

In an effort to prevent apologies from being viewed as separate, singular texts divorced from a larger social context, Yamazaki (2004) argued that we must view organizational or societal apologies as a process “represented in text to be sure but text that demonstrates interaction, negotiation, and even co-creation” (p. 156). These apologies, then, are dialogues situated in larger socio-political and socio-historical contexts, and as such, scholars have an obligation to consider the larger social context in which the apology is occurring. Often, organizational or societal apologies are in response to a social legitimacy crisis (Hearit, 1995). In this case, the VAMC disclosure and apology program is responding to the medical mistake epidemic. Social legitimacy cannot be controlled by law or government, and thus, must be regulated by organizations and the general public. Organizations are not bound by laws to apologize or make amends for a social legitimacy crisis. Rather, they enact ways to address the social legitimacy crisis because of their interdependence on the general public to exist. The rub is that apologizing can incur legal liability by admitting guilt; not apologizing is met with public anger and disgust (Tyler, 1997). Traditionally, action is not taken unless a social legitimacy crisis ensues and only then can apologia and apology be used.
Organizations in a situation where an apology is required always have the goal of showing that the organization is caring and decent. Organizations that want to maintain the appearance of adherence to key social values must “demonstrate concern for the victim(s), bolster individual or organizational values, make it clear that no harm was intended, and/or actively take steps to prevent the harmful action from occurring again” (Rowland & Jerome, 2004, p. 198). The VAMC disclosure and apology program that requires disclosure and apology in instances of medical mistakes is responding to the medical mistake crisis, and seeks to affirm that the VAMC and VAMC physicians are dedicated to the care of patients. Interestingly, the VAMC program does not seek to distance institutional actors from their wrongdoing; instead, the apology is intended to place responsibility for the mistake on the hospital and the physician. By doing so, the physician and the hospital seek to demonstrate adherence to patient safety and quality health care.

In the case of organizational wrongdoing, apologia is not apology, but rather is a response to a social legitimation crisis in which an individual or organization seeks to justify behavior (Hearit, 1995). Apologia may certainly include apology, but generally focuses on the justification of behavior. The VAMC program serves as a way to respond to the crisis of a medical mistake by providing information about the event and offering and apology for the event. The act of disclosure and apology is what makes this program unique. Disclosures and apologies from physicians and hospitals may not justify any kind of action, but are simply meant to express remorse for the event. These acts of apology, or what Burke (1970) callsmortification, are part of an individual or organization’s effort to respond to the mistake, to story their side of the incident. While other approaches seek
to deny guilt or place guilt on others, mortification requires the accused to admit to wrongdoing and to ask for forgiveness. This forgiveness is usually accomplished through apology and with the promise of preventing the wrongful act from happening in the future. The apologist must “accept responsibility, acknowledge the suffering of the victims without attempting to diminish the undesirable consequences they suffered, and directly apologize for the offensive act” (Benoit & Brinson, 1994, p. 82). Although physicians and hospitals cannot promise medical mistakes will not happen, they can promise an increased effort in the prevention of mistakes.

Summary and Research Questions

The seventeen mistakes in the Joan Morris story are certainly tragic and illustrate the myriad of medical mistakes that can occur all because of a larger medical mistake: miscommunication (Eisenberg et al., 2006). Disclosing, apologizing, and talking about medical mistakes provides physicians and patients a space to make sense of the mistake and health care encounter (Gallagher & Levinson, 2005; Gallagher, Waterman, Ebers, Fraser, & Levinson, 2003). This chapter has explored how the discursive construction of medical mistakes and the rituals of malpractice litigation and morbidity and mortality conferences reify a culture of shame and blame. The chapter also explored some of the proposed changes to this culture as the institution of medicine attempts to transition to a culture of patient safety. This chapter also explored the literature on the communicative act of apology, highlighting the unique terrain organizations and individuals must negotiate during moments of wrongdoing.

A particularly useful theoretical standpoint from which to explore the discursive and material actions and consequences of the VAMC disclosure and apology program
rests at the intersection of narrative and structuration frameworks. Narrative sensibilities provided a useful vocabulary to make sense of how physicians story their experiences with medical mistakes, apologies, and the changes to hospital and institutional practices in the wake of medical mistakes. Moreover, narrative theory allowed me to situate VAMC physicians’ stories in the larger historical and institutional stories of medical mistakes and the practice of medicine. The structuration framework provided a theoretical and practical language from which to make sense of the symbolic and material (re)structuring and organizing of the policy as well as the ways in which the program enables and constrains physicians in the practice of medicine. Narrative and structuration sensibilities allowed me to privilege the experiences of physicians as well as the structures that influence these experiences. This dissertation focused on how the structuring of the VAMC’s disclosure and apology program influences the ways in which physicians narratively talk about medical mistakes, the program, and the practice of medicine in a culture of patient safety. Based on the medical community’s literature on medical mistakes and apology scholarship and guided by my narrative and structuration sensibilities, the following research questions guided this dissertation:

RQ1: How do VAMC physicians narratively make sense of medical mistakes?

RQ2: How do VAMC physicians narratively make sense of the VAMC’s disclosure and apology program?

RQ3: How does the VAMC’s disclosure and apology program enable and constrain physicians in practicing medicine in a culture of patient safety?
RQ4: How do the policies and procedures of the VAMC’s disclosure and apology program contribute to and challenge the practice of ethical and responsible medicine?

RQ4a: How, if at all, do these policies and procedures discipline physicians and the ways they practice medicine?
Chapter Three

Methodology

My rendering of these texts is an act of interpretation. I have not assumed either that it is complete or that it is the only possible rendering. However, it is a full, or thick, rendering. I have used these texts on mistakes, first, to create a description of clinical medical work, and second, to create a description of clinicians at work. These documents contain an irreducible substratum, a raw fact of reportage, which is this: medical mistakes are inevitable. I have worked with this raw fact of reportage. I have asked, given these data, what is clinical work like and what is it like to be person who does this kind of work, a person who is mistaken? (Paget, 2004, p. 10)

In this dissertation, I relied on my interpretive sensibilities and qualitative methodologies to construct what Paget described as a thick rendering of medical mistakes and apologies. An interpretive standpoint allowed me to explore inherently meaningful social action and inquire into the meaning behind participants’ actions (Schwandt, 2000). Schwandt (2000) argued that interpretive scholars must interpret the actions in order to achieve verstehen, or understanding. An interpretive standpoint allows scholars to explore a phenomenon from the perspective of the actors (Lindlof & Taylor, 2002). An interpretive standpoint recognizes that, because we are concerned with the actor’s perspective, there will be multiple tellings and retellings of stories. These multiple renderings of stories mean that we can render thick descriptions of events, however partial and indeterminate those descriptions remain. An interpretive epistemological standpoint is a hermeneutic standpoint, emphasizing that the researcher “grasp the situation in which human actions make (or acquire) meaning in order to say one has an
understanding of the particular action” (Schwandt, 2000, p. 193). In this dissertation, I sought to capture the voices and experiences of physicians, explore the ways in which they make sense of mistakes and apologies, and remain reflexive and open to the narratives which they share. I attempted to provide a richer understanding of complex and mistake-filled world of medicine.

An interpretive standpoint is particularly salient for my interactions with physicians at the VAMC. Like Cheney (2000), I see realities as socially constructed by and between humans. Meaning-making and sense-making are collaborative endeavors. The same can be said of my interpretive sensibilities to research. I believe that research should “privilege [the] deep understanding of human actions, motives, and feelings. It should illuminate how cultural systems are used to attribute meaning to existence and activity” (Lindlof & Taylor, 2002, p. 11). My epistemological and ontological approach to research is one of possibility. Interpretive views of the world are partial, indeterminate, and co-constructed with those around us. For medical mistakes, it becomes monumentally important to understand the ones that commit mistakes navigate the symbolic, material, social, and corporeal exigencies of their lives. In order to understand how individuals make sense of and be in their realities, I adopted an epistemological position that allows me to empathically identify (Schwandt, 2000) with individuals. Empathically identifying with people allows researchers to appreciate and privilege individuals’ motives, beliefs, thoughts, and desires. This epistemological framework guided the research design of this dissertation.

In this chapter, I explain the various elements of the dissertation’s research design. First, I further explicate my interpretive orientation to research, along with
several initial concerns of my particular dissertation. Building from my orientation, I
describe the research setting and the participants with which I plan to be involved. Then,
I explain the methods of data collection, focusing on in-depth interviews, document
analysis, and observations. Finally, I briefly discuss how I analyzed the discourses.

Interpretive Fieldwork

Interpretive research and fieldwork situates the researcher in the socially
constructed worlds of others. Researchers engaged in interpretive fieldwork are
concerned with understanding the ways in which cultures are symbolically represented,
enacted, and embodied by the individuals that exist in those realities. Qualitative research
serves as the lens through which to make sense of these realities because qualitative
research privileges the experiences of individuals. Denzin and Lincoln (2000) identified a
central tension that undergirds qualitative research. On one hand, qualitative research
represents a “broad, interpretive, postexperimental, postmodern, feminist, and critical
sensibility” (p. 7). On the other hand, qualitative research is drawn to positivist and
humanistic conceptualizations of human experience. This epistemological tension
positions qualitative research as a set of practices that embraces “multiple disciplinary
histories” wrought with tension and contradiction (Denzin & Lincoln, 2000, p. 7).

It is this tension and contradiction that makes qualitative fieldwork appropriate
for the study of medical mistakes and apologies. The world of medicine that physicians
must negotiate is also wrought with tension and contradiction, and an epistemological
framework that appreciates tension and contradiction is needed to make sense of this
world.

Qualitative research, then, is
an interdisciplinary, transdisciplinary, and sometimes counterdisciplinary field. It crosscuts the humanities and the social and physical sciences. Qualitative research is many things at the same time. It is multiparadigmatic in focus. Its practitioners are sensitive to the value of the multimethod approach. They are committed to the naturalistic perspective and to the interpretive understanding of human experience. At the same time, the field is inherently political and shaped by multiple ethical and political positions. (Nelson, Treichler, & Grossberg, 1992, p. 4)

This conceptualization of qualitative research privileges human experience as a site for multiple interpretive practices as well as recognizes the political and social exigencies that influence these interpretive practices.

I see qualitative research and interpretive fieldwork as an act of quilting. The positioning of qualitative research as an act of quilting calls for me to see research as the co-construction of different elements together into a coherent story (Denzin & Lincoln, 2000). Quilts often tell a story, and framing research as a quilt helps to make sense of the stories of a particular phenomenon.

The product of the interpretive bricoleur’s labor is a complex, quiltlike bricolage, a reflexive collage or montage—a set of fluid, interconnected images and representations. This interpretive structure is like a quilt, a performance text, a sequence of representations connecting the parts to the whole. (Denzin & Lincoln, 2000, p. 6)

The quilting metaphor to research appreciates the process and the product of research (Flannery, 2001). How the quilt is made is just as important as what it looks like when it
is completed. Moreover, the construction of the research quilt appreciates the difficulty that is associated with piecing together others’ voices into a coherent voice. Seeing research as an act of quilting implies a creativity that is born out of taking separate, and sometimes disparate, voices and piecing them together to present an eloquent narrative (Flannery, 2001). Quilting is akin to the idea of constellations of stories, woven together to tell a larger narrative. Although the finished research quilt is one complete narrative, you can appreciate each individual piece of fabric, much like you can appreciate each individual narrative and voice.

Interpretive research has the ultimate goal of understanding the ways in which individuals make sense of and exist in their particular social realities. Interpretive research calls on researchers to focus on specific situations or contexts in order to piece together a large quilt of human existence. To do this, I relied on ethnographic methodologies to make sense of a specific situation and context: the disclosure and apology program at the VAMC. Ethnographic methods are concerned with “describing and interpreting observed relationship between social practices and the systems of meaning in a particular cultural milieu” (Lindlof & Taylor, 2002, p. 16). To do this, researchers must go out into the field of study and collect the forms of data most appropriate to understand the context. In this dissertation, I attempted to provide a detailed portrait of medical mistakes and apologies through privileging the voices of physicians as a first step to understanding the cultural milieu of medical mistakes.

Fieldwork inspired by ethnographic principles asks researchers to develop thick descriptions of events, which lead to verstehen (understanding). My positioning of fieldwork for this dissertation was as a hermeneutic method. Fieldwork as a hermeneutic
method involves interpreting events by empathically identifying with participants and their discourses (Schwandt, 2000). The circular nature of hermeneutics ensures that researchers will have a rich understanding of the discourses and can provide a holistic interpretation of the narratives (Lindlof & Taylor, 2002). As Lindlof and Taylor (2002) noted, the primary way in which researchers accomplish thick descriptions is through observations. However, thick description can be accomplished in other ways. This is particularly salient in the case of ethnographies of health and the practice of medicine.

Ethnographies of health and the practice of medicine that rely primarily on observations only provide accounts of medicine from the perspective of institutional interactions or medical decision-making (Bloor, 2001). Instead, researchers of health and medicine must consider what are the best methods to make sense of a particular situation or context. “Ethnographic authorship must retain a commitment to veracious description and systematic method alongside a reflexive awareness of the ethnopoetics of scholarship” (Bloor, 2001, p. 183). To appreciate the ethnopoetics of the situation and remain true to thick description, scholars must decide how to best accomplish this with their particular project.

In the case of medical mistakes, observations were not the most fruitful way to get a thick description of the situation. This is the case for several reasons. First, medical mistakes are not scheduled events; they often just happen in the moment. There was no guarantee that I would be present to witness a medical mistake. Moreover, there was no guarantee that I would know when a mistake has happened as compared to a known complication. As someone who is an outsider to the medical profession (which I will discuss more in depth later in this chapter), I may not have realized a mistake had
occurred. Third, issues of privacy and confidentiality surround medical mistakes. Witnessing a mistake does not mean that I would have the permission of the patient to write about, even if I had permission from the physician or other medical practitioner who committed the mistake. Finally, the dual focus of the dissertation is on how physicians make sense of apologizing for mistakes. Legally, I was denied access to witness the actual act of apologizing for confidentiality reasons. For these reasons, I heeded Bloor’s call to select methods that would be most fruitful to get a thick description based on the situation.

Research Concerns

The discussion of whether or not observation is the best method to obtain thick descriptions offers a segue into other research concerns specific for this dissertation. There were three key concerns that I had to negotiate and constantly be reflexive about during the research process. The first concern was that of gender. I am a female researcher entering a field dominated by men. As I will discuss later, the primary means of discourse collection for this dissertation is in-depth interviews. Schalbe & Wolkomir (2002) expertly noted that the interview situation in and of itself is a potentially threatening experience because the interviewee relinquishes control to the interviewer. The potentially threatening nature of the interview may cause participants to question the researcher’s competency and their legitimacy as a researcher (Gurney, 1985). This causes the interview to potentially become a site for the struggle for control. Moreover, I asked physicians to reflect on particularly vulnerable moments and the ways in which they responded may be predicated on gender (Arendell, 1997). For example, the stereotypical belief that men do not make (or admit to making) mistakes could have affected the ways
in which they talk about mistakes. Gender ended up not being a concern at the VAMC. I was warmly welcomed by everyone at the VAMC I interviewed. The physicians graciously answered my questions and were genuinely interested in my work. I never felt that gender influenced the ways in which physicians, co-creators, or the Chief of Staff interacted with me.

The second and third concerns, interviewing elites and being an outsider studying a profession that is particularly insular, especially when it comes to medical mistakes, were more of a concern than gender. In research settings, the researcher traditionally is the one in the privileged position of power. The researcher’s privileged position of power is often a concern for researchers because of the current focus on marginalized groups (McCorkel & Myers, 2003). The researcher’s position of power, however, is often problematized in medical settings. In research conducted in medical settings, the hierarchy and power balance is often reversed (Pope, 2005). In medical settings, the physician is often at the top of the hierarchy. Odendahl and Shaw (2002) explained that elites are generally recognized by the fact that they often have more knowledge, money, and status than others in society. More importantly, their worlds are often shrouded in secrecy, a cloak of privacy masking their activities. For physicians, the rituals and activities with medical mistakes are often shrouded in secrecy.

Moreover, the elite nature of physicians was compounded further by my distinctively outsider position. The insider/outsider debate “challenges those of us who use ethnographic methods in our research in our ‘home’ country to reexamine out taken-for-granted assumptions about what constitutes ‘indigenous’ knowledge” (Naples, 1996, p. 84). As an outsider, I brought different sensibilities to the field and could be more
objective about what I saw in the field and heard in interviews. I had the opportunity to probe the structures of medicine and critically question the ways in which physicians talk about the structures because I did not use the same stocks of knowledge. I was not bound to the same fossilized institutions and I had not heard these institutional narratives multiple times. However, as an outsider, I risked missing important subtleties that an insider would see. Pierce (1995) argued that to prove your researcher “worth” to elites, researchers should “study up” on the elite group (p. 106). This solution proved useful for negotiating my place as an outsider. Over the past three years, I familiarized myself with the literature on medical mistakes as well as medicine in general. This assisted me in probing during interviews and demonstrated my competency as a researcher. Many of the physicians were impressed with my understanding of medical terminology and ability. An example of this was when the Chief of Anesthesiology taught me, along side an anesthesiology resident, how to intubate a patient using the anesthesiology dummy.

Settings and Participants

Because this dissertation was concerned with how physicians make sense of medical mistakes and the act of apologizing for them, I selected a hospital system that has been implementing apologies for 20 years: The VAMC. Established in 1931, The VAMC, located in Lexington, KY, is a fully accredited, tertiary care medical center. The VAMC houses 209 beds and is a general medicine and surgery facility. The VAMC consists of two different facilities. The first facility provides primary acute medical, neurological, surgical, and psychiatric inpatient services. The second facility provides emergency care, medical-surgical care, acute psychiatry, intensive and progressive care,
outpatient care, and ambulatory surgery. I was on-site at both facilities, but I spent my time primarily at the second facility, which is the primary care facility.

The VAMC is part of the VA MidSouth Healthcare Network, which consists of six VA medical centers in Kentucky, Tennessee, and West Virginia (“Facilities Locator & Directory,” 2007). As a licensed VA hospital, any registered veteran and their immediate family are able to receive care at the hospital. The Lexington area has an estimated veterans’ population of more than 92,000. Working under the hospital motto, “Serving those who have served the world over,” the VAMC cares for more than 25,000 veterans each year and has over 5,400 admissions and 200,000 outpatient visits (Kentucky Telecare, 2005). The VAMC is also a teaching hospital in conjunction with the local university’s Colleges of Medicine and Dentistry. Each year, approximately 490 medical and dentistry students and residents train in the medical center (Kentucky Telecare, 2005).

The VAMC is a nationally recognized VA facility. In 2002, the facility received the inaugural John M. Eisenberg Patient Safety Award for their advocacy of the disclosure and apology of medical mistakes. The award is co-sponsored by the National Quality Forum and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), of which the VA is a member. The facility is also well recognized for their research and implementation of extended care treatments for veterans as well as their inpatient/outpatient post traumatic stress disorders program.

**Gaining Access to the VAMC**

To gain access to the VAMC, I initially contacted the VA National Center for Patient Safety, the flagship office for issues of patient safety and quality control in the
VA system. After discussing the project’s scope and goals with the director of the National Center for Patient Safety, he gave me contact information for Debra, the NSQIP (National Surgical Quality Improvement Program) Officer at the VAMC as well as the Chief of Staff’s office. I initially contacted the Chief of Staff’s office and scheduled an appointment with the Chief of Staff to discuss my project. I met with the Chief of Staff in May and he gave his initial approval for my project. The Chief of Staff’s written approval was needed to complete the Institutional Review Board’s (IRB) protocol.

For this project, I had to complete three IRB forms for three different institutions: Ohio University, University of Kentucky, and the VAMC. I completed the Ohio University IRB and permission was granted (see Appendix C). After the Ohio University IRB permission was granted, I had to complete the University of Kentucky IRB. I had to complete the University of Kentucky IRB form because the VAMC, as a teaching hospital, has a joint IRB office with the university. Once the University of Kentucky IRB was completed and permission was granted (see Appendix C), I had to complete the VAMC IRB form (see Appendix C). In order to complete the VAMC IRB form, I had to become a “WOC” with the VAMC. A “WOC” or “Worker Without Compensation” is an individual who has access to and does work at the VAMC facility but is not paid for that work. In order to conduct research at the VAMC since I am not a student or employee of the university, I had to file for “WOC” status. I was fingerprinted and the police department checked for a criminal record. I was granted “WOC” status for a year.

Once all three of the IRB forms were completed and permission was granted, I could enter the facility. In order to find physicians to interview, I was given a list of all of the full-time, part-time, and volunteer physicians practicing medicine at the VAMC. The
list included names, specialty, and VAMC pager numbers of the physicians. My primary informant, Debra, also assisted in finding physicians to interview by calling up surgeons and asking for volunteers. Debra, now the NSQIP Officer in the Chief of Staff’s office, used to be the head surgery scrub nurse, and knows many of the practicing surgeons. The Chief of Staff also sent out departmental memos alerting departments to my presence. I was invited to speak to Internal Medicine residents about the project and met many of my Internal Medicine interviewees at that meeting. Finally, I found physicians to interview through snowballing. For example, if I happened to be conducting an interview urologist in the Urology Department suite, other urologists would see and volunteer to participate. Along with physicians, I also interviewed all three of the program co-creators as well as the Chief of Staff, who is actively involved with the program.

Data Collection

For this dissertation, I used three methods of data collection. I submitted a proposal for approval to the Ohio University IRB, University of Kentucky IRB, and VAMC IRB. The proposals are attached as Appendix C. The study and methods were approved by all of the IRB departments and the approval letters are attached as Appendix C. Once the universities and VA IRBs and my dissertation committee approved the dissertation topic and research protocols, I began data collection. A research log was completed that documents all research activities, including types of activities, times and length of activities and any other information pertinent the research (see Appendix D). The three methods of data collection for this dissertation were in-depth interviews, document analysis, and observations.
In-Depth Interviews

As discussed earlier by Bloor (2001), observations may not be the most fruitful method through which to gain a deep and rich understanding of a phenomenon. The purpose of the in-depth interview is to understand the social actor’s experiences and perspectives of a particular event or context (Lindlof & Taylor, 2002). Using in-depth interviewing techniques suggests that researchers are concerned with seeking “deep” information about personal matters such as an individual’s self, lived experiences, values and decisions, or perspective (Johnson, 2002). Deep information has several meanings and serves several purposes. First, deep understandings are held by individuals about their lived experiences and the ways in which they make sense of their lives and actions (Warren, 2002). Second, deep understandings ask individuals to reflect on their specific understandings of a particular cultural artifact, event, or activity (Johnson, 2002). More importantly, the in-depth interview allows researchers to explore events and processes that cannot be observed effectively by other means (Lindlof & Taylor, 2002). Central to my research design and research questions was the voice of the physician as he or she talked about his or her experiences with medical mistakes and apologies. Because of the difficulties associated with witnessing a medical mistake or being present for discussions of mistakes and apologies, in-depth interviews served as the primary means of knowledge collection.

For this dissertation, in-depth interviews were narrative and respondent interviews. Narrative interviews ask individuals to make sense of their actions through the organization of events and objects into a meaningful story about the event (Riessman, 2002). Narrative researchers view stories as both enabled and constrained by symbolic
and material exigencies, and the use of narrative interviews provide a “window to the contradictory and shifting nature” of narratives and the structures in which they exist (Chase, 2005). Moreover, narratives about personal experiences can be used to create a “web of collective reality” that can highlight a larger organizational narrative (Lindlof & Taylor, 2002, p. 181). Respondent interviews are open-ended interviews that attempt to accomplish any or all of these goals:

1. to clarify the meanings of common concepts and opinions;
2. to distinguish the decisive elements of an expressed opinion;
3. to determine what influenced a person to form an opinion or to act in a certain way;
4. to classify complex attitude patterns; and
5. to understand the interpretations that people attribute to their motivations to act. (Lindlof & Taylor, 2002, p. 178)

All of these goals were important for this dissertation, especially considering my structuration framework. In order to understand how physicians make sense of medical mistakes as well as the structures that dictate their actions in the wake of a medical mistake, I needed physicians to talk about their understandings and interpretations of the structures. Although narrative interviews would tell the stories of their personal experiences with medical mistakes as well as the organizational narrative, more clarification was needed to explore how physicians make sense of those experiences. Respondent interviews allow the researcher to probe further into the narrative to cull out the structural forces that undergird the narratives.

Interview schedules and protocols vary depending on the types of interviews being conducted, the individuals being interviewed, and the interviewee. The interview protocol I employed was a semi-structured interviewing technique to allow participants to
talk about their individual experiences and insights. Semi-structured approaches recognize that the interview is a co-constructed event (Heyl, 2001) and that other experiences may emerge during the course of the interview. Although I was concerned with the questions that I proposed in the interview protocol, I was also open to what might emerge in the midst of the interview. I developed tentative interview protocols for (a) physicians and (b) the creator of the apology and disclosure program (see Appendices E and F). At the start of the interview, all participants were given informed consent forms to read over and sign. I also read over the informed consent form with each participant in order to answer any questions they may have before the start of the interview.

All participants had to sign two informed consent documents: the Ohio University consent form and the University of Kentucky/VAMC informed consent form. These forms were identical except for the institutional logo at the top of the form. I initially proposed interviews with 30 to 40 physicians at the VAMC, as well the legal representative of the hospital who happened to one of the co-creators of the program. I was able to interview 30 physicians. In addition, I interviewed all three of the program co-creators and the Chief of Staff, who is in charge of handling the actual disclosures and apologies. Interviews ranged from 45 to 120 minutes with physicians and ranged from 75 to 120 minutes with co-creators and the Chief of Staff. 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 by the dissertation author. The transcription resulted in 330 pages of physician interview text and 51 pages of administration interview text, resulting in a total of 381 pages of single-spaced typed interview text.
Observations

Fieldwork is both a process and product where researchers’ lives are embedded within the fieldwork experience (Tedlock, 2001). Observative fieldwork inherently asks researchers to abandon their “certainty and expertise” and be open to what they see (Lindlof & Taylor, 2001, p. 133). Observation, then, involves getting close to the participants of particular social settings (Lindlof & Taylor, 2002). Observations, traditionally known as participant observations, describe being in the presence of others and recording the events of the social settings. For this dissertation, I adopted a participant-as-observer stance (Lindlof & Taylor, 2002). As a participant-as-observer, I acknowledged my role as a researcher entering the field in order to understand a specific event or activity. As a participant-as-observer, I was able to observe the organizational workings of the hospital through multiple organizational meetings as well as “practice medicine” along side attending physicians in their training of younger physicians.

Access and time are major concerns in any field-based project that involves observations (Smith, 2001). This is even more complicated in a hospital setting were issues of privacy and confidentiality are paramount (Pope, 2005). Gaining access to certain medical facilities, such as hospitals, is more difficult than gaining access to clinic or private offices. I anticipated being able to observe at the VAMC; however, I did not know how many hours I would be able to observe, nor did I know what I would be able to observe. Moreover, my observations were hampered by the fact that I could only be at the VAMC facility a few days a week. I had to drive 4 ½ hours to reach the VAMC, and that along with my other university duties, prevented me from spending time every day at the facility.
Ultimately, I spent 36 hours engaged in participant-observations at the VAMC, resulting in 72 pages of single-spaced typed text. I had the opportunity to observe individuals working through many complex health issues. In terms of the program, I was able to observe a closure. A closure is the formal meeting of a patient or family and the hospital when it has been determined that a bad outcome is the result of a known complication, not a medical mistake. Legally, I was not allowed to witness a disclosure and apology because of the “active” nature of disclosure cases nor was I able to attend the VAMC’s weekly morbidity and mortality conferences. I was also able to sit in on risk management meetings that discussed pending disclosure/closure cases. Finally, I was also able to observe the legal staff for several days as they worked on a potential medical mistake case. I was able to witness the legal team talk about the case and interview individuals involved with the case. Legally, I was able to witness these interactions and hear these conversations for two reasons. First, the hospital had not yet determined if the case was a medical mistake case or a closure case. Second, all of the conversations and interviews were available to the public because of Kentucky’s Sunshine Law, which makes legal depositions and conversations available for public consumption.

I was also able to witness several different aspects of the hospital. I was able to observe two ethics committee meetings, where a group of physicians and the Chief of Staff work through difficult patient cases. I was also able to observe morning rounds with Internal Medicine residents as they presented the day’s cases to attending physicians. I observed the legal staff while they dealt with other legal issues, including a worker’s compensation case. Finally, I observed and participated in pedagogical opportunities with residents. I was taught how the electronic medical record system worked. I was also
taught how to intubate a patient along side an anesthesiology resident and even got a chance to intubate the dummy, using real intubation tubing.

During each observation opportunity, I took handwritten fieldnotes and attempt to document key phrases of conversation verbatim. My detailed observation notes also made note of the spaces in which observations occurred as well as any historical or institutional background information that is needed to make sense of the observations. After each observation period, I typed up fieldnotes and began to make theoretical connections between discourses (Emerson, Fretz, & Shaw, 2001). Throughout the observations, I reflexively tried to account for how, as a researcher, I potentially affected the interactions that I observed and how I interpreted those interactions.

Organizational Documents

Czarniawska (2002) explained that additional narrative materials are often needed to make sense of organizational narratives. Organizational documents are artifacts that are critical to the functioning of organizations, providing historical context and additional understanding of an event or phenomenon (Lindlof & Taylor, 2002). Organizational documents offer additional insight by using the language and expressions of the organization, highlighting the social rules of the organization (Hodder, 2000; Lindlof & Taylor, 2002). The medical setting offers a variety of different organizational documents aside from the traditional policies, procedures, and memos found in most organizations. The medical record, physicians’ notes, and admit charts all provide a more layered understanding of how medicine is practiced (Hunter, 1991).

As Hodder (2000) argued, what people do and what people say are often two very different actions. Organizational documents often highlight where those differences
intersect and help to make sense of conflicting voices and differing interpretations.
Organizational documents do this in three ways. First, organizational documents can be linked to the ways in which individuals talk about the topic (Lindlof & Taylor, 2002). For the VAMC disclosure and apology program, physicians use specific language based on the official policy or other organizational documents. In order to understand their full meaning, the documents would need to be analyzed. Second, organizational documents help to recreate past events or ongoing processes that a researcher cannot observe. As Hodder (2000) explained, “the material expression of power can be set against the expression of resistance” in documents (p. 706). Document analysis of the policies and procedures were needed to understand the tensions that exist for physicians regarding mistakes and apologies. Finally, organizational documents reflect the rationality of organizational decisions (Lindlof & Taylor, 2002). Document analysis is essential in order to understand the reasoning behind organizational decision-making. In order to help make sense as to the reasons why the VAMC program was created, organizational documents that tell the story of its creation are needed.

Documents for this particular dissertation included, but were not limited to, the VAMC’s original policy, the national roll-out policy, additional VAMC policies created in response to the disclosure and apology program, and VAMC literature regarding patient safety. Now that I have discussed the three methodologies that I will use, I will explain the data analysis procedures I used to make sense of the collected data.

Data Analysis

As discussed at the start of this chapter, I analyzed the discourses I collect through narrative and structuration lens. As discussed in Chapters One and Two, I entered the
field and approached my interviews with an interest in how physicians make sense of medical mistakes and apologies and the ways in which hospital and institutional structure enable and constrain that sense-making. The research questions proposed at the end of Chapter Two propelled the construction of the interview protocols that asked physicians, program co-creators, and the Chief of Staff to narratively story their experiences with mistakes, apologies, and the VAMC program. I did, however, enter these encounters with an open mind and eye to issues that might arise for which I had not planned or considered. My narrative and structuration sensibilities provided a way to make sense of the discourses, focusing on the stories individuals tell along with the structures the enable and constrain these tellings and retellings.

Once I completed my collection of discourses, I 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). Because constant comparative analysis is an ongoing activity, researchers are continuously engaged in and with the discourses of their project. From the time I entered the field at the VA, I continuously read through the discourses collected to gain a holistic sense of the discourses and to begin to identify emergent themes. Moreover, reading through the discourses as they are collected and transcribed assisted me in determining if changes in interview protocol were needed or other important issues needed to be addressed.

Constant comparison of these data were continued until I felt that “theoretical saturation” has been achieved (Glaser & Strauss, 1967, p. 110). I felt that I was able to
get theoretical saturation with this dissertation, and this saturation resulted in more questions for future research. The constant comparative process begins with data “reduction” and “interpretation.” After reading all the transcripts and fieldnotes and gaining a holistic sense of the discourses, actual analysis of the data began. The constant comparative method allowed me 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 fieldnotes. Constant comparison data analysis allows researchers to make note of patterned regularities about participations and the ways in which they talk about and enact their experiences. I transcribed all interviews and observation notes in order to fully immerse myself in the discourses. I felt that this enabled me to better identify and work with the discourses. As mentioned above, the interviews resulted in a total of 381 pages of single-spaced text. I also had 72 pages of single-spaced observation notes as well as 64 pages of organizational documents and policies. I initially read all of the discourses twice in order to get a feel for the discourses in their entirety and to make preliminary notes about potential themes. On the third read, I began to mark discourses that addressed similar issues, relying on colored highlighters to keep ideas distinct. I had, however, already begun to make preliminary notes about themes as I was transcribing interviews and began to see themes emerge. The fourth read was dedicated to solidifying discourses representing themes. The fifth read was dedicated to grouping discourses together based on individual themes and made notes about specific sub-ideas that the discourses addressed.
I began to develop the arguments behind themes, and used those arguments to develop the themes, supported by interviews, observation notes, and organizational documents. Initially, I identified 6 major themes that addressed the complex experience of medical mistakes and the VAMC program. After further analysis, I removed one of the themes, resulting in a final presentation of 5 themes. Chapter Four presents these five themes. These themes are organized narratively, beginning with an understanding of the program, moving to the medical mistake experience, and ending with how stakeholders make sense of the consequences associated with mistakes. In Chapter Five, I use these themes to answer my research questions.

Conceptualizing Rigor

In this section, I discuss four tools to evaluate the rigor of the interpretive fieldwork of this dissertation: credibility, authenticity, relationality, and reflexivity. In order to understand how these four standards coalesce with my project, I will first briefly discuss my positionality on truth and how I see my perspective on truth impacting this project.

My positionality of “truth” was born out of the traditions of hermeneutics and feminisms. Truth is not something that is universal or absolute but rather fluid, contextual, partial, and indeterminate. There are multiple truths rather than just one Truth. My positionality of multiple truths was first grounded in hermeneutics, which is concerned with how we make sense of and understand our social realities. For hermeneutic scholars like Gadamer (1989), truth is the event of meaning. To say that we have constructed some kind of “truth” as scholars is to say that we have co-created, with participants, a meaningful account of an experience. From a hermeneutic standpoint, truth
is a living event, full of change and possibility (Gadamer, 1989). As Moules (2002) explained

Our strengths, as hermeneutic researchers, lie in a belief in the interpretability of the world and in a willingness to allow ourselves to be read back to us. Hermeneutics demands that we proceed delicately and yet wholeheartedly, and as a result of what we study, we carry ourselves differently, and we live differently… I cannot remove my subjectivity from my work, but I can take it up with a sense of responsibility in recognizing how it translates into the way I listen to my participants, what I hear, what stands out to me, and how I interpret it. (p. 24)

My ontological belief that there are multiple truths means that I will not only see and appreciate others’ conceptualizations of truth but also that their truths will influence my truths. Moreover, my feminist sensibilities appreciate the second half of Moules’ comments; that, as a scholar, I cannot completely divorce my subjectivities from my work. I can, however, bracket off what Gadamer (1989) calls my prejudices. Researchers will never be able to truly write themselves out of research. As cautioned by Fine, Weis, Weseen, & Wong (2000), trying to not include ourselves in research is just as silencing as not including the voices of participants. My prejudices allow me to see or hear things that I might not have seen or heard otherwise. Conversely, they influence what I do see and hear in the field. Rather than pretend that those subjectivities do not exist, as a scholar, I need to appreciate those subjectivities in order to appreciate the subjectivities of others (Olesen, 2000).
My fluid, contextual, and partial conceptualization of truths influences the following evaluative tools for assessing rigor of qualitative research. The first way in which interpretive research ought to be assessed is in terms of credibility (Lincoln & Guba, 1985; Whittemore, Chase, & Mandle, 2001). Credibility is concerned with the “conscious effort to establish confidence in an accurate interpretation of the meaning of data” (Whittemore, Chase, & Mandle, 2001, p. 530). Moreover, as Lincoln and Guba (1985) argued, credibility is concerned with whether the interpretation reflects the experiences of the participants in a believable way. This particular standard recognizes that there are multiple interpretations to an event and the researcher is presenting one interpretation of the discourse. As a researcher trying to ensure rigor in qualitative research, I must present a believable interpretation of the participants’ experiences. For medical mistakes, this is especially important because how one physician makes sense of his or her experiences may be radically different from how other physicians make sense of a mistake. Credibility privileges the tensions that may exist between participants’ experiences and calls on researchers to recognize and express those tensions.

Credibility’s interest in recognizing the tensions between participants’ experiences coincides with the second evaluative standard for rigor: authenticity. Authenticity is concerned with portraying research that reflects the multiple meanings and experiences that are lived and perceived by the participants. Authenticity appreciates the multi-vocal and socially constructive nature of interpretive work and the experiences of others (Olesen, 2000). Authenticity is closely tied to Flannery’s (2001) discussion of qualitative research as a quilt. As discussed in Chapter One, narratives inherently call for multiple (re)tellings of an experience so that we may appreciate the nuanced differences
experiences by others. In order to make sense of medical mistakes and apologies, I included the multiple, and potentially divergent, voices of physicians. Medical mistakes are messy, chaotic experiences, and to begin to capture those experiences, I needed the multiple tellings of those experiences. Credibility and authenticity speak to a concern for an interpretive validity that appreciates attentiveness, respect, honesty, empathy, and an openness to the voices of participants and their experiences (Davies & Dodd, 2002).

The third evaluative tool that can guide rigor in qualitative research is relationality. Relationality embraces commitments to the community involved in the research, relationships between the researcher and participants, and the emergent and changing relationships between researchers, participants, and the community (Hall & Callery, 2001). A rapport or connection is important to qualitative research and the evaluative tool of relationality appreciates the connections as well as the relational power between researchers and participants (Lincoln & Guba, 1985). Relationality is particularly important for studying medical mistakes and apologies because I asked physicians to reflect on and talk about intimate moments and experiences they might not have talked about with people outside the VAMC or medical community. Relationality also recognizes the connections developed between researchers and participants and “between knowledge elites and communities in which they live and labor; it is rooted in caring and equity” (Hall & Callery, 2001, p. 268). As discussed in a previous section on research concerns, the power relationship between researcher and participants is somewhat reversed because physicians are considered an elite group. It was important for me to develop a rapport and connection with physicians in order to not only share their stories but to be respectful and appreciative of their experiences.
Finally, the fourth evaluative tool for assessing rigor is reflexivity. Reflexivity asks qualitative researchers to deeply think about and reflect on their role as researcher, the research they are conducting, and the choices made during the research (Hall & Callery, 2001). In a sense, reflexivity combines the first three standards and calls on researchers to be sensitive to participants and the communities in which they exist (Fine et al., 2000). Reflexivity challenges researchers to critically engage their own decisions, subjectivities, and actions in the research field. I can accomplish reflexivity in several ways. First, I was upfront about my research choices. This is particularly true in my earlier discussion about using in-depth interviews as the primary data in this study based on my research questions. Second, I entered the field with an in-depth understanding of medical mistakes and the practice of medicine in order to be true to the participants and their experiences. I had to demonstrate my commitment to medical mistakes and physicians’ experiences in order to get my interviewees to open up and discuss intimate experiences and events with me. I also demonstrated this commitment through my engagement with the data and using a constant comparative method to examine it (Strauss & Corbin, 1998). Moreover, I wanted the voices in project to be those of physicians, but I recognize that this is only one part of the storying of medical mistakes narratives. Physicians are not the only individuals in these stories, and it was my job to help maintain the anonymity of physicians and patients while still sharing those stories and experiences.

Chapter Four presents one interpretation of the discourses collected throughout this dissertation. The results of the data collection and analysis are organized narratively by theme and are accompanied by my interpretation and analysis of the theme. Chapter
Five uses the themes presented in Chapter Four and positions the themes in relation to the research questions presented at the end of Chapter Two. In Chapter Five, I also discuss the theoretical and practical implications associated with the VAMC program and using narrative and structuration theories as guiding frameworks. Chapter Five ends with a discussion of the limitations of the dissertation as well as directions for future study.
CHAPTER FOUR

Analysis

VAMC physicians, co-creators, and the Chief of Staff have to negotiate multiple tensions as they navigate the tenuous discursive, material, and corporeal terrain of medical mistakes, disclosure, and apology. As each theme shows, the medical mistake experience is an experience comprised of personal beliefs, organizational mandates, and societal expectations. In this chapter, I weave between these multiple stakeholders’ stories and experiences and what I, as the researcher, witnessed in order to make sense of the complex, and sometimes tangled, web of the medical mistake experience.

This chapter offers one of the first in-depth glimpses into the communicative nature of medical mistakes, disclosure, and apology in the health care setting. Moreover, this chapter hopes the enlarge societal scripts about medical mistakes—sometimes physicians are victims and the hospital can be a caring and open environment in the face of errors, as opposed to a silent and imposing organization. Although the narratives and experiences of the multiple stakeholders could easily stand alone, I attempt to weave together ideas, feelings, and stories to highlight the common threads of experience. By doing so, I underscore the complexity of enacting “socially responsible” medicine in the face of managed care and bureaucratic organizing of medicine. The themes presented here, although presented as separate analyses, intersect and build on each other.

The chapter begins with the theme “Ensuring Trust, Respect, and Excellence: The Bureaucratization of Medical Mistakes Through the Disclosure and Apology Program,” which highlights the inevitable progression of bureaucratization of a program designed to give agency and voice to physicians. The second theme, “The Right Thing To Do: The
VAMC Disclosure and Apology Programs as (Un)Ethical Action” builds on the first theme’s justification of the program, exploring how physicians and other stakeholders make sense of the disclosure and apology program, highlighting the tension between perceptions about the moral act of apology and the immoral act of mandating ethical action. The third theme, “Bearing Witness to the Ethics of Practice: Narrative Expression of Medical Mistakes” showcases the extraordinarily painful and haunting narratives of medical mistakes as told by providers on the front lines of health care. This theme also speaks to the different ways in which medical mistakes can be interpreted and how the medical mistake experience is truly a co-owned experience. The third theme, “Black Marks and Money: Corporeal and Material Constraints and Negative Sanctions in Medical Mistakes” builds on the third theme, highlighting the discursive and material consequences of medical mistakes. The final theme, “From Failure to Forgiveness: Disclosure and Apology as Embodied Emotional Redemption” focuses on the emotional journeys the physicians, co-creators, and the Chief of Staff take as they attempt redemption for mistakes, showcasing the emotional tension the stakeholders experience as they negotiate an emotionally redemptive program in a traditional medical practice.

The discourses analyzed and interpreted in this chapter were collected from conducting in-depth interviews, participant-observations, and document analysis with VAMC physicians, the three co-creators of the program, and the Chief of Staff, who is the chief apologizer. These themes emerged as a result of multiple readings and constant comparison of all of the discourses. To protect the identities of individuals, I use pseudonyms throughout the chapter for all of the stakeholders. I also identify the specialty and rank of physicians (see Appendix G for a quick-read chart). Because I
observed the legal staff working on an active medical mistake case and because individuals often talked in detail about patients and mistakes, I changed any identifying information about patients in order to protect patient identities.

What is presented in this chapter is just one interpretation of medical mistake, disclosure, and apology experiences. Narrative and structuration theories shaped and guided my understanding and interpretation of the stories, expressions of feelings, and institutional narratives that make up medical mistake experiences. My own personal involvement with the physicians and co-creators, either from sitting in risk management meetings, listening to physicians presenting patients during morning rounds, or simply learning how to intubate a patient along side an anesthesiology resident, transforms me into a co-performer of health care experiences and influences the way I make sense of these discourses. The themes presented are co-constructed expressions of mistakes, disclosure, and apology that privilege the voices of the participants. I, however, recognize my position as a researcher in the interpreting of these experiences.

Ensuring Trust, Respect, and Excellence: The Bureaucratization of Medical Mistakes

Through the Disclosure and Apology Program

*Disclosure of adverse events to patients or their representatives is consistent with VHA 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. Telling patients or their representatives about harmful or potentially harmful adverse events is never easy, and it must be done with skill and tact. (VHA Directive, 2005)

The disclosure and apology program at the VAMC is a program designed to promote ethical action by physicians and hospital administrators in the event of a medical mistake. As indicated by the justification directive of the program, the disclosure and apology program is designed to embody the core values of the VA health care system, emphasizing the continuing health relationship with the patient. The core values of trust, respect, excellence, commitment, and compassion, although not mutually exclusive to the ways in which VA health care practitioners practice medicine, emphasize VA health care practitioners’ dedication to the veteran. Moreover, these values are congruent with the overall values of the Veterans Administration and the Department of Defense, which emphasize excellence, respect, and commitment.

The VA health care system, situated within the larger government institutions of the Veterans Affairs Office and the Department of Defense, represents Weber’s (1946) conceptualization of the modern day bureaucracy. Weber’s bureaucracy generally contains six elements: a clear hierarchical system of authority, division of labor according to specialization, a complete system of rules regarding the rights, responsibilities, and duties of all personnel, exhaustive procedures for work performance, impersonality in human organizational relationships, and selection and promotion based solely on technical competence. The emphasis in the bureaucracy is on categorization and clear organization (Merton, 1957). Moreover, the generality and categorization of the rules in a bureaucracy requires constant vigilance because, although bureaucratic organizing
focuses on generality and categorization, each case or organizational problem is considered on an individual basis. The rules and norms of the bureaucracy are specific enough to apply to individual cases, but vague enough to leave room for some interpretation (Merton, 1957).

Individuals in the bureaucracy are governed primarily by rational-legal authority, which is the presentation and use of power based on rational application of rules developed through a reliance on information and expertise (Miller, 1999). In the bureaucracy, power rests not with the individual, but in the expertise and rationality that governs through a system of rules and norms.

Every single bearer of powers of command is legitimated by the system of rational norms, and his [sic] power is legitimate insofar as it corresponds with the norm. Obedience is thus given to the norms rather than to the person. (Weber, 1968, p. 954)

In essence, 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. Domination, then, exists in and through knowledge and the control of knowledge. Likewise, discourses are bureaucratically organized and understood by individuals in the organization (Philips, 1987). Discourses in a bureaucratic organization will also be structured in a bureaucratic fashion, highlighting the structuring of authority, rules, and responsibilities of all individuals in an organization. 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).
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. It is in the spaces where discourses, norms, and power relations intersect where scholars can begin to explore how the duality of structure, agency and structures, are (re)produced or challenged (Giddens, 1979, 1984). For Giddens (1979, 1984), duality of structures are enacted and embodied differently depending on the structural form of an organization. By focusing on how individuals make sense of organizational meanings and normative sanction, we can see duality of structure in action (Giddens, 1984). In order to explore how an organization makes sense of issues of control and agency, we must focus on three key aspects of the organization: signification, domination, and legitimation. 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).

The disclosure and apology program at the VAMC is situated within the larger VA health care system. The VA health care system is a bureaucratically organized system, based largely on the organization of the military. The organizational structure of the VA health care system is that of a “silo” hierarchy. My key organizational informant, Debra, explains the underpinnings of the “silo” hierarchy.

The silo hierarchy is designed to establish a chain of command (very military like). In the silo hierarchy system, an individual who has a complaint, a problem, or just a question about work, has to follow the chain of command up, over, and then back down to the appropriate person. In the silo hierarchy, an individual cannot break the chain and go directly to the head individual. So, for example, if a
nurse manager has a concern, the nurse manager cannot directly go to the chief of the department or to the Chief of Staff, even though their offices are located next to each other. Debra explained that the silo hierarchy is the “pure, military bureaucracy.” (fieldnotes)

In Debra’s explanation of the “silo” hierarchy, an individual must go through the chain of command, filing forms and following protocol. The “silo” hierarchy represents bureaucracy at its finest. Interestingly, the VA health care system is attempting to phase out the “silo” hierarchy, implementing a new system called the “service line” system. The service line system still has a chain of command, “it is still the military after all,” said Debra, but it removes the need for middle management. This transition from the “silo” hierarchy to the “service line” system is designed to be more patient-centered and is in-line with the VA health care system’s desire to enact patient-centered care. More importantly, the “service line” system attempts to cluster leadership into a small group, creating a “vacuum in leadership.” Understanding the bureaucratic way in which the VA health care system is organized is key to understanding the ways in which the disclosure and apology program is organized and enacted at the VAMC.

The bureaucratic organizational nature of the VA health care system is also important in terms of understanding how the VAMC deals with medical malpractice. Because the VAMC is a part of the VA health care system, which is a governmental entity, VAMC physicians are protected from legal action as a result of a medical mistake. Unlike private hospitals’ approach of naming individual physicians in a suit, VAMC physicians, like all VA physicians, are protected under the umbrella of the government. As Gina, one of the co-creators, explained during a “crash course” of the governmental
legal system, the Federal Torts Claim Act of 1946 says that an individual who wishes to sue someone in the government must sue the entire government (fieldnotes). This means that VA physicians are not named directly in a lawsuit. This, however, does not protect VA physicians from being reported to the national tort databank (which is explained in detail in a later theme).

Moreover, all VA physicians have an additional layer of protection through their medical malpractice insurance, which is paid by the government, and is not affected by private insurance premium rate increases. This does not mean, however, that VAMC physicians do not deal with these “outside” forces. Many of the VAMC physicians that were interviewed, and many of the VAMC physicians that practice at the VAMC, also practice at the university hospital that is connected to VAMC by a tunnel. The main reason that many of the physicians pull “double duty” is because the VAMC, in conjunction with the university hospital, is a teaching hospital. All of the protection VAMC physicians have at the VAMC vanishes when they cross over into the university hospital. Moreover, the university hospital does not have a disclosure and apology program. Instead, the university hospital has a traditional adverse event policy, which requires silence and denial from physicians. This means that many of the VAMC physicians still have to pay private malpractice insurance and negotiate the different ways in the university hospital approaches medical mistakes.

The disclosure and apology program at the VAMC represents the bureaucratic organizational structuring inherent in the militaristic structures of the VA and Department of Defense. The program bureaucratizes the medical mistake experience, making clear what was once dim and hidden. The program is designed to break down the mystery
traditionally associated with medical mistakes by creating a clear and organized policy that designates rules and authority. In fact, “the very identification of acts or of aspects of interaction— their accurate description, as grounded hermeneutically in the capacity of an observer to ‘go on’ in a form of life--implies the interlacing of meaning, normative elements, and power” (Giddens, 1984, pp.28-29). The disclosure and apology program bureaucratizes the medical mistake experience by interlacing medical mistake, disclosure, and apology meaning, normative elements of the VA, and the “silo” hierarchical power structure. Relying on the co-creators, chief apologizers, and policy discourse surrounding the bureaucratization of the program, this theme explores how signification is accomplished through narrative sense-making, how domination is accomplished through bureaucratic organizing, and how legitimation is accomplished through ideological norming.

**Signification Through Narrative Sense-Making**

Signification is concerned with how individuals in the organization make sense of the discourses and communicative meanings behind organizational actions (Giddens, 1984). Exploring signification focuses on the discourse of the policy as well as how stakeholders make sense of the policy. A main component of understanding how signification is embodied and enacted by VAMC stakeholders is appreciating the role of accountability in the sense-making process. In signification, there is a desire for accountability. “To be ‘accountable’ for one’s activities is both to explicate the reasons for them and to supply the normative grounds whereby they may be ‘justified’” (Giddens, 1984, p. 30). The sense-making that occurs as a result of exploring discourses serves as an attempt to justify maintenance or changes in the organization. The VAMC
stakeholders, particularly the co-creators and the Chief of Staff, use narratives to make sense of and justify the program.

*Sense-making through narrative genesis.* Signification occurs first through the stakeholders’ discussions of the genesis of the program. 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. These genesis narratives serve as a way to mobilize the co-creators to take action and create the program. The program was a result of two major medical mistake cases. The first case serves as the major justification for the program. All three program co-creators were involved with the first medical mistake case, and although their tellings provide different perspectives and layers of the story, each highlight the ways in which they see this case as the genesis and reason for the program. Patricia is the co-creator who first identified the mistake. She tells the narrative of how she discovered the mistake.

What I do normally is mortality, 100 percent mortality review. In the course of a mortality review, one day, one of the other nurses was looking at a chart and she said, will you look at this? And I said, okay, and I looked at it and I said, this can’t be what it looks like. Because what it looked like was that we had ordered an IV infusion of potassium. Do you know what I am talking about when I say that? For an alcoholic female who was here getting what we call rally packs. She was dehydrated, she was malnourished, 52 or 53. What should happen is over the course of a few hours, you decrease the amount of IV fluids. You decrease the amount of electrolyte replacement. What had happened with that lady was that didn’t happen. She was also on telemetry because alcohol withdraw is a potentially life-threatening event. We went and pulled the telemetry record and
we pulled the, she was also on a 24 Halter monitor, event recorder. So, we went
and pulled the results from that, and what we thought we saw was documented on
both telemetry and the 24 Halter, and that is that those EKGs showed changes in
her heart rhythm related to an overdose of potassium. So, we took them to Dr.
Pope, who was the Chief of Staff at that time.

Patricia’s beginning of the genesis narrative highlights the bureaucratic organization that
undergirds the VAMC program. Patricia’s narrative shows how the bureaucratic element
of division of labor identified a major mistake.

Moreover, her narrative shines light on how she, as a co-creator, begins the
justification and need for a different way of identifying and dealing with mistakes. 100
percent mortality reviews are case reviews of every death that happens in a year. The
purpose of the 100 percent mortality review is to be able to quantify reasons for death
(natural death, mistakes, accidents, etc.). 100 percent mortality reviews are not a common
approach to dealing with medical mistake. In fact, the 100 percent mortality review is one
of the reasons that the VAMC is known for its approach to patient safety (fieldnotes).
Patricia’s story highlights how, even before the program was created, the VAMC
approached medical mistakes differently. Patricia continues with her recounting of the
genesis narrative.

As we [Patricia and Dr. Pope] talked about it, part of this timeline was this lady
had, I can’t remember, two or three daughters. She’d been estranged for 20 years
because of her alcohol abuse. One of the daughters was in California, one was in a
far off, somewhere else. We spent, you know, in retrospect, it seems like it was an
awful long time, discussing what you do with this. But really it probably wasn’t.
It was one meeting. And we said, okay, ethically we have an obligation to notify the patient that a medical error has occurred. In this case, we can’t notify the patient because she’s dead. That does obviate our obligation to the patient, which now falls to her family. So, we tracked her daughters down, called them and said, you know, we have some pretty serious issues about her care while she was in the hospital and we need to discuss them. They both came in, although they hadn’t seen her in 20 years, had no contact with her. And that was the point where we had to figure out, okay, how do we do this? This is going to be really bad. Up the line people are going to get really pissed because we are going to admit liability for a medical error that’s going to cost the federal government money. But, we aren’t asking permission to do it. We are going to do it because it’s the right thing to do. We all know that. So, there was never a discussion of not doing; only how would we do it.

In this recounting of the genesis narrative, Patricia focuses on the justification for the program. She highlights the need for accountability, not only for the mistake, but for the fact that the mistake was not noticed when it happened. She also expresses the anxiety associated with knowing that the program was resisting the VAMC’s traditional approach to medical mistakes. Patricia’s narrative shines a light on the clear hierarchical system of authority in the VAMC and the potential danger in challenging the system.

Patricia was the co-creator who discovered the initial mistake as a direct result of the bureaucratic organization of the VAMC. Patricia was, and still is, the VAMC Chief Quality Improvement (QI) Officer. As the Chief QI Officer, it is her job to conduct the 100 mortality review. The clear hierarchical system of authority identified the mistake
and guided Patricia to the next individual in the “silo” hierarchy to whom the mistake needed to be reported: the Chief of Staff. At the time of the mistake, Dr. Pope, one of the co-creators, was Chief of Staff. Once Dr. Pope was apprised of the situation, Patricia and Dr. Pope sat down with Gina, the head of the legal department at the VAMC. Gina reflects on her understanding of the genesis case as well as her role in the mistake narrative.

And, a case came across our table that was a death of a woman who was single, estranged from her two daughters, and she had died directly as a result of a failure to appreciate the continuation of a potassium drip that should have been discontinued. She was on a Halter monitor when it happened. It was all, you could see it. It was documented by her own Halter monitor and it was certainly clear that she had received enough potassium to kill her. So, the issue was, what do we do with this? There were a lot of tears. The daughters, we required them to come, we told them, no, we want you to come in to talk to you about our mother. They came, they had a lawyer. We suggested that. We always suggest people have a lawyer if they want one because we don’t want to be seen as overreaching.

Everybody had a big round-table discussion. We had the case resolved for under $100,000 in months, 3 months. Gina’s retelling of the genesis narrative recounts not only her role but again highlights the justification and accountability associated with the mistake. Both Gina and Patricia ask a similar question: What do we do with this knowledge? It is this question that propelled the narrative forward. Although neither Patricia, Dr. Pope, nor Gina were directly involved in the mistake, Patricia and Gina’s reflections highlight a need to explain and
rectify the mistake. It is clear through the narrative retelling of the genesis narrative how Patricia and Gina made sense of the mistake as well as the discussion of what to do about the mistake. The two different recounts of the genesis narrative underscore how the co-creators make sense of the program by questioning the traditional master narrative of medical mistakes.

The retellings of the genesis narrative also emphasizes how medical mistakes are a co-owned experience. The medical mistake is not solely owned by the patient, nor it is completely owned by the physician. Instead, the medical mistake is co-owned by many different individuals in the organization. Narratively retelling mistakes as a co-owned experience helped to re-envision the traditional narrative of medical mistakes. Likewise, “it was the right thing to do” as the recurring justification associated with the genesis narrative also serves as a re-envisioning of traditional approaches to medical mistakes because it emphasizes the challenge to the traditional organizational structuring of medical mistakes as well as the challenge to administrative ideological underpinnings of mistakes. In terms of the organizational structuring of mistakes, Dr. Pope, one of the co-creators, explains how the potassium overdose case forced some of the hospital administrators to rethink the hospital’s approach to medical mistakes.

We said, you know, how does a reasonable honest person deal with something like this because we didn’t have any other guidance, and we didn’t want to try to, we had to look at it from their point of view. 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. And then, we had already decided that an apology without an offer to try to make things right wasn’t a real apology. And
Gina did that. And within, I forget exactly how long, a few weeks, we settled on a reasonable amount that was paid and that was it. It seemed like such, it worked so well, it seemed so obvious, that we just made that, that was our way of doing business from then on. We just invented as it went. There’s nothing new about it, that’s the way most decent people deal with accidents in real life.

Dr. Pope’s comment calls attention to the ideological underpinning of the program: “the right thing to do.” For Dr. Pope, disclosing and apologizing to the family for the mistake appeared to be the best decision, regardless of whether the other hospital administrators agreed with the decision. This ideological underpinning is the start of the bureaucratization of the medical mistake experience because the program attempts to bring to light what was once invisible or silenced.

*Need for different approach.* Re-envisioning the medical mistake master narrative means that individuals in the VAMC stakeholders have to learn a different way to approach the medical mistake experience. Learning a new way to approach mistakes means beginning to rethink not only the ideological underpinnings of medical mistake experiences but also to rethink what organizational strategies need to be implemented. Like Dr. Pope, Patricia also reflects on how the case made her re-evaluate her approach to medical mistakes.

It’s just learning to do things in a different kind of way. So, we took that result to him [Dr. Pope]. Well, I should say the first thing that we did, and I think part of our success has been that it’s not a telling, tattling, gotta ya kind of thing, because I had a relationship in this other way from teaching and mentoring on the other side. I could go to the resident and say, did you know this? And we need to talk to
Dr. Pope about this. It doesn’t fit any of my screening criteria, I’m not sure what we do, but he will know. And, you need to know before I talk to him, and do you want to go with me to talk to him or do you want him to just call you? How do you want to do this? She knew all about. And she said, I was just afraid to tell anybody.

Patricia’s comment calls attention to many of the more traditional approaches to mistakes: silence and fear of admitting that a mistake was made. Co-creators, such as Patricia, point out that one of the goals of the program was so they could change the mentality associated with mistakes. In order to accomplish this new ideological approach to mistake, the new program forced the co-creators to rethink how they organizationally approached medical mistakes. Gina explains how the group came together immediately in order to deal with the case.

Then we met, risk management, at that point in time, we were meeting every Friday, I think, but he called an emergency ad hoc get together kind of meeting. We need to talk about this. And we did, what at that time was called a focus review. Focus reviews are not covered under confidentiality statutes and they weren’t at that time either. So, we did what is called a focus review, which means we went through and did an excruciatingly detailed time line of events, including what electrolytes were in the IV, went through and did notations from the 24 Halter. We talked to the resident and said, okay, what happened here? Did you know about this? What happened then? It’s a whole lot like doing a legal deposition, except it’s not on tape and it’s for us to figure out what’s going on. So, once we had that all down, we all set down at the table and said okay, we have an
unexpected death caused by a medical error. That was the first time that we knew we had something.

Gina’s comment focuses on the “a ha” moment that the group encountered when they discovered that they had a mistake and then had to decide what to do about the mistake. Gina’s comment shows how the creation of the program was truly an organic creation.

This does not mean, however, that the program was not grounded in the bureaucracy of the VAMC. As Dr. Pope points out below, the hospital had already begun to incorporate patient safety issues into the bureaucratic structure of the VAMC. The co-creators used this as a foothold for the program.

As part of my responsibilities [as Chief of Staff], I was responsible for quality assurance and risk management. We didn’t have any kind of risk management program at all. Up until that point, the only way the hospital found out about medical errors unless it was obvious was if someone would sue. That’s when they would find out about it. The statute of limitations was 2 years in the federal government, usually that would happen usually around 2 years after the fact. At that point, people had left, it’s a training hospital, so people come and go. Other people, you know, had bad memories about what happened, records were all over the place, so it was really hard to defend the hospital. So, we just set up a system that we would find out. It involved Patricia and other quality assurance nurses, who would go through charts, find things that had happened, investigate and see whether there had been a violation in the standard of care. We also got, if anyone asked for their medical records, we would be contacted, to be told that, so that someone could go down and take a look at the medical records and see whether
there was a problem. If we thought there was, we would interview people and try to do this while memories were still fresh. The idea at that point was that we would put a dossier together early in the course of an incident and file it away so that if we were sued, we could have some contemporaneous records that we could use to defend ourselves. We never really thought beyond that.

Dr. Pope’s comment accentuates the lived moment of the creation of the program. Even in the retellings of the genesis narrative, the sense of urgency and the unknown is ever-present. The organic nature of the program, born from a sense of urgency and a desire to do the “right thing” was still situated in the bureaucracy of the hospital system.

Interestingly, at no time during the interviews did any of the co-creators mention the second case that further cemented the program at VAMC. All three of the program creators recognize the potassium overdose narrative as the genesis for the program. The second case was a surgical case gone wrong. During a break from deposition interviews of a current potential medical mistake case, Gina told me about the second big medical mistake case.

The second case involved a heart patient who was having surgery to repair a blown heart valve. The cardio-thoracic attending on the case let one of the surgical residents close the tear in the heart valve and close the patient’s chest. Gina couldn’t remember any more about the case, so as she was explaining this to me, she went and pulled the case file. She opened it and read over the brief explanation of the case. Each case file has a brief synopsis of the case. After a moment of reading, Gina told me that the resident did not do the heart valve
stitches tightly enough. The stitches opened and the patient internally bled to death. (fieldnotes)

During Gina’s explanation of the case, she reflected on the fact that this case was not as “clear cut” as the potassium overdose case. Stitches opening post-surgery is a known complication of surgery, mainly because the skin is elastic and may pull against the stitches. The case was more complicated because, although the resident did not sew the stitches tight enough, the elasticity of the skin was a complicating factor.

**Clear definitions.** One of the ways in which the co-creators make sense of the medical mistake experience is by defining the different terminology. As indicated by Gina in her retelling of the second mistakes case, 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, known as VHA Directive 2005-049, bureaucratizes the terminology of the program by clearing 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 VHA facility” (VHA Directive, 2005, p. 2).

The defining the terminology serves as one of the first major ways in which the program is bureaucratized. Likewise, the policy provides a clear definition of what adverse events warrant initial disclosures to families. The inclusion of what bad outcomes may result in a disclosure further bureaucratizes the medical mistake experience by shining a light on what actions physicians can expect to be involved in a disclosure. 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.

Interestingly, the definition never uses the language of “mistakes” or “errors.” Rather, the policy calls for an adverse event to be reported. In the case of the policy, an adverse event includes mistakes or known complications. Mistake language is included in the definition; iatrogenic injury is the medical-legal terminology for a medical mistake. The policy bureaucratizes medical mistake experiences by bureaucratizing any bad outcomes or adverse events. For example, Dr. Kendallee, a 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, may have gotten a little stretch from the surgeon, but those types of things happen without an error, without necessary there being any type of medical error. You can have a bad outcome. And that’s one of the frustration with medicine is that malpractice decisions are typically based on outcomes, not on whether or not there was an error made.

With the disclosure and apology program policy, VAMC physicians no longer have to question whether or not the bad outcome is a mistake and report it to the program.

Instead, the policy is written specifically to compel physicians to report all bad outcomes. This ensures that not only does the program learn about and from mistakes, but they also learn about and from all bad outcomes. This establishes a clear and complete system of rules and responsibilities of the physician regarding medical mistakes.
Domination Through Bureaucratic Organizing

An important element of bureaucracy is that of control and authority. In order to implement and maintain a change to a system, individuals in the organization have to exert power in order to change the system. Domination relies upon the mobilization of two different kinds of resources, or forms of power: allocative and authoritative resources. Allocative resources refer to the ability of individuals to mobilize material and corporeal resources needed to make changes: money, materials, people. Conversely, authoritative resources are concerned with the ability to convince individuals to symbolically make a change (Giddens, 1984). The institution of the disclosure and apology program at the VAMC relies solely on authoritative resources, but has allocative consequences. The program was instituted solely through the discursive practices of the three co-creators. Unintentionally, the enactment of disclosure and apology resulted in the saving of the amount of money that the hospital had to pay in the form of settlements and legal fees.

Like the VA health care system, the disclosure and apology program is also structured in a bureaucratic fashion. It is through this bureaucratic structuring that the individuals involved in the disclosure and apology program, the three co-creators and all Chiefs of Staff, enact domination in the program. Domination occurs through the gaining and sharing of knowledge regarding medical mistakes. Domination is exerted through the program by breaking down the mystery of mistakes and disclosure by creating a clear explanation of closures and disclosure and the disclosure process, by placing authority
with those on the “frontlines” of health care, and finally, by providing assistance to patients and families.

*Breaking down mystery.* The program first demonstrates domination by breaking down the mystery of mistakes, disclosures, and apology. In order to institute this program in the already bureaucratized VA system, the co-creators had to create a clear review process as well as a clear disclosure policy. The policy explaining the program is designed to break down the mystery associated with the medical mistake experience. The organizational guidelines of the policy are very bureaucratic in nature by creating an exhaustive list of rules for the disclosure and apology process. The first organizational task in the policy is for the physician to disclose to the patient or family right after the bad outcome. This organizational task, called the clinical disclosure, is an informal process that provides factual information to the patient or family. As a former Chief of Staff, Dr. Campbell, an anesthesiology attending, explains how clinical disclosure is enacted.

Per policy, and I didn’t get directly involved in this, when a potential medical error occurs, the physician or other health care deliverer involved does what is called clinical disclosure. And that is very simple. 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, and I’m pretty sure it happens most, if not all the time, 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. So, basically, acknowledge that a problem has occurred. We
don’t acknowledge that it is our fault or that it’s not our fault. We just say we are looking into it and you will hear back from us.

The clinical disclosure is designed to begin the bureaucratization process by including the patient and family in the medical mistake experience. Although clinical disclosure is meant to include the patient or family, Dr. Campbell’s comment underscores an important tension in clinical discourse: the clinical disclosure does not acknowledge fault. The VAMC maintains control over the medical mistake experience by not acknowledging fault or admitting blame.

Before a bad outcome or adverse event can be officially disclosed to patients, the event has to be thoroughly evaluated. The Chief of Staff explains how the review process makes sense of an adverse event.

What we do is first of all, we go through a fairly extensive review process, just to make sure we know all the facts and that when there are problems noted that we at least have a plan of how we are going to approach those. It comes to a group called the clearinghouse, where we basically conduct a review. And it can be fairly extensive, depending on the circumstances. Some are not. For example, this hasn’t happened since I’ve been here, but say, we leave an instrument in an abdomen. That’s open and shut. That’s an error. There’s not much you have to do except you do have to come up with a plan to not do that again. We do this review.

The Chief of Staff’s comment highlights the call to action inherent in the disclosure and apology program. For the co-creators and Chief of Staff, finding a mistake means taking action to offer compensation and taking action to prevent another mistake. This review,
done by a group called the clearinghouse, is designed to determine if a mistake has been made. 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 Chief of Staff’s comment pointed out an important element of the re-envisioned approach to medical mistakes: identifying all different sides of the mistake experience. The legal staff engages in extensive deposition-like interviews in order to craft a complete picture of the mistake. I witnessed firsthand these deposition-like interviews for an active adverse event case that was later determined to be a medical mistake case.

Upon arrival to the legal office, Gina informed me that today was going to spent doing depositions regarding a morphine overdose case. This case, which occurred in July, looks at whether a nurse is responsible for giving a patient an overdose of morphine or if the machine that administered the morphine malfunctioned. Gina told me that she was going to be interviewing all five of the nurses in the ICU that night as well as the physician who was in charge of the patient’s care. (fieldnotes)

My witnessing of the depositions of an active case allowed me to see how different individuals involved with the same case craft different narratives about the mistake experience. All of these interviews, along with interviews of the family’s experience of the case, and all of the hospital documents regarding this patient make up the discourses of this medical mistake case.

Similarly, the clearinghouse uses all of these different narratives in order to determine if an adverse mistake is a complication or a mistake. The program has two different approaches to adverse events, depending on whether or not an adverse event is a
mistake or complication. The Chief of Staff explains the two different approaches, highlighting the commonalities and divergences amongst the approaches.

We do, we’ve evolved into two different sorts of things that we do. One is disclosure, and that’s when the error occurs. The other is closure, when we’ve looked and done an investigation and can’t find any errors or deviations from standard. But, the family or the patient needs to have an apology from us that, I’m so sorry, Mr. Smith, that the perception that you have of what we were trying to do for you is not what we were trying to do. Let me explain what we were trying to do, why this happened the way it did. So, they are probably 2 to 1 on the closure, where we do closures and say, you know, we are really so sorry that the whole plan for your care wasn’t clear to you and let me explain that. As for disclosures, probably, I mean, I just ran this report for somebody last year and we had, I think, 22, so this year, I would say more than 20 and less than 50 disclosures.

The analysis required to determine if an adverse event is a mistake or a complication, known as the Swiss cheese analysis, merges the medical and legal realms in which medical mistakes live. If the “holes” match up, then a disclosure is in order. Gina, as head of the legal team, 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, then we participate at that point in the disclosure.
The Swiss cheese analysis highlights the bureaucratic nature of the program because it provides clear rules and instances that require a disclosure.

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. Moreover, the clearinghouse is comprised of administration and physicians or other practicing medical professionals at the VAMC. All of these individuals work together to determine if a medical mistake has occurred. 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 make and enact important decisions in the organization. This is because the bureaucratic organization relies on rational-legal authority, letting the norms of the institution dictate domination. The norms of the organization dictate who gets to make decisions. In the VA system, medical mistake decisions are traditionally handled by upper-level administration. This idea translated over to the disclosure and apology program by turning the important discussion of disclosure and apology over to individuals in positions of administration.

Once it has been determined by the clearinghouse if a mistake or complication has occurred, the Chief of Staff and Gina, the head of the legal department perform the actual disclosure or closure. By this point, all other members of the clearinghouse and medical practitioners involved in the mistake have been systematically eliminated from the process. This elimination highlights the role of control and domination the administration maintains in the process. The Chief of Staff makes an effort to be present at all of the closures and disclosures, and insists on making the disclosures, closures, and apologies
himself. This further reinforces the control of the situation and of the information presented to patients and families. Gina explains how the intimate setting for disclosures and closures work to maintain control by following the rules set forth by the policy.

If he [The Chief of Staff] is making the disclosure, which he does 99 percent of the time, just like Dr. Pope did, then he will usually have Betsy [the paralegal] there, because we write a note, a disclosure note to document what happened. Sometimes we are kind of in the background and sometimes we are up front. It just depends on how serious the matter is. [The Chief of Staff] will often have, as I said, an expert if it’s a case involving, well, we have one recently involving an esophagectomy. So, he an ENT [Ears, Nose, and Throat] surgeon there to answer very specific questions. And what happens is, we gather around the table and he proceeds through, he uses somewhat the breaking bad news format. He first of all states why, why we are all here, introduces everybody, who they are, and what their purpose is. So, it’s clear. It’s not a bunch of shirts sitting around the table with these poor people. He will then go through the clinical occurrence, give all the clinical facts. When he concludes what happened, and he tells what went wrong, he doesn’t name names, just what went wrong. We try not to point fingers. This is a disclosure made by this institution, not because Dr. X screwed up. It’s because the VA 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. Moreover, following the rules of the policy
highlights how individuals adhere to the rational-legal authority, where obedience is given to the norms and rules of the organization.

*Replacing authority.* Domination is further achieved by the program’s ability to pass medical mistake authority 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 hospital legal staff, which are usually housed off-site, or separate from the hospital. The legal staff is only called when a mistake occurs. The disclosure and apology program repositions authority and gives it to individuals on the frontlines of health care. Moreover, the program is designed to break down the “silo” hierarchy by cutting down who is involved in the reporting and disclosing of medical mistakes, instead embracing the “service line” organization. Patricia explains how the program attempts to break down the “silo” hierarchy.

The unexpected benefit is that there is a rather than these 6 degrees of separation, there’s really only one. Because the staff talk to me and I talk to the top management. So, I think that’s one of the biggest benefits and the reason that’s a great benefit is the top management isn’t operating in a vacuum or in isolation, making decisions based on information that think they understand, which they don’t understand.

Along with cutting down the “6 degrees of separation” usually involved in the medical mistake experience, the program is designed to provide information to the management groups who normally make decisions but do not have complete information. By doing this, the program initially places authority with the individuals who provide care and have to deal directly with medical mistakes. In the case of the VAMC program, the program
places authority with the Chief of Staff and Gina. Gina reflects on the how the program renegotiates authority to the Chief of Staff.

You know, at the upper levels of most organizations, in the very top management, the board of director, the Chief of Staff, they don’t have a really good handle on the day-to-day operations of what’s going on in their hospitals. Executive boards, boards of directors, chiefs of staff, directors get reports that go from the staff who perform the work through a person who pulls data to a person who puts the data together to generally then another level who reports the data. So, you’ve got lots of places in between the top management and the people who provide care. Dr. Pope said from the very beginning that one of the unforeseen great things that happened is he knew exactly from the front line staff what was going on every single day in this hospital.

Gina’s final comment truly highlights the intent behind the renegotiation of authority. In the VA system, the Chief of Staff, although an administrative position, is still involved in the medical decision-making and the practicing of medicine at the VA. Per VA policy, all Chiefs of Staff must have active medical licenses, even though they do not have time to practice medicine because of administrative duties. They idea behind this decision is that a Chief of Staff who is making decisions that impact the way physicians practice medicine should have an understanding of what it means to practice medicine (fieldnotes).

Moreover, Gina’s earlier comment about how the point of the disclosure is to point out 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. Dr. Pope reflects on his reasoning behind making the Chief of Staff in charge of the process.

I was involved with most of them. I delivered most of them. It was, we felt that this was so important that it shouldn’t be, it should come from someone high up in the organization. Because it gives in and of itself, that conveys a sense of how important the organization thinks it is. It’s not like I gave it to a clerk or something. It was relegated. I was the highest ranking physician in organization, I was right under the director. So, I did it.

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. This repositioning is key because these individuals control the knowledge of medical mistake experiences. From my observations, I have seen how Gina and the Chief of Staff are actively involved in the process, and thus actively control what knowledge is disclosed and by whom. What is interesting about the repositioning of authority to practitioners of the frontlines is that the physicians are only involved with the clinical disclosure. Physicians are involved in the initial dialogue with patients and families, but are excluded from the institutional disclosure and apology in an attempt to reframe mistakes as an organizational failure.

*Domination through assistance.* Finally, domination is achieved by VAMC stakeholders providing assistance to the patients and families. Domination through assistance means that the VAMC is actively involved in every aspect of the mistake experience, readily providing information whenever a patient or family needs information
or help. Thus the VAMC actively controls the knowledge and information about medical mistakes.

The first way this is accomplished is through the final organizational aspect of the program. At the end of any disclosure, the team offers some form of compensation to the patient or family as a way of “making right” what has been done. Patricia explains how the final act of assistance occurs.

So, in addition to you know we part of the disclosure process is to offer options. You know, here’s what, here are your options for you know either compensation or whatever. We explain about the tort claim process, we explain about the administrative process, which comes before a tort claim. We help them through that. We also help the providers who have a potential report to the national practitioner databank. Any place they ever go for a job, there’s going to be a query to the databank and it’s going to say, X number, $100,000 paid on behalf of XX for X case. And so, they get an opportunity to explain that but also now we help them do a 500 word explanation that will also go with the query from the databank.

Patricia’s comment calls attention to a couple of key aspects of domination through assistance. First, her comment recognizes the need for knowledge in the medical mistake experience. The tort claim process, which is the filing of a claim in federal court, is a difficult process. Even though the VAMC has disclosed and apologized for a mistake does not mean that a patient or family will be satisfied. In some cases, patients and families still file a claim if they feel the answers and compensation offered by the VAMC are not adequate (since 1987, only 3 cases have continued on after the institutional
The VAMC still has control over the knowledge needed to file a claim against the facility. Second, her comment demonstrates the control the program has with physicians by pointing out the assistance they provide when physicians have to file a claim with the national tort databank. Again, the individuals in the program have the knowledge needed to file a report, and thus, have control over the knowledge.

Ultimately, the program demonstrates domination through assistance because, in the face of not providing assistance, the VAMC would still be seen as the villain in the medical mistakes experience. There is, then, a fine line between having control of information and flaunting control of information. Regardless of the “good” intentions of the program and the individuals involved, not every patient or family believes the re-envisioned approach to medical mistakes. The Chief of Staff comments on this fine line between having knowledge and flaunting knowledge.

You want to be respectful. If you make someone mad at this stage of the game, you end up in court over just damages, which is fine. But, it’s still more expensive and people who litigate take away less money because the cost litigation and the attorneys’ fees are more if they go on to court. So, we try to be fair to them by not creating, you know, you never say your lying dog client. You say, your client failed to acknowledge that or your client may have been having some memory issues, because she didn’t say this.

The program attempts to use the multiple forms of knowledge they collect from the clearinghouse to make changes and prevent future mistakes. Individuals involved in the program use the knowledge of future assistance and future prevention as a way to prevent patients and families from framing the VAMC as the villain. Instead, the VAMC gets
reframed as the hero offering help and assistance in the face of tragedy. Gina reflects on how providing assistance ultimately is designed to make the experience less painful for the patient or family.

If there are process improvements or things that he [the Chief of Staff] can tell them that have changed because of what happened, then he explains that. They always want to hear that. Then we conclude with, now, because you lost your three toes as a result of our failure to properly diagnosis your melanoma or whatever, we feel that you are entitled to some compensation. We never want to appear to be “the government” taking advantage.

The VAMC uses knowledge as an authoritative resource in order to implement and garner acceptance of the program. As the above discussion of control illustrates, there is a fine line between having and sharing information and using that information to coerce patients into not filing claims in the federal system. Ultimately, the ways in which the program controls through information and knowledge leads to its acceptance by physicians and administrators.

*Legitimation Through Ideological Norming*

In order for a program or policy to truly be enacted and embraced by an organization, it must be legitimized. The legitimation process is concerned with the norms that reinforce the understanding and sense-making associated with particular discourses (Giddens, 1984). These normative elements center upon the multifaceted relationship between the rights and the obligations “expected” of those participating in the organizational interaction. These rights and obligations are meant to justify each other. 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. Overall, the legitimization of the program requires the multiple stakeholders to embrace the re-envisioned medical mistake grand narrative. The disclosure and apology policy legitimizes the embracing of VA values and ideology as well as instills the multiple stakeholders with the belief that the program has created a “safe space” for stakeholders when dealing with potential medical mistakes. Both of these embodied practices further legitimizes the program at the VAMC.

*Embracing VA values and ideology.* As mentioned at the beginning of the theme, the VAMC disclosure and apology program attempts to foster the VA values of trust, respect, excellence, commitment, and compassion. These values undergird the ideology of the VA: to provide care to those who have dedicated themselves to the country. All of these values are embodied in the program’s desire “to do the right thing.” Patricia explains 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. That’s really the stated goal and the rest of it is how we do that. One of the big goals of the program is to maintain the physician-patient relationship. We have gone away from blaming...Our goal is to do the right thing by the patient, whatever that might be, maintain the relationship between physician and patient, and fix the organizational flaws and infrastructure that allowed all these things to happen at the same time that lead to this. That’s really the goal.
The bureaucratization of the medical mistake experience as a result of the disclosure and apology program attempts to maintain good physician-patient relationship by disclosing mistakes to patients.

This desire to “do the right thing” is predicated on the VA’s desire to foster and maintain healthy relationships between physicians and the VA hospital system. At the VA, the physician-patient relationship is paramount, lining up with the VA’s commitment to individuals who have given a commitment to the country. Dr. Campbell, an anesthesiology attending and former Chief of Staff points out that, “It’s an everyday building good, maintaining good relationships.” In order to build and maintain good relationships, the VA, and by extension, the disclosure and apology program, must build on that relationship in the face of a bad outcome or mistake. Shining a light on mistakes for patients pulls the shroud away from the mystery of medical mistakes. Patricia expounds on the idea of trust as an ideological foundation of the program.

The whole thing is based on trust. It’s just trust. I trust that they want to do the right thing and when bad things happen, they will come and tell me, and they trust that I will not kill them when they do it and that I will try to help them in any way I can when it happens.

This de-shrouding of mistakes helps to build trust between physicians and patients, as Patricia explains. As she indicated above, trust is multifaceted in the medical mistake experience, and thus, is multifaceted in the disclosure and apology program. Again, the overarching emphasis in on “doing the right thing” as a way to demonstrate trust.

Inherent in “doing the right thing” is a moral imperative to “do right” with other humans. This moral imperative is part of the human condition of connecting with
individuals. As Patricia clearly articulates, “If we mess up, we fess up.” The VAMC could easily have continued to enact the traditional approach to medical mistakes. However, the co-creators, as expressed by Gina, felt they had a moral imperative to tell patients and families about mistakes.

And that felt good. We could have very easily never said a word. Nothing would have ever happened because the daughters hadn’t seen their mother in forever. Nobody would have been the wiser. It would have been easy. But, the moral decision was to do the right thing.

Gina’s comment highlights the tension between the obligations and rights that the program attempts to legitimize. 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 legitimimized.

The desire to “do the right thing” also clearly embodies the VAMC’s ideological commitment to patient safety. This ideological commitment is unique to the VAMC because it was one of the first hospitals in the country and the first hospital in VA system to embrace the ideas of patient safety. As Giddens (1984) explained, “Ideology is no a particular ‘type’ of symbolic order or form of discourse. One cannot separate off ‘ideological discourse’ from ‘science,’ for example. ‘Ideology’ refers only those asymmetries of domination which connect signification to the legitimation of sectional interests” (p. 33). An ideological belief relies on the organizational discourses and expressions of domination to legitimate the belief. The VAMC disclosure and apology program serves as a way through which the VA can further the ideological belief of
The Chief of Staff explains how the program serves as a vehicle for the VA’s ideological position on patient safety.

This is all about patient safety. This is decreasing; the whole patient safety movement what we’ve been doing is intended at getting down the number of unintended negative outcomes to an extremely low level. Using as a model, the air travel industry, which has gotten fatalities down to an extremely low level. A level so low it’s almost hard to count them. Now, flying a plane is a little different than taking care of a patient, because it’s a lot more stereotypical [the Chief of Staff was a captain in Air Force]. You are basically doing everything the same way every time in most cases. With patient care, it’s very complicated, but still there is lots that we can do. And we are reporting these incidents, getting critical pathways, using check sheets, and not relying on our memories. But still, if you look at doctors across the board, you will find that most think that it’s their responsibility to remember everything. But, that’s where a lot of these things come into. The first case that I dealt with involved an intern who forgot to check a laboratory and adjust the medication. Just forgot and didn’t do that. And somebody died as a result. The whole patient safety movement is about that and you’ll never achieve it if you hide the errors. That’s what happening when you deal with malpractice by covering everything up. You go to morbidity and morality conferences and you’re not allowed to keep any records because for fear that some lawyer is going to get a hold of it.

As the Chief of Staff’s comments underscore, the traditional approach to medical mistakes is just one such practice that needs to be changed in order to enact patient
safety. The Chief of Staff points out that there are still many elements that inhibit patient safety in the VA system, such as the inability to take notes during morbidity and mortality conferences for fear of records of an active case getting out into the public.

The desire to bureaucratize the medical mistake experience also highlights the impact patient safety may have on physicians. My key informant, Debra, explains 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 (fieldnotes). In terms of medical mistakes, physicians often report feelings of guilt and fear (Christensen, Levinson, & Dunn, 1992; Newman, 1996). Although these feelings are explored in more depth in theme five, 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. Dr. Pope explains how this purpose aligns with patient safety.

Patients were very happy with it. And then, this completely surprised me, the doctors were very happy with it. We started to get more and more people self-reporting errors and I think what happened there was that the normal thing, the normal way, the standard method of taking care of these things is that hospital administration. The insurance company will tell a doctor you don’t talk to anybody about this, you disclose nothing, if somebody tries to contact you, you simply come to us. And, it makes it impossible, doctors already feel very guilty because doctors have, they not so secretly feel that they should be perfect and should never make mistakes. So, when they make a mistake that hurt somebody, or even worse kills somebody, they have a tremendous amount of guilt and they
feel they just failed. If you then, force them to act in a cowardly way, you know, to hide from the consequences of this, they carry this with them forever. Even beyond that, you could get 5, 6 years, the statute of limitations really doesn’t go, and if the patient doesn’t know that something happened, in that case the statute starts when they know, when they find out something happened. So, you could be sued 10 years later or something like that. So, the doctors liked it.

Dr. Pope’s comment underlines the program’s emphasis on accountability. Part of legitimation is a concern that accountability to action is meant to be intentional.

Moreover, Dr. Pope’s comment reflects the multifaceted nature of accountability in the instance of medical mistakes. In the health care setting, multiple parties become accountable for the medical mistake. Because VA physicians are afforded extra protection from the legal consequences of medical mistakes, the hospital administration as well as the government are also actors that must be held accountable for mistakes. Gina also reflects on the intentionality associated with being held accountable for mistakes.

Our intent was simply, if you really want to know what our intent was, we didn’t want to get sued for something that we wouldn’t know about. 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 bite you. We could then handle them in public because we didn’t have to be worried that somebody was going to find out something and sue us; we had already taken care of that. So, we could handle the systems problems, we keep records of them, if someone wanted to see them, fine go ahead. We didn’t have to hide our information at all.
Gina’s comment again draws attention to the aim of the bureaucratization of the medical mistake experience: to shine light on the VAMC’s once obscure and mysterious approach to medical mistakes.

Creating a “safe” space. Several of the co-creators and individuals who have been Chiefs of Staff highlight a tension that rests in the bureaucratization of the medical mistake experience. On one hand, the program attempts to shed light on medical mistake practices once obscured. On the other hand, the program still attempts to maintain some confidentiality for patients and physicians. Both physicians and patients need to be reassured that information regarding cases is going to be kept private. Article 2, Sections 1-3 of the VHA Directive explicitly state where confidentiality lines for both patients and physicians are draw in an attempt to main anonymity. The protection afforded to physicians and patients creates a “safe space” in which to practice disclosure and, ultimately, medicine. Gina explains,

They [VAMC physicians] feel very comfortable in the practice here. And they feel very comfortable that if they do make a mistake that we will work together and deal with it. They aren’t going to have a cloud fear and dread over their head for years. They do report their mistakes. I’ve got one on an e-mail right now.

If VAMC physicians feel safe in the reporting of mistakes, then they are likely to do so. The Chief of Staff echoed a similar sentiment, likening the program to that of safe harbor laws.

Everyone came to our offices to talk because it was a comfort zone. The people on the committee, everybody felt that it was a safe place. You know, you put safe
harbor signs up for children, that was kind of the way that they felt about it. And I think they still do.

The Chief of Staff’s use of the safe harbor law as an analogy highlights the fact that physicians no longer feel fear about disclosing bad outcomes and mistakes nor the shame associated with judgment. The acceptance of the program as a “safe space” aids in the legitimation of the program at the VAMC.

As mentioned earlier in the discussion about the organizational structuring of disclosing bad outcomes, there is a chain of command to whom mistakes are reported. Patricia and Gina are active participants in the disclosure process. Patricia is one of the individuals to whom mistakes are initially reported, as is my informant Debra. This organizational structuring has been legitimized and adopted by the VAMC physicians, as indicated by Patricia’s narrative of a recent mistake that occurred when I was collecting data at the VAMC.

As soon as there is an error, and let me give you an example from August. There was a wrong-site surgery. It wasn’t a big one, it was just that the wrong lesion on a person’s leg was removed. Before they got out of the OR, the surgeon called me and said, okay, here’s what happened. What do we need to do? There are two things, one thing needs to happen as soon as they know that and it’s called clinical disclosure. That is that the surgeon talked to the patient and said, the lesion that I intended to remove is not the lesion I did remove. We are going to go back and this actually happened last week, too. And they called as soon as it happened. Here’s why that happens. The surgeon calls me, the OR nurse manager calls the nursing office, one of the nurses will call Debra because they are still really tight
with Debra. Then, somebody will call the patient safety officer. Four or five of us will get the same report with different parts of that information within ten minutes of each other. What we do is we come together and say, okay, here’s what the surgeon told me. James will say, okay, here’s what the biomed said about it. Nursing office will say, okay, here’s what the nurses think. And then, we say, Debra who called you? And Debra has a different sort of perspective on the whole thing because they call her as a friend and they know that Debra and I have been close for 25 years, 26 years. And then if the surgeon doesn’t call me, Debra will come next door in about 15 minutes and say, did you hear about what happened up there without giving any names up. So, nobody is getting in trouble. The impact of that is, I think, pretty clear, that within 15 minutes of the time that the person or team knows that an error has occurred, we know about it. That’s important because there’s a potential to impact the risk of further harm to the patient and we can help guide them on how to do that. Do the disclosure to the patient that said, okay, and that’s part of the physician-patient relationship. Tell the patient the clinical part of it. You don’t say negligence, that’s a legal term. Malpractice, that’s a legal term. You don’t use those in everyday surgical practice, so don’t use them when you talk to your patients. Throw that out of your vocabulary. Standards of care and practice, those are terms we use in peer review, so don’t use that in the discussion with your patient. Simply state, I meant to take off the lesion there. I took off the lesion there. We need to go back and take off that one.
Patricia’s comment about a wrong-site surgery calls attention to the fact that program has become a norm in the VAMC. Physicians and other medical practitioners have legitimized the program to the extent that the disclosure of bad outcomes and mistakes to patient safety and quality assurance officers have become the normative practice.

VAMC physicians have not only embraced the values of the program, but have also embraced the values and ideology of patient safety. Dr. Patterson, the only physician who admitted in an interview to participating in an institutional disclosure and apology, illustrates how the ideas of being open and honest in medical mistakes influences the ways in which he approaches medicine.

Number one is build a relationship before you start. You shouldn’t just go in and operate. That’s where I think that people who get so busy in their practice and they are just doing a patient and making money, it’s more likely to happen. People will know very quickly if you care about them or if you are just there to kind of rush them along. They will know that and perceive that. I think that’s number one, if they know you care, they give you some leeway. Number two is just prevent them. Number three, if it does happen, explain it honestly, but you need to I think present to the family that, I don’t want to say that you are in control of the situation, but that you know, things, how should I say that? Again, I haven’t been in too many situations where I walk out and the person is dying. Fortunately, I haven’t been there yet. I’m sure it will come, so this prepares me.

Ultimately, the disclosure and apology program is legitimized through the embodiment and enactment of VA values. By doing this, the program co-creators and Chiefs of Staff
have created a “safe space” for patients and physicians when dealing with the uncovering and demystifying of the medical mistake experience.

Summary

The disclosure and apology program just entered its 21st year at the VAMC. The program’s creation, the result of two accidental deaths, attempts to re-envision health care’s traditional medical mistake grand narrative. This visionary program, however, is situated within the larger bureaucratic structure of the VA health care system. Inherently, then, the program is organized in the same bureaucratic fashion in which the rest of the VA system is organized. Exploring the ways in which signification, domination, and legitimation are embodied and enacted by the program highlight the ways in which programs like the disclosure and apology program are accepted and continue to thrive.

This theme explored the ways in which the individuals actively involved with the program’s creation and enactment make sense of the meanings of the multiple program discourses. Moreover, this theme examined the ways in which the program maintains domination through the control and use of knowledge and how the program enforces the values and ideology of the VA health care system. Appreciating the bureaucratization of the disclosure and apology program is central to understanding how physicians make sense of the ideas of apology and the medical mistake experience. As the discussion regarding signification indicates, individuals use the organizational structures provided in order to structure their own knowledge and discourses regarding medical mistakes.
The Right Thing to Do: VAMC Disclosure and Apology Program as (Un)Ethical Action

*Dr. Stevens: I think about that policy sort of like I do about the speed limit. You can post the speed limit, but you can’t make people like it. I have this hope that we will have enough reform on tort caps that hospitals will able to do the right thing. I don’t believe that people don’t want to [do this] right now. But the barriers are what have to be removed. Telling people they have to drive 55 doesn’t mean they will do it.*

The disclosure and apology program, as discussed in theme one, attempts to re-envision the medical mistake grand narrative by creating a space for disclosure of medical mistakes to patients and families as well as provide the VAMC an opportunity to offer an organizational apology for the mistake. This does not mean, however, that everyone in the VAMC makes sense of the disclosure and apology program in the same way, nor does it mean that everyone in the VAMC accepts the new medical mistakes master narrative as told through the disclosure and apology program. Dr. Stevens, a general surgery attending, uses a helpful analogy when reflecting on the disclosure and apology policy. His comment points out the key tension in the existence and acceptance of the policy: having a policy does not mean that everyone in the organization is going to like or follow it. Moreover, his comment highlights a concern that many of the VAMC physicians have: should a policy even exist when disclosure and apology is the “right thing” to do?

The re-envisioning of the medical mistake master narrative from silence to disclosure highlights a restorying of the VAMC organizational narrative as a health care facility. The restorying of the organizational narrative means that the ways in which
individuals story medical mistake experiences has to also be rescripted. The overall tension created by the disclosure and apology program rests at the intersection of the restorying of organizational self and individual self. The collision between the restorying of the organization and the self creates conflict and contradiction as the multiple stakeholders make sense of the program. As discussed in Chapter 1, conflict arises as VAMC physicians struggle with making sense of the practice of apology as a rule of the organization. Conversely, contradiction is born from the tension between how physician and the other stakeholders make sense of the values inherent in the re-envisioning of the medical mistake grand narrative. For the multiple stakeholders in the VAMC, conflict and contradiction arise from the intersecting tension of the storying of the organization and the storying of the self.

The multiple stakeholders at the VAMC have to negotiate the intended and unintended consequences associated with the ethical action of creating a program and policy that mandates disclosure and apology in the face of an adverse event and mistake. This form of organizational collective action of the part of the co-creators ultimately pits the moral aims of the program against the instrumental aims of the policy. Instrumental aims in the form of functional rules can clash with the moral aims of a program (Ashcraft, 2006). In essence, the program creates a tension between the idea of disclosure and apology being an ethical act with the idea of having a policy that mandates the ethical act. The belief that disclosure and apology is ethical and meeting the bureaucratic requirements of the policy collide, forcing the multiple stakeholders to acknowledge the unknown nature of ethical actions in the face of values that some stakeholders cannot control (Nussbaum, 2004).
Although the program was created in 1987 and has been in practice at the VAMC for 21 years, there is still a tension between how VAMC physicians and how the Chief of Staff and program co-creators make sense of the program. The narrative re-envisioning of medical mistakes opens up the space for divergent interpretations and appreciations of the policy. The use of narrative and structuration theories aids in the positioning of the program as one of possibilities, which means that an appreciation of the intended and unintended interpretations and ontological consequences is needed. At the heart of this conflict and contradiction is a question over who has and should have the right and responsibility in changing the medical mistake master narrative. The multiple stakeholders see the policy as the “right thing to do” because of a moral imperative or as the dehumanization of medicine.

**Disclosure and Apology Program as a Moral Imperative**

For some of the multiple stakeholders at the VAMC, the disclosure and apology program serves as the embodiment of a moral imperative in medicine to acknowledge and talk about mistakes. The program serves as the discursive organizational space to not only begin to right the adverse event wrongs at the VAMC, but also as a chance to begin to right the wrongs of the institution of medicine. The co-creators of the VAMC program see the program as an ethical action for patients, physicians, and the hospital. Dr. Pope, one of the co-creators of the program succinctly sums up the program’s moral imperative, saying, “The goals were to fix the damage that the hospital had inadvertently done. To make it right.” Envisioning the disclosure and apology program as a moral imperative for the hospital and the medical institution embodies three different aspects of ethical action: as the human obligation to do the “right thing,” as a way to maintain the patient-physician
relationship, and as a way to counteract the medical institution’s “old way” of approaching medical mistakes.

The human obligation to do the “right thing.” One way in which the multiple stakeholders see the disclosure and apology program as a moral imperative is because they feel they have a human obligation to do the “right thing.” Here, the “right thing” is, when a mistake has been made, to apologize for it. The stakeholders who see the program as a moral imperative see admitting to adverse events and apologizing as an innately human action, one that is taught to us when we are young. Dr. Nelson, a pulmonary attending, explains the humane concept of admitting and apologizing

I think this is the way people are taught to behave in kindergarten. That’s basically what it is. There’s no magic. I know there are companies out there offering training in this. I think that’s silly, because there is a whole cottage industry growing up. You don’t need to be taught. You just simply say, you get together with your lawyer, you get together with your insurance and say, look, this is the way we want to handle things. There is more and more literature now showing that this works because people sue and a lawsuit is very time consuming and deliberating for everybody, including the client. People don’t generally sue for money; they sue because they want answers because they feel that they have been abandoned and they get very angry.

For Dr. Nelson, physicians do not need to be trained on how to disclose and apologize because they have already been taught how to do that. What does need to happen, however, is that physicians and hospitals need to re-envision the medical mistake grand narrative as one of doing the “right thing.” Dr. Nelson also points out another important
aspect of disclosure and apology: answers and information are what patients and families really sue about, not money. Pointing out the patient’s or family’s desire to have answers about the adverse event highlights the humanness of the medical mistake experience, including what happens after the mistake.

Although the program values the idea that humans have an obligation to disclose and apologize for all mistakes, not just medical mistakes, physicians and hospitals have been reluctant to enact programs like this because of barriers to ethical action. Patricia, one of the co-creators, points out that the policy attempts to reframe mistakes and apologies as an ethical issue, not a legal issue, and how that will aid in the embracing of the program as ethical action.

Just like I don’t see a law, nationally, that says when you make an error, you must do this because it is not necessarily a legal issue, so you can’t remedy it with a legal remedy. It is an ethical issue. It is a moral issue that has to have barriers removed to make it easier to do the ethical and right thing.

Even though the co-creators and some of the VAMC physicians see disclosing and apologizing as a moral imperative, the fear of litigation and repercussions (discussed more in detail in a later theme) is still often positioned as more important than doing the “right thing.” The policy acts as a form of protection and helps to rework the logic of whether or not a physician discloses and apologizes. Gina, one of the co-creators explains the logic behind repositioning disclosure and apology as ethical action.

It gives them protection to do it. It says, oh we can do this now because we have to. It’s sort of like, I can’t go to your house because my momma won’t let me when I really didn’t want to go in the first place (laughs). That excuse. Oh prom,
no, going to be out of town with my mom. It legitimizes for them, and it gives them an umbrella of protection. The hospital says we do it, so boy we are going to do it. And so, you know, it’s a very handy thing. It’s always nice to know that somebody is standing behind you with a big old rule book.

Dr. Nelson, Patricia, and Gina’s explanations underscore the program’s desire the embrace the moral obligation that humans have to attempt to and apologize for mistakes. However, as Patricia and Gina point out, there needs to be re-envisioning of the medical mistake narrative as one of a human obligation to do the “right thing” in order to overcome many of the barriers and fears associated with mistakes.

Maintaining the patient-physician relationship. A second element of envisioning the disclosure and apology program as a moral imperative is that for many of the VAMC physicians, the program helps to focus on the medical relationship between patients and physicians. The medical relationship is an important aspect of the program for two reasons. First, by focusing on the relationship, the multiple stakeholders recognize the fact that there are multiple people involved in the medical encounter and the medical mistake experience, not just the physician or the patient. For Patricia, the whole point of the program is to do the right thing because of the physician-patient relationship. She explains how this is the intended goal of the program.

One of the big goals of the program is to maintain the physician-patient relationship. In our first one with Mrs. Smith [the potassium overdose], we recognize that, and this was long before patient safety was cool, that hardly ever, when we started looking and tracking, and say, you know, if they just hadn’t switched over at that particular time, if the nursing shift report were different, if
this hadn’t happened, or if any one of these three instance of all three at the same time. So, we’ve been looking for systems from day one and we apply behavior against the system. Our disclosures are probably 9.9 out of 10 are explanations of systems that failed rather than providers that failed. I think that’s the difference that many organizations don’t see because there is an organizational obligation to provide the tools and the systems and the infrastructure that Dr. Smith and Nurse Jones and Technician Johnson need to do the work. The system is what we are looking for. Our goal is to do the right thing by the patient, whatever that might be, maintain the relationship between physician and patient, and fix the organizational flaws and infrastructure that allowed all these things to happen at the same time that lead to this. That’s really the goal.

Although Patricia underscores the multiple goals of the program, the first two goals focus on the patient and the ongoing relationship between the patient and the physician. Moreover, her comment shines a light on the fact that the medical experience, and by extension the medical mistake experience, is one of co-experience between the patient, physician, and hospital.

The second reason that it is important to consider the medical relationship, and more important for the VAMC, is because the relationship does not end just because a mistake happens. The primary patient at the VAMC is the veteran, and because the veteran receives free health care at the VAMC, they continue to come to the VAMC and, in some cases, see the same physician. A medical mistake at the VAMC does not mean that the medical relationship between patient and physician automatically ends. The Chief of Staff explains the complicated relational nature of medical experiences, focusing on
how the disclosure and apology program is meant to help maintain the physician-patient relationship.

You have a doctor-patient relationship. The doctor screws up and now they make it worse by slamming the door on the patient’s face. This drives people nuts. You don’t do that. If you just say, look, we made a mistake. It may have been a very serious mistake, but we feel bad about it, we are sorry about it. This is what we are going to try to make it right with you, and this is what we are going to do to try to prevent it from ever happening ahead. That’s what people want. And it’s something that the vast majority of people understand. But it took years, and created a lot of bad blood, and it directed a lot of money into the pockets of the attorneys. So, I think it worked here just because, it’s not that it worked here, it’s just that the standard way of doing things had never worked. It was just an illusion. Doctors are taught from the time they are in medical school many patients are litigious and they will sue you if they get an opportunity. None of that is true. Patients want to keep on good terms with their physicians, because if you sue your doctor, you lose your doctor, you lose your hospital, you’ve got to go someplace else. Most people don’t want that. You have to be almost a sociopath to really get into doing that. And very few patients are like that.

The Chief of Staff’s comment stresses the implications and consequences associated with not appreciating the relational nature of the medical experience. Thus, many of the stakeholders, especially physicians, see the relationship as key to seeing the program as a moral imperative. Moreover, the Chief of Staff’s comment highlights the fact that the co-
creators thought about the patient and the physician first when creating the program. The concern was not on the hospital and the pay-out.

For many of the VAMC physicians, the program and policy allows them to engage in complete honesty with patients without having to deal with the ever-present fear of what could happen because of the adverse event, mistake, and the fact that they are talking to the patient. The VAMC physicians who position the program as a moral imperative see the program and policy as a chance to help patients re-envision the medical mistake experience as well. Many of the VAMC physicians, as illustrated by the reflection of Dr. Campbell, an anesthesiology attending, are often frustrated with patients’ inability to see a difference between a medical mistake and a known complication.

The fact that I can be honest does help out. I had an interscaline block, a nerve block, in a 22 year old for a shoulder procedure. He woke up with wrist drop. His wrist didn’t work. He wanted to a CRNA. You know the problem with that, it was performed and he didn’t get the onset of the block for five to ten minutes and then it set up very slowly and he had no nerve problems. They did the surgery. It was probably a combination and more likely it was a stress injury. And so those are where, you know, that was looked at and reviewed. I felt the standard of care was there. I certainly apologized to patient that they had an injury, but do not say that there was an error. The block went as it should and he got a complication. In terms of the performance of the block, it was without error. He simply had a complication. And it happens sometimes. It came back in 7 months, fortunately. This patient, interestingly, told me that he thought that I had done my best and
that I did a good job, but if his radial nerve didn’t come back, he was going to sue me and the Navy.

Positioning the program as a moral imperative helps physicians deal with frustration of patients not understanding differences between mistakes and complications. The openness of the disclosure and apology program gives physicians the opportunity to talk to patients and families about the differences and explain what happened to the patients. This, in turn, can help with the patient-physician relationship because information is no longer hidden from patients. Dr. Tanner, an ophthalmology attending and Chief of Ophthalmology, provides a counter to Dr. Campbell, shining a light on how the program allows physicians to talk about mistakes and complications.

If there is a complication, I try to emphasize to the patient that complication doesn’t necessarily mean that this is malpractice. Complications occurs. Nobody is happy about complications. Certainly the patients themselves are not happy, but we as physicians are not happy about it either. I try to stress that. We feel badly about this occurring, too, but I try to emphasize that, you know, sometimes things can happen beyond our control and it’s not always, a complication is not always a mistake. Things can sometimes, for example, an explosive hemorrhage. That’s a hemorrhaging that occurs in the back of the eye. There are certain patients that may be at higher risk, hypertensive patients or really elderly patients, and that’s not something that you can really prevent. When it occurs it can be very devastating in terms of ultimately the consequences for that patient’s eye. You can, you know, try to represent the fact that you are sorry that this occurred, but in some ways there was no way we could tell that this was going to occur
beforehand. We tried to handle the complication as best we could during the procedure, and now it’s we have to wait to see what’s going to happen. Again, I always try to emphasize that because patients always think that any time there is a complication there must have been a mistake. That is not always the case.

Dr. Tanner’s explanation highlights the communicative challenge associated with just trying to explain the differences between mistakes and complications. More importantly, Dr. Tanner’s comment stresses the underlying human compassion associated with any bad outcome. VAMC physicians feel bad about any adverse event, regardless of whether it is a mistake or a complication. In essence, Dr. Tanner’s comment shows that regardless of how an adverse event is eventually defined, he still feels the same about it. These feelings are helpful because it shows the patient that the physician does care about the care the patient receives as well as care about the patient as a person.

Moreover, the patient-physician relationship is fostered by seeing the program as a moral imperative because the program provides space for dealing with the medical mistake experience and providing chances for closure of the experience. For Dr. Lasher, a urology resident, disclosure and apology provides patients and families with the closure that keeping silent about the mistake prevents from happening.

I apologized. I said, I’m really sorry that, I apologized for any death that occurred in my patients because I didn’t, as I think about those cases and think about the care that I gave those patients, I’m sure it was not perfect, but it was the best I could give them and I couldn’t, I didn’t have to identify something bad that I did wrong to apologize. I apologized because we didn’t get the outcome we had hoped for and I knew how devastating this was for them. And, that we could not
have somehow changed the course of events. I didn’t apologize because I thought I did anything wrong; I apologized because I thought they needed that. They needed that for closure. And they needed to know that we did everything that we could. And that we were really sorry as fellow human beings. We were sorry. It’s important, I think, to say that you are sorry that you couldn’t have changed the course of events. I didn’t do anything wrong, I did what I was trained to do, but it didn’t work out, and we know that sometimes it doesn’t work out. I would say that you don’t have to do something wrong, that you have identified as wrong, or as a failure on your part to apologize. I think humans need the apology and I think it really helps.

Dr. Lasher’s reflection not only draws attention to the fact that patients or families need closure in the medical mistake experience, but also that it provides a chance for Dr. Lasher to say that he did everything possible to save the patient. In a way, positioning the program as a moral imperative provides physicians the opportunity to get closure as well. The traditional approach to medical mistakes is that after the mistake occurs, silence and denial prevails. The medical mistake narrative as a narrative of a mistake, in essence, is cut off and never fully completed. The program fosters narrative closure.

Finally, envisioning the program as a moral imperative helps to foster the patient-physician relationship because physicians no longer have to hide or be silent about the experience. Like providing physicians the chance to have closure of the mistake experience, the program provides space for physicians to be honest and open with patients. The program, in its re-envisioning of the medical mistake grand narrative, brings physicians from out of the shadows and helps patients see that they are not hiding
information. Dr. Ferris, an ambulatory care attending and Chief of Ambulatory Care, sums up this idea, saying, “They [patients] see it as a very favorable thing. They realize something’s gone wrong and if you don’t admit your faults, then they figure you are covering it up.” Just like the frustrations that physicians experience when they cannot explain to patients the differences between mistakes and complications, VAMC physicians are frustrated by the fact that not talking about mistakes forces patients to see them as hiding information about the experience. Dr. Grey, an optometry attending and Chief of Optometry, briefly discusses the frustration of not having physicians explain mistakes.

I think it’s a good idea. I know my brother’s wife was misdiagnosed, and she died. A heart valve problem. And if the doctor had just talked to him and said something, he would have accepted that. But he didn’t. He won’t talk to him.

Dr. Grey’s brief story highlights how many VAMC physicians understand the frustrations that patients experience when information is hidden and physicians remain silent. Interestingly, Dr. Grey’s story is multi-vocal because it reflects the frustration from both the physician’s and the patient’s perspective. Many of the VAMC physicians believe that the both physicians and patients experience the benefits of eliminating silence about mistakes. Dr. Shepherd, a general surgery resident, points out the benefits of being able to talk about mistakes.

They don’t think you are hiding something from them. You did X, Y, and Z, which you said you would do and this is how it happened and you know we did this and she died. So, if they are convinced that you are honestly and openly disclosing what happened, if you apologize for that, for what happened. I had a
colleague who didn’t like to talk to patients and he got sued many times a year, every year in practice. And when you are in a high-risk specialty like cardiac surgery, neurosurgery, transplantation, any organ transplantation, vascular surgery, and some big general surgery cases, you know when they go wrong, people die. So, you are going to get sued, no matter what relationship you have with the family. But, I didn’t get sued very much and I really think it’s because I spent a lot of time with families.

Ultimately, the patient-physician relationship, under the auspices of the disclosure and apology program, is fostered and maintained because physicians no longer have to be silent about the medical mistake experience. In its finest moments, the program encourages open and honest communication about the adverse event, mistake, or complication. For VAMC stakeholders who see the program as a moral imperative, the program is concerned with the patient, the physician, and the care that is provided, not the hospital, which highlights the idea that the program is concerned with the ethical action of apology and disclosure.

*Breaking down the “old” system.* Finally, envisioning the program as a moral imperative helps to continue to break down the traditional approach to the medical mistake grand narrative and reinforce the new master narrative. By positioning the moral imperative as the central tenet of the program, the multiple stakeholders are, in effect, saying that they are privileging a new system that places the individual patient and physician above the hospital’s concern with lawsuits and silence. Maintaining the “old way” of approaching medical mistakes is dangerous, as Patricia points out, because the
old system reinforces silence as well as not talking about the differences between mistakes and complications.

It’s a big mistake. That’s a big mistake. What it does, what that does is cause people to go underground. And there’s always been an underground and as long as that kind of punitive behavior happens, there will always be, because, just because a complication happens doesn’t mean there was an error. People get infections because the appendix ruptured, and it was already infected or because they are diabetics and they are prone to infections or because they are immunocompromised and they are going to get pneumonia when their white count measures at 0.4. So, what pulling huge amounts of data from a big Medicare/Medicaid database does is lump all those together. You can’t separate it. It’s coded as an infection. That’s a mistake. I don’t see it helping at all.

The danger in the old system is that it keeps the traditional approaches of silence and denial inculcated into the medical mistake master narrative. The program at the VMAC attempts to separate and clearly define the terms (as discussed in theme one). Building on Patricia’s comment, Dr. Anderson, one of the VAMC’s two OBGYN attendings, comments on how the program prevents physicians from going “underground” with their approach to medical mistakes in the sense of hiding the mistakes or keeping silent about the experience.

The preferable way is for us as a profession and us as an industry to say that this is right thing to do, we are going to do it. In other words, be your own policeman. And that’s kind of the way that professionals look at things. The preferable alternative is for them to be their own policeman. For example, if I lacerate a
bladder while performing a C-section, it would be very inappropriate to say, I’m sorry Mrs. Smith, I made a terrible mistake. I lacerated your bladder. I need to look into why it happened. I need to look into the issues involved.

Both Patricia and Dr. Anderson highlight key frustrations that physicians have to negotiate with the old program, and the ways in which the program helps to break down the traditions of the old system. The disclosure and apology program is meant to eliminate the old system, including the ways in which hospitals and physicians dealt with mistakes. As part of a moral imperative, the program serves as a way for physicians and hospitals to act in an ethical fashion and not keep silent about mistakes.

Moreover, the program attempts to break down the traditional emotional response to mistakes: fear of admitting to a mistake. In the traditional approach to medical mistakes, physicians are fearful of what will happen if they admit to a mistake. Dr. Earhart, an ambulatory care attending, reflects on how the program attempts to break down the false belief that disclosing and apologizing means admitting guilt.

Well, one, it’s difficult to do because you are in fact admitting that you did wrong. Two is that when you do apologize, and you do it ahead of any court sort of stuff, you are admitting guilt. I think that if you admit guilt, then of course, the court case is over with. So, in this case, we have the opportunity because we have what are called tort claims here, to tell people that we did in fact make mistakes. When we made 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.
The program recognizes the humanness in being able to open and honest with patients. Moreover, the program recognizes the humanness in being able to be open and honest with the self. Dr. Xavier, an ophthalmology resident, points out the benefit of being able to be honest with patients, explaining, “We are in a society at large where everybody assumes fault. I would like a way to do that, because truth is, we are all at fault sometimes, and it’s good to have that breathing room.” Overall, the program embraces the belief that physicians, as humans, have the moral right and obligation to disclose and apologize for mistakes. Talking to patients provides physicians the opportunity to accept the limits of what they can do for a patient as well as provide the therapeutic addition of eliminating fear from the conversation, as Dr. Vaughn, an ophthalmology resident, explains.

I think it’s great. I think it takes away that fear that you are going to be sued that someone is going to take away all you have worked for. It’s somewhat therapeutic, in a confessional type of way, to tell a patient, I made a mistake. I’m sorry. I don’t know, there’s nothing I can do right now to make that better except try to treat your family member and in X, Y, and Z ways. I think it’s nice to have that ability to admit that you are wrong and tell the family.

Positioning the program as a moral imperative highlights the relational nature of the medical experience. Pointing out the relational nature of the program helps to underscore the human desire to do the “right thing” when a mistake happens. The program provides physicians a space to break away from the traditional approach to medical mistakes and promotes open and honest communication with patients.
Disclosure and Apology Program as the Dehumanization of Medicine

Although there is a lot of support for the VAMC amongst the multiple stakeholders, for some of the VAMC physicians, the program represents the dehumanization of medicine. For these physicians, the dehumanization of medicine comes from the tension that exists as a result of a policy that dictates disclosure and apology. For these physicians, it is not the fact that they have the opportunity to apologize that is the problem. The problem is that the hospital had to create a program and policy in order to do it. Moreover, there is a problem with the policy because it gives the power of apology and the power to decide if an apology is needed to administrators, not the physicians. In this interpretation of the policy, dehumanization of medicine occurs in three ways: first, the policy sets the wrong tone about intent of mistakes, second, the policy breaks down the patient-physician relationship by placing responsibility completely on the physician, and finally, the policy takes away professionalism in medicine.

Sets wrong tone. For many of the VAMC physicians, the disclosure and apology program sets the wrong tone for medical mistakes because it inherently positions the mistake as an intentional act in the minds of the patient. For many of the physicians, the policy created a fear that patients were going to see the physician as intentionally making a mistake. Dr. Sampson, a urology attending, reflects on the fact that patients may see the mistake as intentional rather than as an accident.

I think apology sets the tone that I’m sorry I did something to you. And that’s different. I think that changes the dynamic almost in a legal term, almost assumes
intention. And I think that’s wrong in medicine because you know, with very rare exceptions, it’s not an intention.

For Dr. Sampson, the fear that patients or families may see the mistake as intentional directly relates to the legal consequences of mistakes: litigation. Because the medical mistake experience is emotionally charged, Dr. Sampson is concerned that patients may see the mistake as done on purpose. Dr. Sampson went on to explain that part of this fear stems from the fact that, “In the media, people only seem to apologize for mistakes that seem intentional. Almost like they did it on purpose and knew it was wrong.” The cultural expectation of apologizing because of an intentional mistake is also what sets the wrong tone for Dr. Campbell, an anesthesiology attending.

Apologies are, in the appropriate setting, are the appropriate thing. But in an inappropriate setting, they are false. It’s just like hitting the wrong note in a chorus. It’s the wrong thing to do I think. We are supposed to apologize to patients who have awareness under anesthesia. That’s a situation where I would apologize. I would say I did everything I could for you and I apology that you had to experience that because that is a terrible thing. But I have to be able to say that I did everything. Otherwise, you are saying that I’m an idiot and just go ahead and sue me because I shouldn’t have done that. I mean, this country wants apologies. This is a country of apology to me. They want to hear you apologize. This is what I think this is all about. It’s a culture. It’s instead of honesty.

What is important to note is that VAMC physicians who see the program and policy as the dehumanization of medicine do not see apology as a “bad thing.” Rather, they are concerned with what tone the existence and use of a policy sets. For physicians like Drs.
Sampson and Campbell, the concern is that patients see the existence of a policy as a sign that the mistake was an intentional act.

A second key component of how the program sets the wrong tone, for some of the participants, is that the program does not establish, up front, the difference between mistakes and complications. This, then, sets the wrong tone for patients because patients do not learn until later in the process if an adverse event was a complication or a mistake. In order to help patients see the difference, Dr. Burke, an anesthesiology attending and Chief of Anesthesiology, used to give epidural patients a complete list of complications so that they would be informed.

It scared them. That they could seize, they could have brain damage, they could have cerebral hypoxia, they can have compulsions and seizures. Those are the things they didn’t want to hear about. That their hearts could stop and maybe that was because of the way this culture has tried to idolize this pregnancy thing. You know, pregnancy is supposed to be an absolute benign and wonderful adventure. And everybody is just happy and joyous and all that stuff. Well, if you go to a doctor, then it becomes the practice of medicine. Don’t go to a doctor. Go to a midwife, have it at home, whatever you want to do. But, doctors are dangerous. We put stuff in people that can kill you. And we can kill you in a heart beat. I have an issue with apologizing because it sounds like I did something that was wrong. If I throw a brick and break a window, I would apologize. If I hit your car, I will apologize. But, I don’t honestly feel that I have to apologize. I feel like I owe you an explanation, here’s what happened, where’s why, where’s what I did. But I don’t think I owe you an apology.
The logic here is that if the patient knows that a particular adverse event could arise, why should the physician have to apologize? Complications are not the result of “doing something wrong,” but rather are the results of the uncertainty associated with the practice of medicine. Dr. Kee, an anesthesiology resident, echoes Dr. Burke’s concern with apologizing for complications.

As far as apologizing, I’m not sure that apology per say is the appropriate thing. I think that if I’ve explained to you that if you want me to put this needle in you and I’m qualified to do it, and I tell you that there is a possible adverse situation that could occur and it does, what do I have to be sorry for?

Like Dr. Burke and Dr. Kee, many of the physicians had a problem with apologizing for complications. Mass apologies for any and all adverse events creates the wrong tone by suggesting that any deviation from the “perfect” practice of medicine is a mistake. By apologizing for both complications and mistakes (which the policy does), the policy continues to reinforce the belief that physicians should practice medicine perfectly and without error.

Finally, for some VAMC physicians, the policy sets the wrong tone by fostering the bureaucratic organizational structure of the VAMC, VA health care system, and health care in general. The fear here is that by creating a policy, the focus becomes less about patient-centered care and more about getting compliance numbers up. This sets the tone that health care the VAMC, and VA in general, is not concerned with patients but is rather concerned with numbers. Dr. Johnson, a vascular surgery attending, reflects on his concern with the program.
I think it’s hard to create policy for that kind of thing. I think that in order to get compliance or prove compliance it would create another bureaucracy. More hoops to jump through for institutions, and we have enough of that as it is. I’m not sure I support something like that. I would rather see legislation on the other end, limiting settlements, you know, malpractice, tort reform. I think perhaps the two should go hand in hand. You can’t just say that we are going to apologize for the bad we do and not have tort reform at the same time. It just doesn’t make sense.

The bureaucratic nature of the program means that the humanness of medicine gets lost, since one of the main facets of bureaucratic organizing is the fostering of impersonal relationships. More importantly, this perspective fails to acknowledge the moral and legal imperative of apology and disclosure in response to medical mistakes. Interestingly, even Dr. Pope, one of the co-creators is worried that the bureaucratic nature of the policy will set the wrong tone, mainly because some individuals place too much emphasis on the wrong part of the program. As mentioned in theme one, there are three components to an institutional disclosure: disclosure, apology, and compensation. For Dr. Pope, the emphasis on apology is misguided.

It puts the emphasis on the apology, which is where the emphasis shouldn’t be. Of the three aspects of what we do, there’s disclosure, an explanation of what happened, a description of what’s been done to avoid it in the future, and an apology. The apology is the least important. It comes naturally in most cases, but it’s a lot of people have gotten the idea that, they sort of look at this in bits and pieces and think that what it means that if you apologize to the patient then they won’t sue you and that’s it. And, no you can’t do that. There are places that have
gotten into this, but they don’t include compensation. But, if you look at the
compensation, it’s a key part.

Placing emphasis on the apology sets the wrong tone for the program because it means
that patients and families focus on the potential element of wrongdoing and not on how
the hospital is attempting to “right” the medical mistake. The fear of setting the wrong
tone is concerned now not only with the level of intentionally falsely attached to
mistakes, but also with the fostering of impersonality associated with the bureaucratic
organizing of the program.

*Breaking down the patient-physician relationship.* For VAMC physicians who see
the program as a dehumanization of medicine, the policy breaks down the patient-
physician relationship. The patient-physician relationship disintegrates as a result of the
policy’s emphasis on the physician as the person solely responsible for mistakes. Dr.
O’Malley, a general surgery resident, reflects on how in other cases, responsibility and
apologies are not required, saying, “When was the last time a lawyer apologized when
somebody went to the electric chair? When somebody went to jail for 20 to life? I’m
against it, by the way. I think it is absurd.” Interestingly, Dr. O’Malley turns to the legal
community and the outcomes of their decisions to illustrate the disconnect between the
policy and the practice of medicine. Connecting a “bad outcome” in law and in medicine
shows Dr. O’Malley’s concern with the fact that in some cases, apologies are not needed
because a mistake was not made.

This particular concern builds on how the program sets the wrong tone by not
setting a difference between mistakes and complications. Even though the program co-
creators mentioned that many times the disclosures are a result of system failure, not
human failures, for some of the VAMC physicians, the policy places the emphasis of the mistake on physicians, not patients. Dr. Daniels, an ambulatory care resident, reflects on the concern that patients will “lawyer up” and see the mistake as solely the physician’s fault.

And I think if you put too much emphasis on apologizing, you put the question in the patient’s mind, ummm, he goofed up, he screwed up, and maybe I need to get a lawyer. But if you’ve done everything exactly the way you said it would be, which is what I’ve always tried to do, I tell patients this could happen, this could happen, and this could happen, so you still want me to do it? And they say yes, and most of the time it doesn’t happen, I tell them that.

Not separating the treatment of complications and mistakes, which may force patients to get a lawyer because they think that a mistake has happened, means that the patient may be worked out of the patient-physician relationship because the difference is not clear. Providing an apology in the case of a closure and an institutional disclosure means that patients may have a difficult time seeing the difference, creating strain on the relationship.

Ultimately, many of the VAMC physicians are concerned that the program and policy does not appreciate the role of the patient in the medical mistake experience. Here, the concern rests on the fact that the policy does not appreciate what the patient brings to the medical mistake or complication. Dr. Sampson, a urology attending, talks about his concern with the policy and its lack of appreciation for the patient’s role in health care.

Disclosure is fine. I think if there’s a bad outcome or event, they should disclose. I think apology, no. I would fight that. Unless it’s going to be a two-way street.
You are just putting the onus on the physician. I’m not going to touch anybody that is a diabetic, is sick, and weighs 500 pounds because something bad is going to happen. I don’t want to apologize for that. They should apologize for being in that shape when they come to me to have an operation. You know, I think, again, it just assumes that it’s just all my fault. And it’s not necessarily. There are times when it’s not. We used to say, you know, oh patient’s disease. Well, you know what, sometimes it is. So your choice is to either say, well, die with your cancer, I’m not touching you. That’s not very appropriate either. But at the same time, if you are aggressive and disclose ahead of time, and say it’s informed consent, it’s all of these things, you know. Just because they have a bad outcome, you know, if you have a 30 percent risk of something, well, 3 out of 10 people are going to have it. That doesn’t mean that I need to apologize to 30 percent of my patients because they were in that group. Disclosure, absolutely. Disclosure starts the minute you’re going to do something to a patient or treat them. This is what we should do, this is why we are doing it, these are things that can happen. And then disclosure should continue after the treatment. Here’s how it went. This is what we did. It went perfect, just like we thought. Or, you know, it didn’t go like we thought. Disclosure is fine. Apology I am resistant to.

The policy to Dr. Sampson does not appreciate the fact that the patient is an active agent in their health care. Dr. Sampson’s comment also highlights the temporality of disclosure as different from mistakes. Disclosures are the communicative result of mistakes, not the mistake itself. If the program and policy are meant to be patient-centered, then the program has to acknowledge what the patient brings to the operating room or doctor’s
office table. By not doing this, the program and policy just reinforces the traditional belief that the patient is only a body on which to perform medicine. Ultimately, some of VAMC physicians are concerned with the fact that the emphasis on apology and wrongdoing, not on the patient-physician relationship.

**Defining what is (un)professional.** Finally, and perhaps most important for some of the VAMC physicians, the disclosure and apology program dehumanizes medicine by defining what is considered the professional practice of medicine. For many of the VAMC physicians, regardless of how they feel about the policy, the idea of apologizing for mistakes is considered the “right thing” to do. The conflict arises in the fact that many of the physicians do not believe that a policy or law is needed in order to tell them to do what they should already be able to do. Having to mandate or tell physicians what is the ethical way to handle a mistake takes away their professional power in medicine. Dr. Davis, a cardio-thoracic attending, eloquently explains his concern on the policy defining professionalism.

If we have to have policies imposed on us to do what I think is the right thing, I think it’s just makes me feel that as a profession…Why are [we] resisting that? Why do we need policies to make us do that? It’s the right thing to do. I also don’t like hospital administrators telling me that they want a risk manager to accompany me into a room with a patient to make sure that I don’t say something that would put them at a higher legal risk. They also imply when they somebody do that, and this has happened around the country and physicians are going along with it, some of them doesn’t have a choice, that the implication is that our people can’t help you because probably you don’t know how to do it very well. And I
would never go along with that. That is my responsibility. I thought I did do it pretty well because I stayed as long as it took to work through this with families. And frankly, if we need a risk manager or some other professional to come in and do the disclosure for us, I can’t see how that is really going to go better than a physician that was responsibility to do it. It might even increase litigation. You know if somebody else does it, why didn’t the doctor do it? Maybe he doesn’t want to be honest with me. I want some damages from him. So, I have mixed feelings about the policy because it, open disclosures and apologies should happen. They need to happen. If it imposed upon us, could there be unintended consequences? Could people, smart people can figure out ways to twist things and make them work for their benefit. I don’t know as we talk about right now, I’m not sure how all of that would play out. It’s the right thing the do, I’m just sad as a health care professional that that’s what it takes.

Having a policy define professional behavior when it comes to medical mistakes, for Dr. Davis, serves as a way to take away power from him as a physician. Dr. Davis’s comment also harkens to an idea of who has the right to make decisions in the practice of medicine: physicians or administration? For many of the VAMC physicians who see the policy as the dehumanization of medicine, the policy serves as a way to take away medical decision-making.

Additionally, some of the VAMC physicians see the policy as a way to control how they practice medicine. Now, not only does the program take power away from physicians, but it also mandates and controls the ways which physicians interact and have
a relationship with patients. Dr. Reynolds, a general surgery resident, expresses his concern with a policy that tells the physician how to treat and care for patients.

I don’t think a policy is needed on how you deal with an issue with your patients. Period. I’m not going to do that. I’m not going to prostrate myself in front of a patient in abject apology, unless I really screwed up. You know, if I did something really dumb, I would certainly apologize. But that’s like saying that if you lose that tape are you going to come back and apologize to me?

Part of Dr. Reynolds’s concern stems for the mystery associated with the actual enactment of the program. Regardless of his lack of knowledge, Dr. Reynolds’s comment highlights a fear of being told how to practice medicine and handle medical mistakes.

The bureaucratic nature of the program, and the practice of medicine in the VA health care system, inherently sets up an exhaustive set of rules that are controlled by administrators. There is a concern that the policy takes away from the physician’s ability to make decisions in the face of uncertainty. Dr. Patterson, a urology attending and the Chief of Urology, reflects on his concern that the bureaucratic nature of the program constrains his ability to practice medicine and deal with medical mistakes.

I’m always very cautious about a policy or a law that assumes that the government can make a decision for every individual situation. I just don’t think that is a good thing. I’ve seen it. Government medicine has great things about it, but it has a lot of problems, too. One of the beauties of the outside world is there is more of that creativity and more of that, you know, people work harder. The government is an assembly line, one size fits all kind of thing. But, as I said, when
the day is done, we give very good care to our patients. They are pretty happy. At least in urology, I think they are.

Dr. Patterson’s comment about the lack of creativity highlights an interesting concern. The policy further dehumanizes the medical mistake experience because it decreases the amount of creativity that physicians need to deal with the uncertainty and ambiguity of mistakes and medicine. If physicians need to be creative and unconstrained in the face of ambiguity, the bureaucratic nature of the program dehumanizes the medical mistake experience by not providing space for the physician to decide how to handle the mistake.

In a related vein, the policy dehumanizes medicine by unintentionally mandating the emotions associated with the medical mistake experience. Here, the concern is with the fact that the policy, although not explicit, suggests that physicians should feel bad about mistakes and complications. For physicians like Dr. Lovin, an optometry resident, there is a deep concern about the fact that the policy may force physicians to express emotions that are not there. Dr. Lovin explains her take on emotions and the policy.

I think it’s funny that you would have to have a policy to mandate an apology, but having your previous question about why do people find that they don’t have to apologize, I can see why that brings that up. Because maybe there is a lot of lacking in feeling like apologies are needed such that if you mandate an apology, then maybe that could either breed or promote or inspire more sincerity. I’m not sure. It’s hard to think that there’s a policy out there to make you do that because apologies or appreciation that sort of thing is always something that you feel like is more of a heart-felt personality, personal sensitivity type of issue. It’s a professional, not legality, type issue. But, if I think, if apology is warranted, it
would be nice to think that, you know, in an ideal situation, that those in power
would just automatically do one out of a professional level instead of having some
law that says, well, when this happens, you have to issue a formal apology. So, I
guess I should say, for the benefit of the people we serve, apologies are nice. For
the benefit of the medical profession, sounds kind of strange to have a policy to
say that. But then again, I work for the federal government, and we have policies
for everything.

Dr. Lovin’s concern about how the policy could affect how patients see the physician as
being genuine or sincere is an interesting unintended interpretation of the policy.

Connecting apology and the emotions associated with apology and medical
mistakes is certainly an easy connection to make, as Dr. Xavier, an ophthalmology
resident, points out, and has very serious implications for the acceptance of the program.
Dr. Xavier expresses his concern for “legislating empathy” and its impact of the patient-
physician relationship.

Along the same lines and one the same token, legislating empathy, and I would
say this [of a] majority of physicians, there is a desire for that honesty in our
relationships. Most of us in our early years of medicine, idolize the patient-doctor
relationship. You think about the old-timey doctor carrying the bad who knew
everybody in town and they all wanted to come over and have a picnic on Sunday.
You know, that the idolized American version of the doctor, but at the same time,
there’s, it’s not always the experiences of being. So, a lot of physicians get sued
because of that. And then, there’s another sect of physicians that quite honestly
don’t have the ability to empathize and reach that care and cross that line of touch
with patients. It’s not going to change anything. They still aren’t going to be able to communicate with their patient. They still aren’t going to be able to show that level of care to them. They will just give the emotions that they are told to give.

Dr. Xavier’s comment underscores two chief concerns with re-envisioning the medical mistake master narrative. The first concern is for if the policy legislates or mandates the expression of certain kinds of “appropriate” emotions. The second concern focuses on the nostalgic image that physicians and patients see when they think of the patient-physician relationship. For physicians like Dr. Lovin and Dr. Xavier, mandating the “appropriate” emotions or telling physicians how to express the emotions dehumanizes medicine because it takes even more control away from the physician. Now, the program not only tells them how to deal with medical mistake and how to practice medicine, but it also tells them how to feel.

Finally, for some participants, defining what is professional dehumanizes medicine because it reinforces the major problem with the old system: seeing medicine as a form of perfectionism and any mistake as a sign of failure. Dehumanization occurs here because the policy reinforces the traditional belief in medicine that physicians are superhuman and God-like, incapable of making mistakes. The idea of medicine being a “perfect” science still exists. For some VAMC physicians, although the program does attempt to re-envision the medical mistake narrative, it fails to re-envision the larger medical grand narrative of “perfect medicine”. Moreover, for some VAMC physicians, the policy reinforces the societal belief that physicians should not be given any leniency when it comes to mistakes. Dr. Sampson, a urology attending, points out the dangerous
loss of control that can result because the policy does not reframe the idea of perfectionism.

Where does it stop? So, everything short of perfection, I lost 30 cc, not 20. I’m sorry. No difference, but at what point, who defines what perfect is? If we are going to set the goals as being perfect, then you better start paying a million dollars an operation because you know what, it’s going to take that long to get one done. You just, I think that it’s a matter of everybody wants perfect, and that’s part of the way, our problem is health care. We want perfection, we want to best, we want the newest, we want the greatest. But, I don’t want to pay for it and it better be perfect. Now that seems to be, you can’t get that from your plumber or your car mechanic or your store. I’m going to buy that dress, but it had better be perfect, or else I want an apology. Well, maybe it’s all tattered. No. So the stitches are a little crooked. So what? As a society we kind of want to have it both ways, but we aren’t willing to take the downside or do what it takes on the other end. I think that’s probably the resistance. Disclosure is fine. But how do you define it? If the goal is perfection, okay. Go ahead and define that. I think that it should be a part of your professionalism. That it’s understood that that’s what you should do. And if you don’t do that, then that should be a reflection on your lack of professionalism, not something that you’re liable for. If your doctor doesn’t disclose, go to somebody else.

For VAMC physicians like Dr. Sampson, the policy does not attempt to rewrite the idea that physicians and medicine are not perfect. Dr. Sampson’s comment underscores his
desire for a change in the bigger picture of medicine, not just a change in the medical mistake narrative.

This does not mean that Dr. Sampson or any of the other doctors do not appreciate these changes. What it does mean is that some of the physicians see the disclosure and apology program as a problem because it does not address bigger issues in the medical narrative. Dr. Montgomery, a general surgery attending and the Chief of General Surgery, explains through the use of a story about tomato soup, how the program does not address these bigger issues.

It’s nonsense. You can quote me on that. No, I think what, I’ll tell you what’s happening and I kind of hinted at it, I think we are way, way, way off base. I’ll tell a little side story about process versus culture. When I was in Tampa, we had a patient, and I rounded, and I would usually say to the patient, what can we do, is there anything that you need. What can we do to make your stay better, that sort of thing. And he said, well, I’d really like some tomato soup. So, he wants some tomato soup. And I said, fine. So, I turned to the nurse, and I said, well, can we make sure tomorrow that he has some tomato soup? Anyhow, I left for a meeting, and I came back and I was doing rounds again. I said, how are things? He said, how are things? He said, I would like some tomato soup. And it was like, 5 days later. I said to the nurse, well, what happened to the tomato soup. And she said we got it. And I said where is it? And she said, it’s over there. And there were five cans sitting on the windowsill. But you see nobody had stopped (gestures for me to complete the thought)…

H: To open them.
M: Yes! He couldn’t open them himself. But you see, they met the process, but they didn’t meet the culture. So, if you want cans of tomato soup, you can let the government regulate health care. If you want to meet the patient’s needs, you need to teach health care professionals to care about the patient. Do you see what I mean? When you talk about the policy, policies are coming out of the fact that we aren’t doing our job well.

Dr. Montgomery’s comment underscores a need for a complete overhaul of the medical system. As Dr. Montgomery’s comment demonstrates, it is extremely difficulty to make policy changes and enforce those policy changes when what really needs to change is the broader culture (Kirby & Krone, 2002). Without changing the prevailing problem with medicine, as a “perfect” science, the program will continue to dehumanize medicine. Overall, some of the VAMC physicians see the policy as the dehumanization of medicine because it attempts to take away control of the medical experience from physicians and just it to administrators. Moreover, decisions get made by people who are not necessarily on the frontlines of medicine. The dangerous concern that the policy implicitly mandates what emotions are appropriate for the medical mistake experience and how to express them further leads some VAMC physicians to see the program as the dehumanization of medicine.

Summary

The disclosure and apology program at the VAMC attempts to re-envision the medical mistake grand narrative by writing in an alternative approach and ending to the medical mistake experience. The multiple stakeholders at the VAMC see the policy as the “right thing to do” because of a moral imperative or as the dehumanization of medicine.
When seeing the policy as a moral imperative, VAMC stakeholders focused on how the policy enacted the moral obligation humans have to do the “right thing” in cases of mistakes. Moreover, positioning the policy as a moral imperative focuses on the relational nature of medicine by suggesting that the policy fosters the patient-physician relationship while simultaneously attempting to keep the traditional approach of silence out of the new experience. Conversely, VAMC physicians who see the policy as the dehumanization of medicine are concerned with how the policy sets the wrong tone for adverse events by framing them as acts of wrongdoing. This, in turn, creates riffs in the patient-physician relationship. Finally, the dehumanization of medicine attempts to define professionalism for physicians, which some VAMC physicians believe should be defined by physicians.

Although this theme identifies two of the interpretations of the policy, physicians do not set the policy as strictly one or the other. Instead, each interpretation highlights what the physicians see as the important elements of the medical mistake grand narrative and how those elements are enabled or constrained. Moreover, these interpretations reflect a bigger concern with who has the right to mandate apologies and make the decisions about when they should be used. Ultimately, these interpretations reflect a desire by physicians and other stakeholders to decide if disclosure and apology is part of the medical encounter or if it moves beyond the scope of medicine into the administrative and legal realms. Ultimately, both interpretations are concerned with the medical relationship between the patient and physician and the way the medical mistake can impact care.
Dr. Anderson: Oh yes. There’s no question about that. I’ve been very fortunate, as I mentioned, I’ve never been sued. Well, I was actually named in one suit, but working for the federal government you are dropped, and later on the suit was actually thrown out of court. So, I’ve never, and part of that is just luck, I’ve never had any really bad outcomes. It could be ascribed as an error I’ve made.

I’ll tell you one that is kind of a little bit funny. It had no problems at all. It had no problems at all. I can remember when I was a resident and I was working up a patient with very common, she had excess nausea and vomiting related to her pregnancy and I was, it was kind of a routine, not a serious thing. But, it needs treatment. So, I kind of nodded off a little bit and I’ve been writing the orders, and when I woke up I noticed that I’d ordered an MRI for her, which of course was a completely inappropriate test. And, then I’ve done, you know, made the wrong dosage of particular medications. I’ve had complications, I don’t really think they are medical mistakes, but I’ve had complications of deliveries where I probably could have done it better. I’ve broken clavicles during the delivery process, and if you do it just right, you aren’t going to break the clavicle. So probably, my technique was probably not, I couldn’t point to where I did this specific thing, but I suspect that my technique was not as good. So, yeah, I’ve, but I’ve been fortunate that I haven’t had any serious outcomes. But you know, the deal is there is some I think aptitude involved in that, but there is also a great deal of luck.

The practice of medicine, as Dr. Anderson, an OBGYN attending argues, is a mix between technical competence and luck. Physicians have to balance using static medical
knowledge in the face of the uncertainty associated with individual cases. This clinical judgment in medicine attempts to equally privilege the ethical aspects of practicing medicine and the technical competence required to practice (Montgomery, 2006). When presented with medical mistakes, physicians must call upon the ethics of the practice of medicine in order to make sense of the experience. For the physicians in the VA, the old adage of “deny, deny, and defend” has been replaced with a more reflexive approach to mistakes. This reflexive approach forces physicians to critically question technical competency as well as the ways in which to address mistakes.

In essence, this reflexive approach to medicine attempts to connect the epistemological way that physicians learn and the ontological experience of health. “Theories about thinking and methods of knowing do not conflict with the ethics of medicine as a practice. They cannot. The ethics of patient care prevails” (Montgomery, 2006, p. 204). Ultimately, the human experience of health is the primary concern for physicians. The storying of medical experiences, as called on by Charon (2006), asks physicians to pay attention to the narratives that are told in the practice of health, as well as to reflect on these narratives. Physicians must then take this knowledge and act to change the medical landscape. For physicians storying the medical mistake experience, the goal is to learn from past mistakes and attempt to prevent mistakes in the future.

Montgomery (2006) argued that this reflexive approach to medicine is concerned with five elements that attempt to connect human experience and knowledge. The first element is concerned with physicians embracing clinical judgment in response to individual patients. “This is not because they are scientists, but because they are physicians caring for human beings who are ill” (Montgomery, 2006, p. 204). Connected
to this element is the second element of calling for constant examination of knowledge. This second element asks physicians to constantly question and challenge their knowledge base, ensuring that physicians are working with current and reliable knowledge. The third element of ethical practice harkens back to the human nature of medicine and is concerned with creating a health environment that values egalitarian openness. The fourth element of the ethics of practice encourages a commitment to continued learning. Finally, and perhaps most importantly, the ethics of practice readily acknowledges the “human condition that is part of clinical work and not dooming them to think only of dissociated body parts” (Montgomery, 2006, p. 205). Ultimately, the ethics of practice ask physicians to bear witness to the experiences of medicine, through the learning and practice of health (Charon, 2006).

The ethics of practice are concerned with both the successes and failures inherent in the practice of medicine. For the physicians practicing medicine at the VAMC, these elements of ethics of practice manifest in two primary ways in the retelling of medical mistakes. First, physicians narrate the experience so that there is a co-ownership of the medical mistake experience, allowing physicians to bear witness to the fact that there are multiple actors and plots that make up the medical mistake experience. Second, physicians recount the medical mistake experience as one of a learning experience, where they can bear witness to each others’ experiences.

Co-Ownership of Medical Mistake Experiences

Many of the VAMC physicians, in their enactment of the disclosure and apology program, highlight the multiple perspectives necessary to tell the medical mistake story by including the patient and the physician in the narratives. Traditionally, the physician is
silenced by the medical and legal communities, and they are unable to tell their stories. The telling of medical mistakes narratives serves as a way to bear witness to the stories of the physicians as well as the stories of the patients. Moreover, the chance to recount these stories means that physicians have a chance to have the experience legitimized. No longer is the medical mistake experience a sequestered experience.

In the storying of the medical mistake experience, physicians are not silenced in the medical mistake experience, and their voice is included in the multiple layers of the narrative. The physician and the patient are not the only people involved in the mistake experience; often the narrative involves family and other medical personnel. When asked to talk about a medical mistake experience, some of the physicians attempt to show the multiple actors in the medical mistake experience. Dr. Davis, a cardio-thoracic surgery attending, shares the story of a young girl’s death as a result of heart failure. His story spotlights the multiple voices in the medical mistake story.

I remember a case about a young woman who was probably early 20s and had end stage cardiomyopathy. She had a viral cardio myocarditis that ended with congestive heart failure that was basically terminal. Her heart was a big dilated sack that didn’t contract well. She was like 22 years old. So, there was not much to do expect transplant her, and I met her under those circumstances, a dying woman knowing that she had no other alternative. And, we gave her a ray of hope by saying that we think you are a candidate for transplantation. So, we worked her up and evaluated her and decided that she was a candidate. We presented her to the transplant committee and she was approved. And, so she got on the waiting list for a transplant. And over a period of months it was pretty tenuous. The
mortality rate on the transplant list is about 25% a year, so you know, at the end of the year, a quarter of those people are going to be dead because you couldn’t get a heart for them. People are on the list for periods of time. She got a heart. We got a heart after about six months. Transplanted her and coming out of the heart and lung machine, the heart really limped along. So, it was clear that either the heart couldn’t support her circulation or there was something bad with that heart. And you never know. You never know. You are very careful about which hearts you accept and how you harvest them. So, to make a long story short, her heart was just not supporting her and I had to put in heart assist devices, pumps, to augment the output of this transplanted heart. We were doing everything we could do to keep her alive, and then try to get her another heart. And that went on, that was agonizing, it went on for about 3 or 4 months. We couldn’t get another heart for her. I basically lived with this family. And she died. And it was very difficult and hard for them to understand. I tried to help them.

In Dr. Davis’s narrative of his young heart patient, he focuses on the mistake of rushing to give his patient a heart only to find out that the heart was not a good heart. Although the story was from the point of view of Dr. Davis, he did not reduce the patient to pathology or a disease; he talked about the patient as a human being. This repositioning of patients as human beings in the medical mistake experience and giving physicians the change to tell their narratives, shows a commitment to recognizing the human condition in health care.

Narrative represents events of moral importance as embedded in the lives and ongoing concerns of human beings (Hunter, 1991). The ethics of practice is concerned
with recognizing the human connection between patients and physicians. This does not mean, however, that the patient is always situated in a positive way. Dr. Xavier, an ophthalmology resident, illustrates that some physicians do not always put the complete onus of the mistake on oneself.

Mine is of course, I’m the youngest in ophthalmology, so mine is from last year actually when I was just a general medicine intern. It was actually my first night ever on-call as a resident. I was in the intensive care unit at another hospital. I wasn’t there. I have a tendency, or I guess I have a tendency to be the black sheep among residents. I collect the most calls, the most patients. That was true that night. We admitted an overwhelming number, we admitted 12 patients to the intensive care unit in a 20 hour period. I was just smoke coming out of my ears. There was one particular patient, and I had to see all of them. There was an upper level resident working with me and an attending, and I had to see all 12 of these during the night. I came to this one particular patient, a young, 20 something year old, who had had a neck fusion surgery that day. He had a postoperative fever of 102, had some fluid on his lungs. To be honest, my third year resident and my attending had already seen the patient written little brief notes what their theories were, what the patient had. Not in trying to cut corners, but more in trying to just handle the flood that was coming at me, I kind of looked at their notes, and not having a broad differential basis, it was still very early in my intern year, I looked at the patient, tried to figure it out, but I relied on their notes a lot as well. I won’t lie about that. I did. I sat there and wrote my note, tried to figure out what was going on, added a couple of orders. The guy kind of sat there, and they called me
about him a couple of times. He was a very demanding patient, very demanding on nursing staff, very, I want water, I want it now. I want this and that. He got sicker and sicker over the night, to the point where he was on the cusp of being intubated the next morning. I just, you know, it wasn’t that I wanted to blow him off, but I’ll be honest, his demands were frustrating me. It was a completely stressful night for me. It was hard to balance that stress on me as well as care for this patient appropriately. I got frustrated and mad at times during the night because of I want this, I want that. The truth was, a different attending rotated on and saw this patient, and said how in the world could you miss this pneumonia. It was a pneumonia that had just settled and developed post-operatively. Probably for an aspiration in the case, and the attending didn’t say anything about it, the third year didn’t say anything about. But honestly, I shouldn’t have missed any of this. In my mind, there are things that I shouldn’t miss as a first year, second month intern. I felt miserable.

Dr. Xavier’s story also serves another purpose in understanding how the medical mistake narrative privileges multiple voices and layers in a story.

Ultimately, physicians tell these stories because they highlight the unexpected nature of medicine and disruption in care. In the case of medical mistakes, trouble with a capital T could result in death. Dr. Campbell, an anesthesiology attending, reflects on how sometimes the disruption in care is easy to fix.

I’ve had a syringe swap, which is very common in anesthesia, where you grab the wrong the syringe. The vial looks the same. I gave somebody some steroids, which I thought was a reversal agent. The patient didn’t…it was supposed to be a
reversal muscle relaxant. The patient didn’t respond to that, they remained weak, and his muscles continued to be relaxed, he was unable to breathe. I discovered it and whoops. Then I gave him the right medicine. The medicine I gave him is actually used for nausea, so it’s common to give anyway. So, I don’t even remember if I told him because it really wasn’t an inappropriate medicine to give, I didn’t mean to give it, but it was something that would have…maybe it delayed his wake-up by two to three minutes when I figured it out.

Dr. Xavier’s story highlights the need to be constantly present in the medical encounter. Moreover, his story illustrates the need to be aware of the possibility of a mistake.

The unexpected nature of medicine means that sometimes the treatment for a mistake is the cause of the mistake. Dr. Kee, an anesthesiology resident, talks about the odd treatment for a wet tap in patients.

Probably one of the more common mistakes in anesthesia is, actually it has up to new people 5% in experienced providers, I’ve been doing this for 15 years, 12 years post residency, is a wet tap, where you are putting in a epidural and you go slightly too far. Instead of placing it in the epidural space, you end up in the spinal space and get spinal fluid back. I have wet tapped two or three patients who later developed severe spinal headaches, required a blood patch. It’s kind of an interesting treatment. After a day or two, if it’s not getting better, you draw 30 to 40 cc of blood from that patient and do another epidural and give them that blood in their back. I’ve done that three to four times in 12 years. And I’ve apologized to the patient. I’ve let them know that this was an error; it was my mistake. The needle went further than it should have. It does happen and I’m sorry it happened.
to them. The risk is low, but for them, it was 100% and dealt with the consequences. The good news is that the blood patch tends to be 95% plus effective.

Dr. Kee’s story shows the unexpectedness of medicine. As medicine and technology changes, the chance of a mistake happening increases. Additionally, the change in technology means that mistakes can now happen in ways they did not happen before. This creates more of an opportunity for unexpectedness and disruption.

As Dr. Lasher, a urology resident, discusses, the unexpectedness and disruption can create chaos.

There was a patient that we did a laparoscopic nephrectomy. Had a big blown out kidney, we peeled off all of the peritoneum and it was just stuck everywhere. In the course of dissection on the left side, we had just a little tiny tear on the spleen. It was one of these where it happens an awful lot. So, we put a little stuff on it, it looked great, no problem. The guy went home in three days. Did great. Feeling fine, no issues. I said, you know, we had a little of this, a little of that, and we had a little ding and everything was fine. Two weeks later called and said he was straining to have a bowel movement and he felt a pop. So, what ultimately ended up happening is that his spleen has swollen. It’s a rare complication of not taking out a spleen every time you have a little ding. It had swollen and when you pushed and pressed down, it spontaneously ruptured. So, he came in and ended up having to have exploratory surgery and they took out the spleen. He did fine from that and went home. He came back two weeks later, saying, this feels like the same thing. It ended up being a complication from the spleenectomy, he ended up
having a fistula, an abscess in his retra-peritoneum, which ended up being from a fistula from his stomach. So, this a guy who, these were all known complications, and had everything, but yet. I was very honest, I disclosed everything, he came in, I said well, this is what it is. I’ve never heard of one happening, but they can. I didn’t know about spontaneous rupture of the spleen, but it’s something that now coming about because, we aren’t taking spleens out all the time. I guess when you take down these blood vessels, the stomach can get ecstemic. So, each step of the way, he was a 1 percent complication but he just happened to have three of them. Yet, he was okay just because I didn’t apologize. I empathized, I sympathized. But, I didn’t necessarily apologize because there wasn’t anything intentionally that we had done to cause this. It was just a rare circumstance that could happen with that procedure. So, he was fine with that. He was not a malicious individual and we just chatted and chatted. I said you know, (laughs), I don’t know what to tell you. I’m afraid to do anything else. But, it ended up being just fine. He ultimately did well.

The telling of medical mistake narratives, ultimately, serve as a space for reflection and contemplation about the mistake.

The medical mistake narrative calls physicians to recognize when they might not be fully present in a medical moment or when they might not have the knowledge or experience needed. Dr. Johnson, a vascular surgery attending, recalls a recent case where a mistake leads to a patient’s death.

The one that I was referring to is a patient that we did an operation on. It was, I thought it was going to be a fairly difficult operation going into it, and asked one
of my partners to assist, just to have a resident there. The operation, quite frankly, couldn’t have gone better. We just kind of flew right through it, everything went perfect and beautiful. I was just pleased as all get out. And, within four days, the patient was dead. And, the mistake was that, I’m a vascular surgeon, so we put a graft in to revascularize the intestine. The graft thrombosed. There are subtle signs and symptoms and I attributed those to other causes, never thinking that it was a graft problem, until the patient literally crashed in the ICU.

For Dr. Johnson, he simply did not see the problem leading to a patient’s death.

Conversely, Dr. Burke, an anesthesiology attending and Chief of anesthesiology, reflects of how his lack of technical knowledge and skill led to a mistake.

Another time as a junior mid-level resident, I pulled a tube out of a kidney without unlocking the thing and caused a pretty big bleed in the kidney. You know, it was, I don’t even think the patient got a transfusion, but he was in the hospital for a few more days. And that was an example of me not being properly trained to deal with the piece of equipment or something that I should have known.

These types of stories illustrate that mistakes are often not an outcome of vicious behavior of physicians, but rather mistakes in clinical judgment. The Chief of Staff recalls a case that he witnessed early in his medical career. Here, he recounts the mistakes of a “wonderful” obstetrician, highlighting how easy it is, even for the most seasoned physician, to make a mistake.

When I was in an administrative position in the Air Force, we had an oncologist and one of our major teaching hospitals that was in my area of responsibility that
prescribed a chemical point error in chemotherapy for one of their fellow physicians, a cardiologist, and basically killed the person. So, my boss at that time was a line officer, he was not a physician, he was a flyer. A very, very nice fellow, but he basically wanted the physician court marshalled. I told the General, General, you know, we can’t do that. I mean, this was an honest error, and I guarantee you that doctor is beating himself up worse than you and I could ever punish him for doing that. And I knew that because I’d talked with the physician involved. You have to realize that these are process problems. These aren’t people problems. I’ve made errors. He remembered his wife was seeing me for her annual. Well, we are going to stop her seeing you. But he understood the point I was trying to make. So it’s just, you know, that oncologist was a very, very fine oncologist. Wonderful. The best one in the Air Force. But, he just made an error in multiplying.

Another element of the recounting of medical narratives is the focus on the sensational nature of mistakes. Many physicians told stories of mistakes that resulted in death, severe deformity or leaving foreign objects in patients. Dr. O’Malley, a general surgery resident, tells an extremely gruesome story about a patient’s death, highlighting the life or death nature of making a mistake in medicine.

The biggest mistake I can remember making was in a, we had a Korean airliner flight, 747 flight, that crashed in Guam three miles short of the runway. It had a mass casualty situation, 252 passengers and about 31 came to the hospital, which about 22 or 23 survived. I put a central, large Bohr central line in a patient’s groin, meaning to place it. A large sheath catheter in a burn patient, was burned,
and I didn’t know the severity of the burn, and I placed in the artery instead of the vein, which is way too large of a catheter to place in the artery. This would have required a vascular surgeon to repair. This was a mass casualty situation and we only had two operating rooms, but we made it into 4 emergency room bays. When he was further evaluated in the intensive care unit, it was determined that he was 100% burned and not viable. That catheter, they simply used it to transduce his blood pressure. At the time I placed it, there was no pulse, the patient didn’t really have a pulse, but he was still alive. So, again that was certainly an error, but it was an expected patient death, with 100% burns. He probably spoke only Korean, and since he died that night, I couldn’t…I would have apologized to him for the mistake.

The recounting of this narrative serves as a way for Dr. O’Malley to get the chance to apologize to the patient years after the mistake happened. When the patient dies, the physician does not get the opportunity to apologize for mistakes. These types of stories are particularly poignant because, as Dr. O’Malley alludes to, they showcase the human nature of medicine.

The human nature of medicine and the concern for human connection in medicine means that physicians are inclined to draw a line in what it an “acceptable” mistake and what is “unforgivable.” Dr. Haun, a urology resident, illustrates this point when talking about mistakes that are unacceptable.

So, you know, they are more probably more common than people would want to know or think, but when all is said and done, which are the ones that really matter and which are the ones that don’t. There are some little things that don’t matter
and they aren’t issues. But there’s basic things that you should do. I’ll give you a
great example of a resident this morning. We did two cases, but the first one was a
sling procedure for on a female on incontinence. We do those at the VA believe it
or not. We do have some ladies comes in. So, we fixed her incontinence. The
procedure is done through the vagina and the sutures are passed up behind the
pubic bone and tied. So whenever you make that passage, this is a basic step, that
you always look in the bladder after you have done that to make sure the sutures’
passage did not penetrate or perforate the bladder because that’s a preventable
mistake. If you identify that, you fix it. See what I’m saying? You get yourself out
of that trouble. If you don’t, if you fail to do the endoscopy and document that
you looked after you did this, that’s not forgivable. Because that’s just a basic
thing. You check, yep, this is what I think it is, or I take a time-out. Operating on
the wrong leg. You need a time-out. For us, the one that we can get in trouble
with us is the kidney. There is a right and a left. And we always have the X-rays
in the room. I always make it a habit to always look at the X-ray before we cut. Is
this Mr. Jones? Yes, this is Mr. Jones. These are simple things and they are easy
to do. That all being said, some are inexcusable and should not happen. Probably
a lot of little ones but don’t really matter, like did you put four ties in the knot or
three ties in the knot? Or identifying it and correcting it, like the example. Did I
put a hold in the bladder? Or do I see the suture passing through the bladder
where it shouldn’t be? Fine, I will take it out and place it in the correct location.
Those kinds of things.
Dr. Haun’s comment underscores one of the many complexities associated with the medical mistake experience: what is a “preventable” mistake and how much control do physicians really have in the practice of medicine? Many of the medical mistake narratives told by physicians are of mistakes that could have been prevented. For the VAMC physicians, the concern is not whether or not they will make mistakes (they admit they will make mistakes). Rather, the concern is one being present enough in the moment to appreciate the situation. This serves as an answer to Charon’s (2006) call for attention to medical experiences.

Dr. Haun’s comment above also highlight the decision-making process that physicians go through when working through a mistake. By indicating what mistakes are unforgivable, Dr. Haun attempts to justify when mistakes happen. Part of the justification that many of the VAMC physicians engage in is focused on justifying the degree of control they have over the mistake experience. VAMC physicians have to work through and make sense of the mistake experience, which means that they often have to reflect on the amount of control they have in a medical encounter. Other physicians, such as Dr. Campbell, attempt to show how physicians often have to work through decisions.

One here actually we had a very large gentleman. He had a tumor in his kidney. It thrombosed into his vena cava. We were the third institution he had been transferred to because nobody wanted to take care of him. Nobody was willing to tackle this. So, we had a frank discussion with the patient that he was going to die if we didn’t do anything. It grows up and he couldn’t leave the hospital. He was bleeding. Yet, to take it out could be potentially life threatening. So, we had a frank discussion and said, you know, we can take it out, but you might not make it
off the table. He agreed. We did it and it was just an absolute mess. It was the vascular surgeons and ourselves. We scrambled to get the venacava closed. He had tumor thrombosed everywhere. We were just packing sponges. I think we ended up giving him, probably, almost 18, 20 units of blood. He lost almost 6 liters of blood. It was just amazing. But, he got out of the hospital. He left in seven days. Seven days after his operation he went home. On one of his post-op scans, he was a big guy, so it took two scans. We got a new scanner here. We could see that we had left a sponge inside. That was clearly a mistake. It ended up being that we went back, the sponge counts were correct. But obviously they weren’t. That’s clearly a mistake. You feel badly about it, but at the same time, you know the clinical impact on him wasn’t going to be much. He ended having a metastatic disease on follow-up anyway. And that’s was one of those things were it was a mistake, but I don’t know how I feel about those because sometimes, that’s, you know, that’s awful to leave a sponge there. I rather would not have done it. But, where some of these were, we were basically saving his life, packing vessels away, and so forth.

The recounting of this narrative serves as a way to legitimize his decision. Noting that the patient had a terminal illness also serves as a way to justify decisions. Dr. Ferris, an ambulatory care attending and Chief of Ambulatory Care, in his storying of one of his earliest mistake experiences, now reflects on and justifies the attending physician’s decision to not take action to help a patient.

I was the senior medical student on that traumatology rotation and there was a patient, chronic alcoholics at Detroit Receiving hospital, who was bleeding to
death, from esophageal varieses. EV are dilated veins in the wall of the esophagus due to back pressure from the liver that has become completed choriotic from alcoholic hepatitis. And so this pressure on the esophagus erodes the walls of the esophagus and you start bleeding and there is no way to stop it. And, one thing you can do is put down a Latemore tube, which is a long tube, and you can blow up the tube and put pressure against the esophagus to stop the bleeding. And I watched this guy bleed to death right in front of me and I saw the Chief of Surgery, who was the Chief of the service and the residents watch this happen. And I said why aren’t we doing something? And they said, this guy has end-stage EV and we can put this tube down and stop the bleeding, but as soon as we take the tube out, he will start bleeding again. And, all that is an exercise in futility. There is nothing more that we can do for this man. And as a medical student, I couldn’t understand that. And I felt very, when I went home that night, I had trouble sleeping, thinking about that guy dying. This is first death I’ve seen, and we watched him die. How could we do that? I only understood later that it’s far more humane when somebody’s dying and there’s no way you can stop to let them die. And it’s hard to accept that. For physicians like Dr. Ferris, recounting medical mistake experiences serve as a way to make sense and reflect on the mistake. In Dr. Haun’s case, he learned that this case was not a medical mistake, and that there is a difference between a patient dying because a physician could not help the patient and the patient dying as a result of a medical mistake. This reflective representation of the medical mistake experience forces VAMC physicians to engage in the complex and imaginative “filling out” of the experience.
(Charon, 2006). Not only do the physicians provide the plotline and characters of the medical mistake narrative, but they also show the logical explanation and reasoning behind its construction through their reflection.

The narrative representation of the medical mistake experience forces VAMC physicians to appreciate the corporeal nature of medicine. VAMC physicians recognize the mortality of patients and the “realness” of their mistakes. Dr. Shepherd, a general surgery resident, echoes this sentiment, as he reflexively justifies his decision-making. This reflection the human nature of medicine and the fact that these decisions have a life or death impact on patients.

I won’t necessarily call it a mistake but it was probably a judgment, a wrong judgment. I had a patient, I took his bladder out for cancer. And based on the size of his cancer, the location of cancer and everything, I thought, presented all the options to him, and I thought that we would be able to take out part of his bladder, which is called a partial-sustechomy. And we tried it, tried to reconstruct it, and it probably wasn’t the best decision in the operating, because he did die from metastatic cancer 11 months later. That happened pretty, more than you would, probably 40 percent of the time with bladder cancer. The question is, did I make the wrong decision there at that time? Would he still be alive if I had just decided to take his whole bladder out right then and there? Maybe I didn’t make the best judgment based on what we had before. That’s another example. That’s one of those that you could say could go either way. Was his cancer out and spread somewhere else before I ever did his operation of not? So, but I look at how I explained that to the family, because we actually had to go back and take out the
rest of his bladder because his reconstructive wound was leaking. We did that like on a Saturday night. I remember that. Again, I think it’s all about how you present it. And I wouldn’t necessarily call that a mistake. It’s probably a judgment that wasn’t the best judgment at the time. And we corrected the situation and the guy got through it and survived it. But in the long term, was it best cancer outcome for him? I’ll never know.

Dr. Shepherd’s reflection on one of his adverse events again calls attention to the complex and often murky definitions associated with medical mistakes and complications. Did he commit a medical mistake by not taking out the entire bladder? Or was it the outcome of the clinical judgment physicians use in the lived moments of medicine?

Physicians also attempt to justify mistakes in the storying of medical mistakes by highlighting the role of the patient. Some of the human factors, such as age or ability, influence the ways in which physicians make sense of mistakes. In his narrative about cataracts, Dr. Vaughn, an ophthalmology resident, illuminates how he uses these human factors to makes sense of and justify his mistake.

It was my third cataract as, my third case ever done. We were doing a routine cataract, and in our manipulation of the lens, it fell back into the vitreal cavity, which in ophthalmology during cataract surgery, that’s probably one of the worst surgical complications that you can have. So, we were not able to take the cataract out. We had to call the retina team to come over and it took, a cataract takes 20 minutes to an hour, kind of depending on the case. Most of them are like 20 minutes are so. This guy had to have another surgery performed by another
service, the retina specialist. That took about 4 hours. So, all in all, I was in surgery for 5 hours, kicking myself, trying to figure out what I had done wrong. I still to this day don’t really know what happened that caused this lens to be dislocated into the ventrisus. It was probably a bold maneuver inside the eye because I was still a young and inexperienced surgeon. I made one false move and the whole lens went down. The patient ended up doing okay. He kind of had poor visual potential to begin with. So, it wasn’t, we were basically trying to get the cataract out so that more light could be let into the eye. It wasn’t that he was going to be 20/20 anyway. So, that didn’t matter as much. I went down after the case was over, and I just talked to all the family and said, look, I’m so sorry. I didn’t do anything on purpose. We were doing the best we could and this happened and this how we fixed it. This is how we are going to move forward.

As Dr. Campbell and Dr. Shepherd explain above, sometimes the patient influences the mistake. This further makes the medical mistake experience one of co-ownership, because the physician put some of the onus on the patient, as Dr. Bristow, a general surgery attending, does in one of his mistake narratives.

I was putting in an arterial line and I couldn’t find an arterial line. Usually we put it the regular arteries. I put it in the femoral artery of a patient that was having emergency surgery for a belly case. In the case, five hours or so, they took off the drapes, and his foot didn’t have a pulse; it was cold. The vascular surgeons came in and cut down on where I put the catheter. That was actually not a problem; I put it in the right place, he just had a low foot pulse.
Dr. Bristow’s narrative highlights a tension in the positioning of the medical mistake narrative as a co-owned narrative between patients and physicians. Co-ownership of the medical mistake experience does not exist at all times during the medical experience. As Dr. Bristow’s narrative shows, there are times in the story when the patient physically does not own the story. For the patient, there will be holes in the narrative because, for example, the patient was under anesthesia or passed out because of a procedure. Patients do not know the parts of the story that take place when they are physically present, but not consciously present. In this sense, there cannot be full co-ownership of the medical mistake narrative. Some parts of the narrative are solely owned by the physician.

The physicians’ storying of medical mistakes helps to story the experience of human and clinical complexity. As mentioned earlier, the medical mistake narrative is not one of just the physician. Likewise, the narrative is not just the narrative of the physician and the patient. The mistake narrative also involves multiple care practitioners that influence the outcome of the mistake as well as the way in which the narrative is told. The practice of medicine has become so complex that one disease or illness may require an interdisciplinary team of physicians to treat it. When this happens, physicians can lean on each other for help to fix a mistake. Dr. Patterson, a urology attending and Chief of Urology, illustrates this point as he talks about the relationship between urology and gynecology.

Most of them, if you do surgery, things are going to happen all the time. And there are things that go, we have a saying in surgery, you should do something that you couldn’t get yourself out of. You have to be prepared. That’s one of the things about surgery and it’s a sense of pride in surgery. Anything you get
yourself into, you should be able to correct, fix, or get yourself out of or at least stabilize the situation and call for help. I’ve had that happen before. I’ve put holes in big blood vessels that I wasn’t anticipating. And it can happen and people can bleed to death on the table. But I was able to control the situation enough and either stop it myself or call a vascular surgeon and I could stop the bleeding enough until I could actually get control and they could come in and close that up. It happens to every one of us. We get called by gynecology all the time. They’re operating in an area where they put holes in bladders and they cut urethras all the time and we get called to fix that. And that’s fine. We have our own little private jokes internally about that. But, it’s an accepted thing.

When a mistake happens, the VAMC physicians rely on other physicians’ expertise to fix a mistake. This relationship inherently means that physicians bear witness to each others’ mistakes, becoming part of the mistake narrative.

Bearing witness to other physicians’ mistakes reflects the cyclical nature of bearing witness. Bearing witness to others’ mistakes asks physicians to be present in the moment of the mistake as well as to reflect on the mistake experience. Charon (2006) tells us that the reflexive process of attending and representing narrative makes the creation and telling of medical narratives a collaborative process. Dr. Daniels, an ambulatory care resident, explains how bearing witness to other physicians’ mistakes can be a collaborative process.

Then there’s writing prescriptions. I had one here, and again, I just accept that there is going to be a certain margin of error. A great example, I was writing a prescription for medicine for kidney stone prevention called potassium citrate.
And in this case, I wrote for potassium chloride. So, and it was pointed out to me by one of the primary care physicians who notified me and I said, that’s my mistake. I’m happy to do whatever we need to do to correct it. I called the patient. I’m very open. I said, you know, we gave you the wrong the medicine. We are going to send you the right medicine. Don’t take this one. So, it can happen.

In Dr. Daniels’s case, another physician bearing witness to his mistake meant that the mistake was caught in time before it hurt the patient. By bearing witness to Dr. Daniels’s mistake, the primary care physician became part of the mistake narrative.

Dr. Sampson, another urology attending, explains how physicians bearing witness to mistakes can result in a different mistake narrative than was expected.

One was a patient who we were operating on. He had a very large upper-pole kidney tumor. It was just, we were doing it laparoscopically. It was a difficult operation. We got to the point where we had it almost all out, except it was stuck to the pancreas. We weren’t sure what to do about that. We talked to our general surgery friends. They said, well, just staple across. We did that. In doing that, there was an injury to one of the vein that goes to the spleen. So, we lost a fair amount of blood and struggled with that. We got it taken care of, got it out. We had to extend his incision a little bit from the general surgeons to help get the spleen out and so forth. And, everything was okay, but it wasn’t, it was something that went differently than we had anticipated. We ended up having to lose the spleen. As part of that, but that part ended up being okay. It’s an example of how everything started out okay and unfortunately he was doing great after the operation, had a little fluid in his chest. The pulmonary service, we consulted
them, they did a little tap to get rid of the fluid. They thought that would help him breathe a little better and it did. I got a call about 8 hours later that he was dead. And what had happened, I thought, oh my God, something really bad had happened. I was just convinced that one of our clips had come off or he had bled to death in his abdomen or something just catastrophic. I think it’s again one of those things where I was like, oh no. We had a difficult time with this case, so it obviously was something we had done. It turned out on the post-mortem that it was not. When they [pulmonary services] did the tap, they had hit a neuro-costial artery, and he slowly bled to death. He bled to death in his chest. The outcome was poor, obviously. He passed away, had a heart attack and died that night.

In Dr. Sampson’s case, he thought that he was the cause of the mistake. The mistake narrative was (re)written when he discovered that he was not the cause of the mistake, another service caused the mistake. Dr. Sampson’s story shows his concern for his patient and the fear that he might have caused the patient’s death.

Like Dr. Sampson, Dr. Vaughn, an ophthalmology resident, had to deal with a mistake that was caused by another physician.

I had a patient, and you’ll probably hear this, it’s usually the second doctor someone sees that ends up getting the first doctor sued. It’s not the first doctor, it’s the second one. And they say, oh, well that doctor didn’t know what they were doing, so you need to sue them because that was malpractice. I had a patient who I was seeing in the neuro-ophthalmology clinic who had radiation due to a tumor in the pituitary gland. Basically patients can have loss of vision if they have radiation damage in any of the surrounding area. So, this patient, it’s a year later,
it takes years to develop this, and this patient a couple of years later, from this neuro-surgical intervention of radiation, had blindness in one eye. And they said, something is going on with our computer that day and they had to do it by hand and I knew something was going wrong at that time. I could sense that the patient was very angry. They haven’t said anything. We were the ones who had the diagnosis that this is what happened. And I said to the patient, you know, what you are experiencing and what’s going on, I kind of wanted to paint a tall story that would sum it up in simpler terms. I said, you having this tumor, okay, it’s kind of like a mountain climber going up a mountain and falling and breaking his leg. There’s no way they are going to be able to get down the mountain by themselves. If you stay there, you die. So, a search and rescue group comes and picks you up. They say, we can get you back down this mountain, but there are some jagged edges, some slippery spots. There are spots were we can slip and fall. But, we are willing to pick you up on our backs and take you down this mountain. We will do our best, but you have to understand that sometimes, in our effort to help you, sometimes we could both die, or you could die because we could drop you. I said, it’s the same situation. You came with this brain tumor. If they had done nothing, you could be dead right now. They picked you up on their back and they tried to help you. In so doing, they may have inadvertently hurt you.

Dr. Vaughn’s narrative highlights the difficulty in bearing witness to another physician’s mistake. When a physician discovers that another physician has caused a mistake, there is a tightrope that the other physician has to walk. The physician needs to acknowledge the
mistake, and in some cases, correct the mistake; at the same time the physician has to help the patient understand what to do next.

_Mistakes as a Learning Tool_

In the VAMC, physicians see medical mistakes and the discussion of mistakes as a pedagogical opportunity; a chance to learn from the failure to prevent it from happening again. Situating the narrative storying of medical mistakes as an educational experience allows physicians to focus on challenging and questioning their stocks of knowledge as well as to continue the learning process. Positioning medical mistakes as a pedagogical tool serves several narrative functions. First, situating medical mistakes as a learning tool means that physicians have to pay attention, make sense of, and reflect on all mistakes, even those in which they were not directly involved. This positioning of mistake narratives as learning tools also serve as the culmination of action (Charon, 2006). Physicians use the knowledge they gain from sharing medical mistakes and take action to try to prevent other mistakes. Moreover, medical mistakes as learning tools mean that physicians connect with each other as a community. This is accomplished through physicians being present for the sharing and learning process.

In the practice of medicine, the stories of failures are privileged. Successful stories inherently suggest that a physician has adequate knowledge and has demonstrated technical knowledge. Opportunity for learning, then, resides in the failures. These “failure” stories “illustrate the limits of available knowledge in a field that experiences constant change in information and technique” (Hunter, 1991, p. 72). Dr. Bristow, a general surgery attending, tells a story of leaving a sponge inside a patient illustrates how physicians use these stories as reflexive learning opportunities.
I’ve had, I can think of one instance that happened when I was a resident; two instances actually. One when we had a retained sponge after the case. You know what that is, right? That’s one of those non-forgivable ones because it’s there. There’s no denying it’s there. And it’s the doctor’s fault. And you know, went through the whole morbidity and mortality discussion and everything and as we examined the whole process, we learned to find out. What did I learn from that? I was the chief resident, so that means the attending had already left the room and they go, we are missing a sponge stick. Okay. Okay. Fine. The protocol is that you stop and take an X-ray and you look for it. Right? And as I learned from that process, my junior resident I sent out to go get the report from the radiologist and to look at the X-ray. So it was just a sequence of domino errors that happened. So, the radiology thought we were looking for a missing needle. So, that didn’t get communicated to him properly. And so the radiologist called back to the OR going the X-ray is clear. There’s nothing there. I guess, he said, ok, the report is negative. That’s what it was. It was negative. So, from that lesson I learned anytime that situation had come up since I’m the one that knows what’s missing I will go out and look at the X-ray myself. And, you know, that’s something that I would consider early in my career. And we do that in urology all the time. We look at all of the X-rays, we don’t really trust anybody else’s reading because we have to make the decision. So, that was one. So all these events lead, my junior resident goes out and gets the wrong report from the radiologist who didn’t have the correct information and based on a negative X-ray read, he was looking for something opposite of what I was looking for. And then also what you call the
instrument. And it was a bunch of other things. Anyway, it wound up being that the girl comes back 3 months later, gets a follow-up CT scan, and you see the thing there. And, one other thing I learned from that is that the most common sponge count after an operating case is correct. So it almost doesn’t even matter if the nurses count the sponges before and after. It makes you feel better, but you still aren’t protected. Even when there are retained sponges often times it was an error in counting. So now you see my philosophy about it. You have to count them! That was one that I always remember. That was in 1998 or 1999. So, I don’t feel good about that. I’m still hard on myself about that and still thinking about it. But I’ve learned from it and there are just a couple of things that I would do differently.

Dr. Bristow’s tragic narrative of a “retained sponge” mistake reflects the way in which Dr. Bristow not made sense of the mistake, but also how he uses the experience as a learning tool to prevent another “retained sponge” mistake from happening again.

Like Dr. Bristow, Dr. Williams, an ophthalmology resident, uses a mistake as a learning opportunity to question his own medical knowledge and the ways in which he uses that knowledge in practice.

I had a patient, this was in my early days of facolosofication, a procedure that we use to remove cataracts. I got a corneal burn, something that doesn’t happen all that often these days. It was a patient that ended up with a lot of astigmatism. I began as Gary was saying, that day, I felt terrible. I didn’t sleep well. I kept on, you know, just running the whole picture in my mind the image of the eye looked like at the end of surgery. You could see like kind of whitish area with a lot of
lines in cornea. Now, I would say the only good thing about this, not that this is a good thing to do, the patient was elderly, so it wasn’t a patient that had a whole long life expectancy. She was already in early stages of Alzheimer’s, so it wasn’t someone who needed their eyes a lot in terms of a younger individual. This was maybe one way that I was rationalized it in my mind. It’s not something that is terrific, but it’s not somebody who is going to use their eyes a lot in terms of occupationally. Again, it was a learning experience in that it never had to happen again. So, it was the idea of playing over in my mind what caused it, and how can I prevent it again. I think it was more he family members that were kind of concerned in terms of how come she wasn’t seeing as well as everybody had expected. I was very honest. This was something that happened during surgery. One of those kind of known complications that can occur, and hopefully she will get better with time. It’s not something that we want to work with.

Dr. Williams’ story underscores how sharing narratives serves as a medium to prevent other mistakes. These narratives serve as a call to action for other physicians to not make the same mistakes they made. Interestingly, Dr. Williams not only uses this recounting of a mistake narrative to reflect on the learning opportunity it afforded, but he also uses it to justify his mistake. Regardless of whether a mistake can be a learning opportunity, physicians still attempt to justify mistakes.

Additionally, these medical mistakes stories not only serve as a tool for learning but also act as the ontology of medicine. Dr. Bristow’s narrative illustrates not only how he thinks about the practice of medicine, but also how he now ontologically practices medicine. Hunter (1991) argued that medicine is dependent on narrative; without
narrative, medical practitioners would not know how to make sense of medical experiences.

Medical mistakes as a pedagogical tool appear mainly in the presentation of anecdotes. The physicians at the VAMC told a variety of stories as ways to illustrate their points. Interestingly, most of these stories were sensational in nature. VAMC physicians usually only told stories that resulted in death or severe harm to the patient. This does serve a purpose. Physicians are socialized to only tell the stories of failure, and if possible, to tell the most interesting stories (Hunter, 1991). In the storying of medical mistakes, VAMC physicians are quick to point out what they may have learned from a mistake. This forces physicians to constantly think about and question their medical knowledge. The VAMC utilizes the morbidity and mortality conference as a way for physicians to reflect on and challenge their medical knowledge and competence.

Morbidity and mortality conferences serve a pedagogical function by creating a space for working through all bad outcomes and learning the difference between mistakes and known complications. Dr. Shepherd, a general surgery resident, illustrates the pedagogical function of the morbidity and mortality conference:

Morbidity and mortality [conferences]-- I think those are necessary functions. You need to understand what are bad outcomes, and sometimes we look at them and we say, you know what, that really wasn’t a morbidity and mortality, that was an excepted event or potential complication. It’s not something out of the ordinary. So, it’s good to look at those, those that ones that are truly aren’t issue or ones that really do have a bad outcome and talk about it as a group. It’s part of
our resident education program. It’s critical for them to understand that this is a
life long process.

Dr. Shepherd’s comment reinforces the idea that medical learning is a continual process, 
not one that ends once residency is completed. This commitment to constant learning is 
an important part of the ethics of practice. Dr. Kendall, an infectious disease resident, 
echoes the sentiment about questioning and challenging medical knowledge.

If there is a complication or death, they are discussed, whether there is a mistake 
or not. They are all discussed. Whether there is a mistake or not, we constantly 
ask what could we have done differently. Is there something we could have done? 
Is there a different approach, a different treatment? Diagnosed it earlier?

Whatever the case is to alter the outcome. Sometimes the answer is no; that’s the 
natural history of the disease. Sometimes, it’s yes, you could have done 
something differently.

The constant questioning and probing allows physicians to examine the currency 
and reliability of their medical knowledge. It also serves as a way for the experience to 
become shared in so much as it questions and challenges every physician’s knowledge 
and understanding of medical practice. Morbidity and mortality conferences, as Dr. Davis 
explains, “are supposed to make it safe for physicians to report through their clinical 
department, so they can have a monthly, and it’s usually a monthly review of all cases in 
which patients had unseen events.” These “safe” spaces mean that physicians can be 
comfortable to share and learn from each other. As Dr. Patterson explains,

Well, I’ll tell you this; I have probably learned more from mistakes and from our 
discussion of things at conference, then anywhere else. And malpractice seminars.
All physicians have a thing about malpractice and attorneys, etc. How do I feel? I think the M & M conference is a very constructive, good teaching tool. You know, you’ve heard the old saying, you learn by your mistakes. So, that’s a good thing.

As Dr. Patterson states, the old saying of learning from one’s mistakes can motivate physicians to constantly reflect on past experiences in order to serve future patients. Physicians learn vicariously through others’ narratives. This does not mean, however, that the sharing of medical mistakes is always a pedagogical opportunity. In some cases, attending and reflecting on mistakes can spiral into an unproductive activity. As Dr. Daniels argues, attending to others’ mistake narratives may be just as distracting as it is educational.

Yes, they are very helpful. They’re actually good learning experiences. Now, they may be a better learning experience, for one, the individual who made the mistake, and for the people, in some degree, it’s entertaining. And, you tend not to remember those things as well as something that personally involves you. So, it may not be as good a teaching tool as you might think, but they were certainly entertaining.

The morbidity and mortality conference, ultimately, serves as a discursive space for bearing witness to the failures and learning opportunities of physicians as they practice in the uncertain arena of medicine. Dr. Ferris illustrates how morbidity and mortality conferences are spaces for discussion. He explains, “It was interesting to see the interchange between people of the same discipline, how they actually some would view it in a much different light, then the one who made the mistake, or vice versa.”

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Mentioned earlier, sharing stories can serve as a way to legitimize or delegitimize the medical mistake experience.

Morbidity and mortality conferences serve as a way to legitimize the physician’s experience by asking peers to attend and reflect on the mistake. Storying the medical mistake experience serves as a way to create dialogue between peers since stories as presented and then commented on by others. Dr. Johnson discusses the dialogue that can be created as a result of bearing witness to a medical mistake experience.

I think it’s observing other physicians, you know, as you are going through training, observing senior residents and faculty, learning how they deal with it. It’s constantly going through morbidity and mortality conferences, in which those kinds of things are discussed. It’s, I think, to some extent, it’s the VA has been relatively progressive about and open about mistakes. You learn and observe from that. I think it’s part of my upbringing, and I think it’s part of what we expect of physicians—that they are honest and that there’s integrity involved. You own up to mistakes when you make them. Either try and push them off, blame somebody else, or explain it away. You may argue a point, you may say that this why you did what you did, and have valid reasons for it, but I think you also are also open to listen to others that might point out there are other ways to do things.

In their finest moments, morbidity and mortality conferences provide space for multiple voices to speak on a medical mistake, situating these discussions as places for dialogue and reflection.

Although morbidity and mortality serve as a space for dialogue, like any discursive space, these conferences can turn from pedagogical opportunities to a chance
to discipline and punish physicians. Morbidity and mortality conferences, regardless of their ability to create a space for dialogue, cannot truly recreate the medical mistake experience. Like any story, these narratives are bound by time and space. This bounded nature of the medical mistake narrative told at morbidity and mortality conferences means that physicians are always going to be reflecting retrospectively on the experience. This can be difficult because physicians are never going to be able to prevent the mistake; they can only prevent future mistakes from happening. Dr. Young, an internal medicine resident, illustrates this frustration.

Well, I think it’s important to be able to discuss your complications or your patients’ complication among your peers. For the purpose of eliciting their ideas about perhaps looking back at how the case was managed, and maybe you could have managed it better. But, the problem with that is there is no way that through a description by a case presentation that you can recreate the reality of what you were dealing with as a clinician in real time for those people who are seating in the comfort of a conference room and hearing the case presented. There is no way you can recreate that. There is no way you can recreate the decisions that you are faced with in real time. All of the variables that led to decisions that you made, that perhaps when you look back in retrospective it seems pretty clear, it always seems clear, why that was maybe the wrong decision. But in real time it’s not always so clear.

The inability to create “real time” in the storying of medical mistake experiences means that morbidity and mortality conferences can often turn away from a reflexive
practice into a challenge to demonstrate technical prowess. Dr. Stevens, a general surgery attending, stresses how easily dialogue can turn into a test of knowledge.

So, from that point of view, the morbidity and mortality conference in my opinion can often degenerate into “well, I would have done it this way” “you would have done it this way” “If you had tried this, or if you had maybe considered this other option, maybe it would have gone differently.” How valuable is that? I don’t think it’s very valuable, but I still think it’s important to have that discussion. The problem with peer review at morbidity and mortality conferences in general is that surgeons are very good at owning up to their complications, their patients’ complications. We are very responsible people, we take it very personally. So we tend to, though, overdo what we as individuals have control of. Because the net result of morbidity and mortality conferences is “well if I would have just done it differently, done it this way, maybe it would have turned out differently.”

Thinking that it’s entirely within my control as a surgeon that I can control the entire course of events, when in fact I can’t. And there are systems issues. What was the environment like? What was the equipment you were working with like? How was the interactive working relationship between the people taking care of this patient that led to decisions that led to the outcome that you had? Was it important to consider that I was up all night doing an emergency case and then an elective case the next day and we had a complication? Was that relevant? Is it relevant that I had a scrub nurse that I never worked with before? Is it relevant that the equipment I was using that day was not equipment that I had normally been used to working with? Were there human factor issues with the device that I
was using that made it more difficult and maybe set me up to fail? There are a lot of system issues that we never talk about in morbidity and mortalities conferences. And if you ask the question, well, what could we do differently that would reduce the probability of this event occurring again? And usually it’s not what the individual has control of, it’s usually more about a system involving multiple people, if that makes sense. So, if you are really asking what we can do to reduce probability for that event, it’s unlike that one person by him or herself can change that.

Dr. Stevens’ comment underscores several key elements of the storying of medical mistakes. First, his comment highlights the constant desire of control and pressure to be perfect, even during a dialogic, learning experience. Additionally, Dr. Stevens’ comment emphasizes the contextual factors that are often silenced in the storying of mistakes. The medical mistake narrative is extremely complex, often with multiple factors leading to the mistake. His comment calls for an appreciation of these factors. Finally, Dr. Stevens’ comment illustrates a concern for what individuals can do in the presence of a potential medical mistake as well as what needs to be changed about the system.

Morbidity and mortality conference tend to focus on what the individual can do, what the individual can change. Physicians, then, feel the frustration of a learning opportunity that does not include changing the system. Dr. Montgomery, a general surgery attending and Chief of General Surgery, explains this frustration.

In morbidity and mortality, we are always focused on what the individuals can do. The buck stops with us as surgeons; we have a very strong work ethic, we have this accountability and responsibility that’s embedded in us. It’s embedded in us,
from the years of training, that the buck stops with us, we are the captains of the
ship. It’s been mostly the deepest pockets and the captain of the ship that gets
sued and held responsible for that event. So, I think morbidity and mortality is
important, I wouldn’t want to see it go away, but I don’t think that it gets at some
really important things that if we want to reduce the chances of these things
happening again.

Like any pedagogical tool, the morbidity and mortality conference can help and hinder
physicians in the learning process. Ultimately, the sharing and discussing of medical
mistakes is a learning opportunity. The VAMC physicians use the storying of medical
mistakes as a chance to be reflexive about mistakes and work through, with other
physicians, how mistakes can be prevented in the future.

Summary

The practice of medicine is an art that relies of various logics, including scientific
knowledge (Montgomery, 2006). Physicians strive to be ethical in this artful practice,
balancing respect for technical competence and prowess and the human nature of
medicine. VAMC physicians, in the storying of medical mistakes, highlight the
difficulties of this balance. Ultimately, the ethics of practice ask physicians to bear
witness to the experiences of medicine, through the learning and caring practice of health.
Bearing witness ultimately asks physicians to pay attention to and reflect on the many
different medical mistake narratives told and then use that knowledge to prevent future
mistakes. By bearing witness, VAMC physicians position medical mistakes as a co-
owned experience, not solely owned by physicians or patients. In the multiple tellings of
mistakes, the physicians highlight the multiple voices in the mistake narrative. These
narratives also highlight the sensational nature of mistakes and the decision-making processes that physician go through as they navigate mistakes.

Mistake narratives also highlight the failures of medicine and how physicians can learn from these failures. The storying of mistakes serves as a pedagogical tool to challenge medical knowledge and bear witness to other physicians’ mistake experiences. The VAMC physicians use mistake narratives and morbidity and mortality conferences as a chance to be reflexive about the mistake experience as well as bear witness to others’ reflection. Although the storying of medical mistakes can be a learning tool, the sharing of these stories can also be a chance to discipline physicians through the demonstration of knowledge. The storying of mistakes, then, can be both an enabling and constraining experience for physicians. The narratives give physicians the chance to work through decisions and recognize the human nature of medicine while also reinforcing clinical judgment. Mistake narratives represent the failures and successes of clinical judgment and an ethics of practice, representing “a curiosity about the universe of available information and a commitment to improve the individual clinician’s practice” (Montgomery, 2006, p. 206). These narratives highlight the complexities of the human condition and human relationships.

Black Marks and Money: Corporeal and Material Constraints and Negative Sanctions in Medical Mistakes

*Dr. Davis: They see it as a personal failure. Most health care professionals see it as a personal failure. And they are embarrassed about it. And I think they worry about potential legal exposure, like a lawsuit, but I think that’s way down on the list. I think the most important consideration is embarrassment among your peers,*
and that you somehow personally have failed. You know, failed another human being. We beat ourselves up about it all the time. And it’s a very personal issue, so that’s why it’s sensitive. The problem is, in my view, is that in the way we are socialized in health care and the way we are trained and educated is that the stakes are so high that we cannot afford to fail. Of course the implication there is that we can go through life with no complications, no failures. And no human is up to that task. None. None that I’ve ever met.

In the practice of medicine, two conflicting grand narratives exist for physicians: the narrative of physicians as infallible and striving for perfection and the narrative of physicians being humans (Paget, 2004). Dr. Davis, a cardio-thoracic attending, highlights the tension between being taught to be perfect and the acknowledgment that physicians are human and will make mistakes. These narratives provide divergent guidelines for physicians as they attempt to maintain and negotiate what it means to be a physician. These narratives highlight the enabling and constraining nature of human action and the structures in which we act. “Human societies, or social systems, would plainly not exist without human agency” (Giddens, 1984, p. 171). That does not mean that human action does not have limits, nor does it mean that all of the constraining aspects of social systems is because of the system. Human action is also limited because of the corporeality of human action.

The individual must be there in the flesh to be there at all, and the flesh that is the corporeal self has to be chronically guarded and succoured—in the immediacy of every day-to-day situation as well as in life-planning extending over time and space. The body is in some sense perennially at risk. (Giddens, 1991, p. 126)
For physicians, the limits of what they can do as humans inherently puts them at risk of making a mistake. The profession of medicine’s traditional approach to medical mistakes, “deny, deny, and defend” acts as a symbolic guard to mistakes of the human body. Additionally, this symbolic guard helps to maintain the tension between embracing ambiguity in medicine and striving for perfection because it recognizes the limits of practicing medicine but disregards those limits at the same time.

There is only so much that humans can do, regardless of opportunities and possibilities. These human limits, in conjunction with societal limitations, influence the actions that humans can take as well as the opportunities available to them. In the case of medical mistakes, material and corporeal constraints shape the mistake experience as well as influence how physicians make sense of and talk about the medical mistake experience. Despite the negativity of the term, constraints can be just as enabling as agency—“they serve to open up certain possibilities of action at the same time as they restrict or deny others” (Giddens, 1984, p. 173). Constraints are a way to “get things done,” meaning that they provide opportunity and limits (Giddens, 1984, p. 175).

Recognizing constraints asks humans to make sense of the ideological and philosophical underpinnings of institutions and pay attention to the ways in which they impact how we make sense of experiences.

As Giddens (1984) explained, there are several major forms of constraint. Constraints focus on the limits of human action and the ways in which these limits influence how humans make sense of and talk about experiences. Material constraints are concerned with recognizing the limits of human action while embracing what they can do. The overarching tension in material constraints in medical mistakes is embracing the
fact that humans will make mistakes, including physicians, while at the same time, resisting the fact that it will happen. Material constraints recognize the corporeality of humans and the impact that the social system has on the body. As Giddens (1984) argued

What is constraint when we speak of the constraining aspects of the body and its location in contexts of the material world? It evidently refers here to the limits which the physical capacities of the human body, plus relevant features of the physical environment, place upon the feasible options to agents. (p. 174)

In medical mistakes, the limit is that humans are incapable of not making mistakes, but that they can strive to work to not make them. This reflects the enabling and constraining nature of mistakes: they are going to happen, but it does not mean that physicians should not or will not strive to prevent them.

**Striving for Perfection**

Physicians are socialized into a medical system that demands perfection from its workers. This expectation does not give much consideration to what the physician is physically capable of doing in terms of practicing medicine. Physicians, then, live with this constant pressure of “being perfect.” As Dr. Sydney, an internal medicine resident, explains, “You are living with unrealistic expectations, which is a tremendous amount of pressure.” Dr. Sydney highlights the understanding that there is the material constraint of not being able to meet the unreal expectations of medicine. Although physicians may recognize the material constraints of medicine, they do not necessarily embrace the idea that they can make or should make mistakes. Physicians are ultimately uncomfortable with the idea of making mistakes in medicine. Dr. Stevens, a general surgeon attending, talks about his uncomfortableness with death as the ultimate outcome of mistakes.
I think that physicians are just uncomfortable. It might seem odd, but I think physicians are very uncomfortable talking about death. Why is that? I suspect because we are trained to be healers, we are trained to prevent death. We are trained to do everything we can not to just prevent death, but hopefully to improve the quality of living. And, death is a very, death is a failure. Death equals failure. If somebody dies on our watch, it’s the way that we interpret it. It might seem very unrealistic, and I think it is, but it’s inescapable. I failed. That’s a hard thing to swallow.

Dr. Patterson, a urology attending and Chief of Urology, echoes the sentiment of being uncomfortable with the idea of making mistakes in medicine.

It sure makes me uncomfortable. I think for me, the way I think of it, I look at every specialty and how much room is there for margin of error in that specialty. You know, people joke around and say if you are a brain surgeon you can’t really make any mistakes, you know, or you’ve got to be right now. It’s true I think much more for the surgical specialties than the medical specialties. You can make mistakes, but how many, what can you get away with? What will cause harm and what will not cause harm? I think, the first feeling I get about it is that I don’t like it, I feel bad about it if it does happen. I’ve had it happen before, and I’m very open and willing to admit anything. Unfortunately, I’m kind of obsessive-compulsive when it comes to certain parts of what we do. I would even say that is probably part of my practice.

Dr. Stevens’ and Dr. Patternson’s uncomfortableness with mistakes highlights one of the overarching concerns with perfectionism in medicine. As Hunter (2006) acknowledged,
uncertainty and ambiguity are an inherent part of the practice of medicine. The medical community as well as society in general, however, are still resistance to accept that ambiguity and uncertainty. There is still an emphasis on medical excellence and proficiency which physicians are expected to achieve. Additionally, as Dr. Stevens notes, death is the ultimate failure in medicine because the physician’s job is to heal and cure.

In an attempt to negotiate the messy and uncertain terrain of perfectionism, several of the physicians talked about attempting to justify the mistake. As mentioned above, mistakes are risks that are sometimes a result of the corporeal constraints of the body. Physicians, then, have to gauge the level of risk with a mistake and justify failure in the face of perfectionism. This justification of a mistake, or grading the mistake based on the level of severity, highlights how physicians wrestle with the uncertainty of mistakes while simultaneously make an effort to maintain the expected level of perfectionism. This “active courting of risk” attempts to blur the meaning of “mistakes” by creating clear delineations of the degree of risk. It is no longer a discussion of whether or not a mistake was made, but rather, a discussion of whether or not the mistake was “bad enough” to warrant it a mistake. Dr. Grace, an internal medicine attending, illustrates the justification process in his discussion of naming and evaluating mistakes.

So, I think that of those that are preventable, you do everything possible you can to do that. I always use, I went to a seminar once on aviation, related to medical malpractice, and they really try to parallel the aviation experience, aviation safety experience to medical work to try to help you to think in that fashion. So, what are the simple, basic things that you should do? One, two, three. If you do those, you can avoid some of the mistakes. Some of the mistakes are glaring and ridiculous
and didn’t check things. Some of them are understandable and can happen. And then there’s, so there’s all different things in the spectrum. There’s negligence, there’s gross negligence, and there’s I did everything I could. I could have chosen option A but I didn’t or I should have chosen option B. So, that’s my summary of how I feel about it. Overall, I have a very high standard and I expect a very high standard of everybody that works for me. I expect truthfulness and honesty. Honesty is another thing. You learn really quick who you can trust and if they tell you they did something, they did it, even down to the residents to a certain level, what they are doing. I can’t supervise every exact thing they do, but I take responsibility for everything they do. So, it’s a trust issue, too.

Dr. Young, an internal medicine resident, echoes this sentiment, emphasizing the role of external constraints that impact and influence views of mistakes.

I’m in the office, I get overloaded with volumes and tons of information, and I have to really sort through what is the pertinent information. And do things get missed? They do get missed, but they aren’t life or death misses. When you treat patients, you can’t miss things. It’s all relative, I mean, you can take it down to the point of did you put enough stitches in to close this thing or whatever.

Like Dr. Young, Dr. Lovin, an optometry resident, points to external forces, such as the business of a hospital clinic, in order to justify mistakes. Additionally, Dr. Lovin attempts to justify mistakes based on medical specialty, arguing that some mistakes are worse because of the kind of medicine that is being practiced.

Well, I’m of the opinion that medical mistakes do happen because now that I am here at the VA, there are some days where we are just so busy that it is really hard
to be as hard as thorough as you want. I know that on an optometric level, mistakes probably are not as severe as like a surgical error or a life or death sort of event. You know, when I read about mistakes made in the medical profession, like in the news, there are people who are very upset, understandably so, my heart goes out to them, and I think well, golly, that sounds like that could have been prevented.

Physicians, such as Dr. Grace, Dr. Young, and Dr. Lovin, recognize that mistakes will happen and discursively attempt to redefine mistakes as an attempt to justify the mistake. This justification serves as a reflexive monitoring of medical practice. Dr. Grace’s focus on trust and honesty as keys to success highlight another interesting tension in situating medical practice as an act of perfectionism. Attempting to justify mistakes and embracing the ideological guard of “deny, deny, and defend” potentially removes responsibility of action away from the physician. If physicians are meant to be perfect, then any mistake is not a result of human action, but rather an action of the system. Conversely, and in tension with this, focusing on honesty and trust in the medical relationship positions mistakes as a co-experience. Mistakes, then, can become a shared experience between all members of the medical team, not just the physician who makes the mistake. Patients are not usually included in this share experience; they are merely the physical terrain on which the procedure and mistake occurred.

Ultimately, physicians are unable to separate the tension between striving for perfection and making mistakes. It appears that regardless of medicine’s hesitancy to fully embrace the ambiguity and uncertainty in medicine, the VA physicians appreciate the fact that mistakes will happen. Physicians, then, must navigate and interpret the ways
in which they individually practice medicine in the face of this uncertainty. For Dr. Sampson, an attending urologist, VA physicians have a difficult time negotiating perfectionism in the face of ambiguity in health care. Dr. Sampson’s comment echoes those of many of the physicians interviewed.

I think they happen. We are taught to be perfectionists. I think that most physicians and certainly most surgeons are perfectionists by nature, but we are still human. So, mistakes will happen. They are inevitable and it’s a matter of how big, how severe, and what impact they have on the patient. You could make a mistake that has zero difference in clinical outcome. It’s still a mistake, but you learn, you don’t do that again the next time. But, it won’t impact the clinical outcome. I think that the ones that are the most concerning are the ones that impact clinical outcome or outcome of a procedure or you know a care episode if you will. And those are unfortunate. I feel badly about them when they happen. That’s a good thing. But it’s not something that I ever see that won’t ever be a mistake because that’s just part of being human.

Physicians recognizing mistakes as part of the medical experience because of the human nature of medicine while still striving to not make mistakes in the future embrace a different medical ideology of ambiguity, uncertainty, and excellence.

Humanness as Medical Philosophy

Material constraints are concerned with the corporeal aspects of human action, not just the symbolic (re)construction of discourse through rules and resources. Giddens (1979, 1984) recognized that discourse can only do so much in the production and reproduction of social systems. Inherent in that, then, is the recognition that the human
body is both enabling and constraining. In the case of medical mistakes, doctors can only
do so much in terms of saving or helping patients. However, their medical training
enables them to help patients in ways that others cannot. It is in this recognition that
physicians embrace their humanness. Dr. Tanner, an ophthalmology attending and Chief
of ophthalmology, explains this philosophy of humanness:

We are all human. Doctors are not gods, we do make mistakes. I think it’s
important. My own philosophy is that if we do make a mistake, it’s important to
let the patient know, have some idea in terms of what has occurred, why we think
it has occurred, what we think may be the, what we can do after the fact in terms
of, you know, it requires additional surgery or additional referral. My policy in
general, not just in medicine, but in general, my philosophy in life, is that honesty
is the best policy.

Dr. Tanner’s comments highlight an ideological shift from perfectionism to embracing
the human in medical practice. This ideological shift appreciates the action and limits of
the human body in medicine. Many of the physicians talked about this kind of humanness
being not only a medical philosophy but also the philosophy by which they experience
life. The traditional approach of perfectionism separated out the life experiences of
physicians, forcing them to focus on only medicine. Dr. Anderson, one of two
obstetrician/gynecologist attendings at the VAMC, echoes this idea in his discussion of
mistakes:

I think I’ve pretty much described not only how I feel but what others do, but that
said, you know, I think, my personal philosophy in terms of that is, you know,
everybody makes mistakes. There’s no such thing as an individual, with one
possible exception that has made it through life without making mistakes of one kind or another. So, number one is that it is inevitable. I think the important thing to me in terms of mistakes is number one is that you do your darnedest to minimize the possibility and since most mistakes are not, almost by definition mistakes are not intention, that involves working with a lot of processes, systems, from preventing mistakes from occurring.

Situating humanness as the ideology through which to practice medicine also means embracing the common-sense nature of human action. These physicians acknowledge that embracing humanness is a common-sense approach to medicine and life. This point is illustrated by Dr. O’Malley, a general surgery resident.

I think as a human and a semi-intelligent human being, you can figure it out. You’ve got families, you came from a family, you know, dealing with other human beings, these emotions are pretty strong emotions. It doesn’t take a rocket scientist that someone is emotionally distraught about the death in a family and that you were part of that and they need some support, need something from you.

A large part of the seeing mistakes in medicine as a human activity is the importance of admitting mistakes to others.

Being human in medicine is equally about embracing the idea of mistakes and being able to tell those mistakes to others. The Chief of Staff uses the story of generally making mistakes to illustrate the common-sense nature of admitting to mistakes in medicine.

The other thing that I think is important about mistakes is that you fess up to mistakes. I had a period when I was the chief executive officer of a public hospital
in El Paso, Texas, and we did a thing where actually we’d accidentally gave Christmas presents to our employees, and the statutes permitted this up to a certain amount. We exceeded the amount of money that you were supposed to spend on each thing, and of course, in Texas everything operates under the sunshine law, so this came out. The newspapers came in and had an interview with me, and not the headline, but in big type in the El Paso Times the next day, CEO of Thompson Hospital admits we goofed up. Because that’s what I did. I say that. They said, well, why did it happen? And I said, you know, we goofed up. We made a mistake. And actually it kind of demonstrated the value of that because number one it made me feel good because I didn’t have to sneak around, so I felt good about it. And number two, it was actually very well received. Everyone thought it was kind of fun. And I think everybody can relate because they goof up. They can relate. I think you really get in trouble, and it’s not just in medical errors, when you make an error of any kind you just don’t say well, I made it, I’m sorry, we’ll try to keep it from happening again.

A part of this common-sense understanding of medical mistakes is the belief that not admitting mistakes is an unnatural or “unhuman” quality. As Dr. Campbell, an anesthesiologist attending, explains,

We are human and it is going to happen to everybody. Anyone who says they have never made a mistake in medicine is, has just made one, because that’s not true. It occurs, it occurs to everybody and it’s something that everyone has to deal with.
The Chief of Staff’s and Dr. Campbell’s comments highlight the importance of remembering that humanness does not just exist in everyday life and stop the minute a physician practices medicine. By recognizing that being human is common-sense in the practice of medicine, physicians can become more comfortable with the ideas of ambiguity and uncertainty.

This common-sense approach to the humanness of medicine and medical mistakes also allows physicians to focus on the patient and the physician’s ongoing relationship with the patient. Embracing a more humanistic approach to medical mistakes means that physicians not only position themselves as humans and doctors, but physicians also have a chance to practice patient-centered medicine. As Dr. Stevens, a general surgery attending, argues, admitting mistakes means that physicians can connect on a different level with patients and strengthen the patient-provider relationship.

You know, I used to sort of say half jokingly, tongue in cheek, that there are only two errors, and that’s the ones we don’t admit to and the ones we repeat. But there’s a fair bit of truth in those statements. And, the admitting is kind of admitting to yourself, admitting to the patients, admitting to the team, and that’s kind of what you are dealing with, how do we deal with patients? I’ve been very lucky in terms of you know malpractice suits and in 25 years in service that I have been practicing, I’ve had sort of one settlement in all those years. But I think some of that, I mean I don’t necessarily think that’s a reflection that I’m a great physician, I think some of it has to do with an important component of it, and that’s the relationship with patients. And, you know, I’ve always found that patients are very, extremely forgiving if you are honest with them.
Dr. Stevens’ comment highlights the fact that this re-envisioning of medicine as a human activity not only shines the spotlight on the physician as human but also reminds physicians that patients are humans, not pathologies or diseases.

By appreciating the humanness of both patients and physicians, physicians and medical practitioners come to see the medical mistake experience in a different way. Sometimes this appreciation comes when physicians and medical practitioners become the patients. Dr. Lovin talks about an awakening of sorts when she became a patient and how that made her see medical mistakes with a different lens.

You know, myself being mostly healthy and not actually having to go a lot of doctor, I probably feel like a lot of times medical mistakes can be prevented. However, within the last year, I had a baby, so I went to the doctor more frequently, and just kind of observing now being on the medical side of the profession, but actually also being a patient and seeing a doctor very frequently, especially towards the end, while there were no issues with my situation, it did become apparent to me that I can see how medical mistakes can happen. I don’t know if there’s a good way or a bad way or how to prevent them, but I think that if you are in the line of duty where decisions have to be made quickly, life or death can be on the line, or some sort of very severe outcomes at risk, somehow, I think that those individuals whether they be under a lot of stress or time constraint, I don’t necessary want to say that they should be given more leeway, but just, there should hopefully be more of a support group for them to help minimize potential errors. So, I know a lot of health care professionals have so
much responsibility on them that the more of support network around them to help basically check for the small things to minimize it would be beneficial.

Dr. Lovin’s experience of being a patient made her rethink her understanding of medical mistakes. For Patricia, one of the co-creators of the program, experiencing a medical mistake helped her focus her appreciation of the role of being human in medicine.

The sad thing is that the public doesn’t realize that [physicians are human]. Physicians have this façade that they think, you know, that patients will not have the same sort of respect for their opinion if they show a human side, and it’s exactly the opposite, I believe. My personal physician is a resident that I raised when I was in the ICU here. And he is my doctor because for that very reason. He is very personable, he allows me to know that he’s a person, not just my physician. I know his wife, I know his kids, I know about his divorce. I mean, he’s a person. When the mistake happens, which it did, see this scar? He shouldn’t have taken that off my face. And he told me after this thing popped open, because it was way too big for him to do, that he should have sent me to a plastic surgeon. But he said, you know, I knew you wanted it off, I knew you were going to Minnesota and so I just did it. And I took the stitches out too fast. What happened was that it just popped because it hadn’t healed yet. You know, am I going to model? Is that going to impact my life? No. Other people might go, um, I could sue him and get enough to pay off my car.

Dr. Stevens’ and Patricia’s ideas not only highlight the humanness in physicians and patients, but also focus on the co-ownership of the medical mistake experience. Part of recognizing the human nature of medicine is remembering that the patients are just as
active in the process of mistakes as the physicians. Unlike the tension of responsibility present in attempting to be perfect where responsibility is potentially passed on to others in the medical experience, the mistake experience is shared by VAMC physicians and patients. This co-ownership of the mistake experience is due in part to the unique mistake program at the VAMC. The apology and disclosure policy encourages a co-ownership experience between patients and providers by including the patient in the mistake process.

When a mistake is made, the VAMC physician immediately discloses the mistake to the patient (or patient’s family if the mistake results in a death). This initial disclosure ensures that the patient is included in the mistake experience, as opposed to being just the body on which the mistake occurred. The patient (or patient’s family) is included throughout the disclosure and apology process. The policy mandates that the patient or family be constantly kept up-to-date on the process of a mistake case. The patient or family is part of the process until the end and are actively involved in the full institutional disclosure and apology or the closure, which occurs when the bad outcome is actually a known complication, not a mistake. Embracing the medical philosophy of humanness asks physicians to consider the patient and the physician in the mistake experience. Dr. Vaughn, an ophthalmology resident, reflects on this experience:

I think that patients obviously they want to know if a mistake has been made. But, more importantly, how do you as a physician feel about it? Are you empathic? Are you saying, well, we are human? They want to know are you truly sorry about it and what are you going to do to fix it. Whenever I have a medical mistake, or a complication in surgery, I go and talk to the family that day and on
the first visit after the anesthesia has worn off and they are clear headed. I try to paint the picture as realistically as I can. I express my deep, that I’m very sorry that this happen, that sometimes these things do occur. I let them know that I’m really sorry that it happened. And I try to show them that other patients who’ve had this complication, you know, how they’ve done with it, what the eventual outcome has been. In our situation, most of the surgeries are cataract surgeries, so therefore most of the complications we are going to have fall into the cataract surgery side of things. Most people don’t have a really good appreciation for the technical skills that are required for cataract surgery, and so most of them think that it is a 5 or 10 minute outpatient procedure. I go in, I get it, and the next day I’m seeing. But that’s not the case. You have to really paint the picture in terms of what’s involved in a cataract surgery, how things can happen during surgery. Why their case may have been a little more complicated to begin with. If there’s any other factors that went into the outcome or mistake, let them know that this is where you are at right now. This is what we are going to do to treat you. I’ve seen other patients in your situation and this is how they’ve come out. Letting them know that there is hope and what to except.

Many of the physicians argued that the relationship that physicians have with patients are a major indicator of how patients and physicians respond to medical mistakes. Dr. Stevens’ comment about patients being more willing to forgive physicians for making mistakes highlights the human nature of medicine. Dr. Xavier, an ophthalmology resident, argues in a similar vein, suggesting that patients do not assume the worst of the physician if the physician is open and honest about a mistake.
I think along the same lines, this maybe will sound a little silly at first, but preparation for making mistakes begins before the mistake happens. I’ve seen both sides of this in that I’ve seen not just ophthalmology but in other fields, a mistake happens, but the family didn’t really have much rapport with the physician or with the health care worker before that mistake happens. When the mistake happens, it’s not we’re terribly sorry this mistake has happened, it’s now good versus evil. One side versus the other. Instead of us working with the patient to deal with the mistake, work through it and get the best result possible, it becomes, they are very antagonized because this mistake has happened and they didn’t really like you cared about them in the first place. They didn’t feel like you were taking the time with them. And that’s when the worst and ugliest side of this kind of rears its head. Whereas if you’ve taken a little more time, it’s hard to do, to remember that, when you are in a busy clinic day, but I think that’s just as much a part of dealing with medical mistakes.

Embracing a human philosophy to the practice of medicine is not an easy task. Not all physicians fully embrace this medical philosophy. Many of the physicians simply acknowledge that mistakes will happen. This does not mean that they are willing to accept them completely; it simply means that they accept the presence of mistakes in medicine. As Dr. Earhart, an ambulatory care attending, explains:

So, I mean, overall, I accept that there’s going to be mistakes. There will be. I mean, we are not machines, and we aren’t perfect. We’re just not. But any time you have humans who are imperfect people and can make errors or mistakes, they are going to make mistakes. That’s my vision of it.
This “acceptance” of mistakes in medicine again positions the tension of embracing ambiguity and uncertainty in the practice of medicine. Physicians admit that they are human, but they do not attempt to privilege that presentation. Conversely, though, they are not willing to privilege perfectionism. Rather, some physicians may be more inclined to attempt to find a middle ground between perfection and humanness. The acknowledgment of risk is still present in this middle ground approach to medical mistakes. As Dr. Johnson, a vascular surgery attending, explains, “I think it [medical mistakes] happens. I think it’s part of medicine. We try and create systems and to prevent it and we try to educate ourselves to prevent mistakes, but unfortunately, we are human, and some mistakes happen.” Physicians are willing to give some ground to being human and recognizing mistakes, but they are not always willing to let go of striving for perfectionism. Dr. Grey, an optometry attending and Chief of Optometry, illustrates a similar sentiment when he states:

Well, we are human beings. Even if we are doing our best and working hard at it, we will make mistakes. That can’t be helped. We just have to study, work hard, and practice, keeping a mind on what we are doing. Try not to make those mistakes.

Part of the difficulty in fully embracing the fact that physicians as humans are capable of making mistakes is that there are a variety of systems in place to prevent mistakes, making it sometimes difficult to embrace the human role in mistakes. Dr. Ferris, an ambulatory care attending and Chief of Ambulatory Care, points out that although mistakes are good, physicians can be trained to prevent many of them. He explains, “Well, I think it’s a very good idea to make medical mistakes. Obviously, you know they
are going to happen. There are safe guards to make sure that you don’t make many of them.” This can be danger, however, because it can take the focus and the onus away from the physician and put it back onto the system. Dr. Montgomery, a general surgery attending and Chief of General Surgery, illustrates how easy it is to take the human physician out of the practice of medicine:

To some extent, American medicine is becoming over-regulated and under-performing. So, what do I mean by that? Some of the measures that we’ve got have made us process-focused. We think that processes that measures quality. They are not; culture is really the measure, if you measure the culture. So, you have to be very careful because many of the processes, while they are well-intentioned are surrogates for culture. Let me give you an example. So, we have in the VA, we have things about to try to reduce surgical infection rates. We have been giving pre-operative antibiotics one hour before the incision is made. In essence, you could give the antibiotics as the incision is being made and you would meet the performance measure, but not necessarily the culture or the context. There was a story about a case that was an hour and 10 minutes and the nurse said, well wait a minute, should we cancel the case? Now, that’s what I would called false errors, where the process overtakes the culture and can actually have a negative impact.

Recognizing the human physician in the practice of medicine can be a difficult task; physicians attempt to maintain the expectations of medical precision and excellence in the face of attempting to connect with patients and continue to see medicine as a relational activity. As illustrated by many of the VAMC physicians, it is easy to embrace
the idea that physicians are humans and can make mistakes while still slipping into the traps of perfectionism. An important part of recognizing how this tension manifests in medicine is recognizing the corporeal and material limits in the practice of medicine. Although perfectionism and humanness as medical philosophies are discursive formations, they are grounded in the ability and limits of the human body and what actions they can take.

Disciplining Through Organizational and Societal Sanctions

Regardless of whether physicians are willing to fully embrace the ambiguity and uncertainty associated with medicine or if they continue to strive for perfection, if a mistake does happen, the physician will be disciplined for making the mistake. In social structures, when mistakes or deviations from normal human activity occur, individuals have to experience the negative repercussions of the mistake. These repercussions, or negative sanctions, are a result of human action that defies institutional norms and expectations. Negative sanctions range from “the direct application of force or violence, or the threat of such application, to the mild expression of disapproval” (Giddens, 1984, p. 175). Negative sanctions are meant to be a disciplinary agent, a way to teach individuals in social systems that deviation from norms and expectations will not be tolerated. Moreover, negative sanctions are very “visible” so that all individuals are aware of human behavior and what happens when an individual does not act properly. The visibility of negative sanctions, or even the prospect of negative sanctions, makes human action and its discipline a public activity. The idea is that if an individual is disciplined in a visible manner, individuals will work to prevent mistakes from happening again.
In the case of medical mistakes, physicians are disciplined through two different kinds of negative sanctions: malpractice cases and the national tort databank. These two negative sanctions discipline in different ways. Malpractice cases serve to discipline physicians on a public level because these cases are normally very public and are reported in the news. The national tort databank serves as an organizational disciplining sanction because VA physicians get a “black mark” on their record, one that can be seen by hospital administrators. As explained by my VAMC contact and informant, Debra, any time a mistake is made at a VA facility, the mistake is reported to the national tort databank. Reporting to the tort databank is mandatory when a mistake happens. The outcome of the mistake, in terms of court or trial settlements, is not reported; just the mistake. A narrative of the mistake is typed and submitted to the databank. This narrative includes the patient’s name, doctor’s name, VA facility at which it occurred, and what happened to lead to the mistake. These negative sanctions continuously discipline physicians because they can never be erased from the physician’s record, and thus, are constantly part of the physician’s practice of medicine. Dr. Campbell illustrates the consequences of the “black mark” on medicine:

Anybody can sue for any reason and your name goes in the national practitioner databank. Period. No ifs, ands, or buts, and if a case is dismissed, never go to court, the ones that do go to court, 90 plus percent are found in favor of the physician. And of course that’s because the ones where there was a mistake settled. But that’s just extremely frustrating that you are punished if some absolute nut decides to litigate and they get some lawyer to pick the case. It’s just outrageous, totally outrageous that you can’t erase that. You get a black mark on
your record without any review of any sort. Just by being named and that never
goes away. Ever. So, there is a reluctance to own up to things and just a great
frustration with the system that presumes guilty and punishes you with this
national practitioner databank.

Many of the physicians blame society’s ideological belief that suing a physician
will automatically make up for the mistake as the reason behind the constant disciplining.
This “sue-happy culture that we have” as Dr. Grace, an internal medicine attending,
succinctly states, assumes guilt and forces physicians to prove their innocence. Part of
this false disciplining comes from the belief that all cases of bad outcomes are medical
mistakes. Dr. Johnson comments on the frustration and impact of this assumption:

I think that the litigious society that we live in is a reality. Unfortunately, I’ve
been involved in cases, and in my opinion, many of them were absolutely
nuisance cases. No mistake was made, and yet. Society as a whole does not
distinguish between malpractice and a bad outcome. I think that, I just think that
physicians are very, very wary of being put at risk for malpractice. It’s a real
issue. The VAMC is protected for a certain extent, I think, because of laws. But,
you know, if I were in private practice, and depending on what part of the country
I was in, I could be paying up to $100,000 to $120,000 a year per premiums. And,
if you get sued, or settlements are made against you, it’s just like that, that your
malpractice premiums go way up. It’s survival. It’s a problem.

Outside of the VA, medicine becomes less about the patient-provider relationship and
more about surviving the medical experience. It is important to note the advantage that
VA physicians have. Because VA physicians work for the Department of Veterans
Affairs, which is a governmental entity, they are protected from being named or sued as individuals in a malpractice case. Under the Federal Torts Claim Act (FTCA) of 1946, any individual wishing to sue a federal employee for medical malpractice cannot sue the individual employee, but instead must sue the federal government. An added advantage of the FTCA, as explained by Debra, is that because VA physicians are housed in the federal government, the federal government pays VA physicians’ insurance premiums. This is an advantage for the VA physicians because their insurance rates do not go up yearly like the insurance rates of private practicing physicians. This is because the Department of Veterans’ Affairs houses their own insurance company, funded by the federal government. With private insurance, malpractice cases warrant an almost automatic increase in premium rates. In the VA system, the rate is fixed based on the national average cost of malpractice rates. These rates, however, are influenced by private practice malpractice, meaning that when the average rates go up, so too do the VA malpractice rates.

The repositioning of medicine as an experience of survival rather than of healing places the spotlight on the ways in which constant disciplining, or the fear of constant disciplining, can influence human action. Although the national tort databank serves as a disciplinary agent on a professional level, that punishment is really only visible to members of the profession. Conversely, malpractice and tort claims are societally visible and, thus, disciplines in a different way. Malpractice and tort claims serve as the more severe form of discipline because the consequences appear on a bigger scale.

Additionally, whereas the punishment of the black mark in the databank is primarily discursive, the sanctions associated with malpractice are extremely material.
Physicians that practice in hospitals normally do not pay for malpractice insurance; the hospital pays the malpractice insurance costs. In the VAMC system in Lexington, many of the physicians, including the ones interviewed, worked at the local university hospital, which is connected to the VAMC by a tunnel. This means that although these physicians do not feel the malpractice pinch in the VA system, they feel it in their practice of medicine at the university hospital. Dr. Patterson illustrates the frustration associated with malpractice as a negative sanction as well as the frustration with the material consequences.

Malpractice I think is way off the mark. There’s a lot wrong with malpractice. My gut feeling is that malpractice angers me and upsets me very much. I think it’s, of course, I have the stereotype perception that it’s a bunch of attorneys trying to make a bunch of money and make a big case of something. And the problem is that the reason that is out of control, there are a lot of reasons, but physicians themselves have not been very hard on their own. We haven’t policed our profession as good as we should have, so somebody else has done it for us. That’s my feeling. I think it’s very unfair that you suffer, like, okay, let me give you example. If you are good driver and you have a good record, you usually get better car insurance. But if you are a good doctor and you have a good record, you don’t. Is that fair? No, it’s not fair. But that’s what happens. I used to joke around, I was over here at the clinic, and it was first time I had ever had malpractice insurance outside of the government. I would get a letter every year from my malpractice carrier, saying congratulations, Dr. Patterson. Now it says something like, thanks for having a good year. We are only raising your rates 15 percent this
year. You know, you’ve had no claims. And I’ve never had a claim since I’ve been out of residency. But nobody cares about that. Those are the good stories that they don’t put on the news. And all kinds of things. And also, I think as I’ve worked in this system, I’ve learned that the government is a big target. The government is perceived as having deep pockets. So there are people who are going to go after bigger money rather than fool with somebody who doesn’t have. I’ll tell you what I think would really solve a lot of this malpractice crisis. I’ve read this in some journals and stuff and I think this would be a great solution, is to basically just drop your malpractice coverage. You know what that does? Most hospitals and doctors are so afraid of it, you got to have $1.5 million front-end coverage and $3 million tail coverage, that’s what you’ve got to have for a coverage. Maybe 3 at the front, something like that. And there’s something known as the target phenomenon. So you will attract, the more coverage you have, you are going to attract greater hospital litigation. So, the thought is, take the bull’s eye off your back and say, I’m not going to have coverage. Fine, you can come see me, I’m a great doc, you can come see me, but you need to understand when you walk in the door that you know, if you have a claim, you know. But, there’s a mentality in our society and our government, it’s nobody’s fault. And doctors are perceived as they are all paid well, so they should pay. That’s a perception. The thought of malpractice and that whole thing just nauseates me and what really angers me, if you want to know about that, it’s that you know, when you see these cheesy attorneys, it’s usually during the day TV, all in-between Judge Judy and Jerry Springer and all those. When you see those
ads, they aren’t usually medical malpractice, but they are doing the same thing on car insurance and injuries. But people don’t realize that what they are doing is that those attorneys that do medical malpractice will claim that they are helping society as a whole. They’re not. Just look at the example of some places where they can’t even get obstetrics anymore because the malpractice is too high. So, you know, I mean, you may have made a few people rich, but you’ve hurt the populous as a whole because you no longer have a neurosurgeon or you can’t have an obstetrician to deliver babies because nobody can afford the insurance. Fine, you’ve done it to yourself.

Interestingly, although Dr. Patterson is frustrated with the malpractice system as a negative sanction, he acknowledges that the medical community does not police or sanction physicians. Instead, the sanctions had to come from outside of the medical community. Additionally, Dr. Patterson highlights the recursive nature of medicine and malpractice. The more malpractice insurance a physician has, as a way of protecting him or herself from negative sanctions, the more likely they become a target for negative sanctions. Physicians’ frustrations with negative sanctions, then, are not because there are sanctions, but rather, because those sanctions are often unfounded or misplaced. Dr. Sampson, a urology attending, echoes a similar sentiment in his frustration with malpractice as a negative sanction.

I think that the malpractice, there needs to be check on the system, because just as any process, there are things that can go wrong in the process. So there needs to be a check on that system. I think the idea of malpractice is good; there needs to be somebody looking out on the patient’s behalf, saying is everything okay. The
problem in this country is that it is just gone amuck. I’ve been sued four times. Of those four times that I have been sued, the only one was for that bad outcome. That was a bad outcome, and that, you know, something that ultimately did not have anything to do with me other than the fact that had I never operated on him, he would have been okay. The other three lawsuits were absolutely frivolous. One saying that I haven’t said something when I had a consent form and a picture and a diagram and had a record of a conversation. Yet, four years, multiple conversations, multiple depositions, I don’t know how many hundreds of thousands of dollars, arbitration, everything, I ended up getting dropped. But, four years of being drug through the mud and so forth. Another recent one, you know, the gentleman suing, pardon my French, but it was just assine. An assine one. You look at this and everybody and an incredible surgeon, how could this be, and yet, there we go. Five years, hundreds of thousands of dollars, you get drug through the mud. I sat in arbitration. I just sat there and listen to everyone tell you how bad of doctor you are and awful you are and everything else. That’s, those sorts of things make me very angry because I think that in general, when you are self-critical, when you use mistakes or bad outcomes as an opportunity to look for an opportunity to improve and then when this is, when there is a legitimate one, you feel bad. Often, those are settled because you they are legitimate claims. It’s the ones that are the fishing expeditions are the ones that end up causing the most bad feelings and anger.
The idea of policing physicians is a recurrent theme, as illustrated by Dr. Patterson and Dr. Sampson. Both believe that a policing force is needed in order to administer negative sanctions, but they are frustrated by the current system.

Giddens (1984), in his discussion of negative sanctions, explained that the purpose of sanctions as a form of constraint are meant to be punishments by others that highlight power differences. Within the medical community, it would be difficult for physicians to discipline physicians unless they hold a position of power higher than another physician. This may be one of the reasons that the negative sanctions of medical mistakes come from the legal community, a community outside of the medical realm. As Dr. Patterson points out, the medical community has yet to come up with a truly disciplining sanction, so mistakes are not policed. Negative sanctions in the form of malpractice litigation highlight the fact that a medical mistake moves out of the medical arena and into the legal arena, where lawyers now have control.

Like Dr. Sampson, Dr. Sydney, an internal medicine resident, has seen the emotional frustrations associated with malpractice. Rather than share a personal experience with malpractice, Dr. Sydney talked about watching his brother experience malpractice.

Other bad experiences I’ve had, my brother’s a dentist. He had a dental assistant who sued him for, she had a baby who had a genetic defect, and his insurance policy said you are on your own because you are covered for your employees, your patients, the baby is neither and you know, the state came in and reviewed his equipment and everything was within the standards. His practice was within the standards. After two years of worrying that he was going to lose his house,
who knows, you have a 2 to 3 year old baby that is very severely damaged. You can find some expert somewhere that says it was exposure to radiation, which a dentist office is going to have. And then tears in the jury’s eyes and you know, rich dentist, poor assistant, and you might lose a couple million dollars. And he was on his own. There was no merit whatsoever. It got dropped, but two years of pain for that.

These physicians’ comments illustrate how, in the case of medical mistakes, negative sanctions such as malpractice can have serious material and emotional consequences. These consequences further reinforce the belief that physicians needs to maintain silence about medical mistakes, which offers additional frustrations, as Dr. Campbell argues.

Well, it’s a crazy system. I think there is only one other country in the world that, if any, maybe there’s none that doesn’t use a panel of experts to make a determination if malpractice occurred or not. And that’s extremely frustrating. In years past, the risk manager or the hospital attorney would tell you to just keep your mouth shut. The frustration for the family was not getting information…In private practice, the friends I have, you know, their risk managers tell them to keep your mouth shut. That’s wrong. They don’t typically. They talk to the patients. That appears to be helpful, not hurtful, in the majority of the cases because the frustration is anger at the doctor and the inability for the patient or the patient’s family if they died or are severely injured to find out what happened to their loved one or what went wrong. What happened? Nobody will talk to them.
They are told to clam up often by the hospital lawyer and let it shake out in court.

It’s extremely frustrating.

Part of Dr. Campbell’s frustration is born from the fact that the medical community is not the community providing discipline. The consequences that Dr. Campbell talks about emerge from the silence of the medical community and the community’s inaction in policing and disciplining their own.

Physicians’ frustration with the lack of policing by the medical community is also grounded in a fear of what kind of action will come as a result of a medical mistake. Dr. Montgomery discusses the hesitancy physicians experience, using evidence-based medicine as an analogy to admitting guilt.

I think a lot of it is tort. I think a lot of it is the risk, the feeling that this is an admission of guilt and it will be held against them. I’ve done a lot of work on clinical practice, evidence-based guidelines. And one of the big oppositions to that is the feeling is that if we accept it, then you accept that you have to practice that way. It doesn’t say that. I mean evidence-based guidelines are guidelines. I mean, so we would hope that physicians would individualize the treatment and realize that this is a guideline. Now, if you deviate from the guideline, there should be a reason for it. Maybe that patient is allergic to that medication or maybe they don’t want to take it or maybe there are other reasons that you would not do that. But I think there is feeling that if they concede to guidelines and then they don’t practice according to the guidelines, then there is risk to legal repercussions. I think that’s the same, it’s a very litigious society at the moment.
Physicians are still actively courting risk in the practice of medicine, and courting risk means being aware of the consequences associated with the risk. If physicians embrace the uncertainty and ambiguity associated with medical mistakes, they inherently must deal with patient care on an individual basis. This individualized based care is where the risk in medicine lies.

The negative sanctions of medical malpractice are not just experienced on an individual level. Hospitals are also forced to negotiate the consequences of negative sanctions. As a business, hospitals experience different consequences as a result of negative sanctions, primarily consequences that have to do with financial and organizational appearance. Dr. Davis illuminates how hospitals have to navigate negative sanctions:

They [hospitals] worry about legal liability. And they worry about their good name in a community. And their brand name in a community. So they don’t want to be on the front page of a newspaper associated with some harmful event to a person who got care in their hospital. They have, all hospitals have risk managers, and what the risk manager’s job is is to worry about legal liability risk to the hospital, not, and I emphasize not, about risk to patients. I’m not suggesting for a moment that somebody who runs a hospital doesn’t care about patients getting hurt for a minute, I don’t believe that for minute. They do. But, their primary, if you are in the office of the CEO of Senior Leadership in a hospital and there is a public, something becomes publicly known through the media about an adverse event, they go into damage control. How can you limit damage control in terms of
our perception our brand name in the community and how can we minimize our legal liability exposure?

As Dr. Davis’ comment illustrates, medical mistakes are equally a concern for hospitals. The primary difference between physicians and hospitals is the kind of questions and concerns that emerge. How hospitals have to negotiate negative sanctions inherently influences how physicians make sense of negative sanctions and practice medicine.

Medical malpractice is not the only societal disciplinary tool that influences how hospitals and physicians negotiate negative sanctions. The introduction of managed care and health care reform serves as a more “hidden” form of discipline because it creates another set of constraints that must be followed. If physicians fail to practice medicine though the lens of those constraints, physicians and hospitals will become further disciplined. Dr. Grey talks about how these “hidden” forms of discipline:

The other is that medicine is kind of not as personal as it used to be. There are a lot of technical and business, it’s so involved, it’s hard to talk to people. We have so many patients because of health care reform and insurance and the regular set up. We have to see so many patients that we can’t get involved with our patients anymore. It all tends to make it impersonal. That’s just one part of it. And, pushing the doctors the way they do with insurances and Medicare and all, it leads toward mistakes. Doctors don’t feel like they have the time they should have with the patients and do the things that they think they need to do. There would be less mistakes, better quality. And, it’s something the doctors can’t help. We can’t help it. It’s just our society and the system that we have. Health care is so expensive,
and everyone expects so much, all that together. Health care is so expensive because the insurance. The insurance is so expensive because of health care.

Dr. Grey’s comments illustrate two important aspects of negative sanctions in medicine. The first aspect is how the disciplinary nature of negative sanctions is cyclical. Insurance is one of the disciplinary tools that companies use to punish physicians. When physicians make mistakes and are reported to the national tort databank, insurance companies increase the cost of that physician’s insurance rates. That raising in insurance rates, then, forces hospitals and clinics to increase the cost of health care in order to cover the increased insurance rates.

Secondly, the cyclical nature of this form of discipline continually reinforces the disciplinary nature of negative sanctions. Dr. Grey’s comment also highlights the interesting way that negative sanctions end up disciplining the groups they mean to help. These kinds of health care sanctions are experienced by health care providers and patients. Patients are not supposed to be disciplined as a result of a medical mistake; however, they end up paying as a result. Physicians have the enduring “black mark” on their record and may have to pay higher insurance premiums because they made the mistakes. Conversely, those monetary sanctions are then passed to the patient, disciplining the patient in a monetary fashion, as well.

**Summary**

Physicians are presented with a complex and complicated web of tensions when physicians make sense of the practice of medicine and medical mistakes. The primary tension of whether to strive for perfection or embrace his or her human flaws is inherently influenced by the physical limitations and constraints of the body. Regardless
of whether physicians wish to be perfect and excellent, they will always be limited by what their bodies can do. Tied to this tension, then, are how physicians make sense of each side of the tension. Issues of responsibility and ownership of the medical mistake experience intertwine with the pressures of being prefect and human.

These tensions are further compounded by societal and organizational disciplining of mistakes through negative sanctions. For physicians dealing with medical mistakes, the negative sanctions are both publicly visible and enduring, marking a physician throughout his or her practice of medicine. Physicians have to negotiate not only the corporeal limitations of the body in the practice of medicine, but must also negotiate the material exigencies that also lead to sanctions. Additionally, as the physicians here have mentioned, disciplining because of medical mistakes is not limited to the physician; hospitals and patients also have to deal with the consequences of medical mistakes.

From Failure to Forgiveness: Disclosure and Apology as Embodied Emotional Redemption

*Dr. Vaughn: It’s almost like hitting a pedestrian on the sidewalk. You are driving your car, you’re preparing, you’ve got your headlines on, you’ve buckled your seatbelt. You are going down the road, whatever, for whatever reason, if you were to hit somebody, you aren’t setting out to do that. You are going about your business. Sometimes things happen and you would feel horrible about and you would replay it in your mind about how you could have done things differently. Maybe you were talking on your cell phone. Maybe you were distracted. Regardless, you feel horrible about it. And I feel horrible about any mistake I have. Horrible.*
Dr. Vaughn, an ophthalmology resident, offers an interesting analogy about medical mistakes, likening the emotions of medical mistakes to that of accidentally hitting someone with a car. He highlights the tension between preparing, buckling your seatbelt, turning on your headlights, and being distracted. According to Dr. Vaughn, small things can result in mistakes. Along with this tension, his analogy is interesting because it shines a light on several of the elements that go into mistakes, including the emotions associated with making a mistake. As discussed in previous themes, making mistakes in medicine is part of the medical experience. When a physician makes a mistake, he or she must deal with the emotions associated with that mistake. Making a mistake in the medical realm is a different experience than making a mistake in other professions because the mistake can result in a patient’s death. Physicians are socialized to learn how to manage their emotions in the medical encounter, encouraged to be emotionally detached (Halpern, 2001).

VAMC physicians, like any individuals working in an organization, are prone to making mistakes. Burke (1954) argued that when individuals in a system fail or reject the rules and norms of an institution, they go through an emotional cycle in order to work through the mistake, make amends, and get back to enacting the norms and rules of the organization. This cycle is predicated on “two great moments,” (Burke, 1954, p. 283) “original sin” and “redemption.” “Original sin” is the result of inherited guilt or sin from others that come before from someone else’s sin. Sin, inherently, leads to feelings of guilt and shame because an individual knows that he or she has deviated from the hierarchical rules of the organization.
Its ultimate expression in a system of moral purgation based on the two
“moments” of “original sin” and “redemption,” it would seem to follow that the
“guilt” intrinsic to hierarchical order (the only kind of “organizational” order we
have ever known) calls correspondingly for “redemption” through victimage.
(Burke, 1954, p. 284)
Emotions such as guilt and shame are required for an individual to be redeemed, for if the
individual does not feel any kind of remorse for deviating from the norm, then he or she
has not truly sinned.

In order to be rid of guilt, individuals enter into the purification stage of the cycle.
Purification can come in two forms: mortification and victimage. In mortification, the
guilty individual offers some kind of personal sacrifice (Samra, 1998). Mortification
requires the guilty individual to symbolically offer something to society in order to
restore balance to the organization. Typically, mortification involves publicly
acknowledging mistakes. Victimage focuses the guilt outward, identifying a “victim” or
scapegoat and a villain. Victimage is a strategic act that looks to transfer guilt by blaming
another for the mistake. An important element of the purification process is selecting a
purification act that is equal to the sin. “The act of purification then must be appropriate
to the sin of the guilty for drama to succeed as an act of redemption” (Samra, 1998, p. 2).
In mortification, the self-sacrifice must be equal to the sinful act. In victimage, the victim
or scapegoat must be an appropriate actor on which to place the blame. Purification, then,
is a very strategic discursive act and influences whether an individual can be redeemed.

Redemption, the last part of the cycle, is achieved when the organization
recognizes and accepts an individual’s mortification act. Burke (1970) identified several
options for redemption, ranging from rewards to punishment. For redemption, the most appropriate option is *counter-order*, where redemption is achieved through transcendence of sin by demystifying the sin and the organization. Transcendence through counter-order provides individuals an opportunity to see the inner workings of an organization in order to understand why the mistake occurred (Shultz, 2000). Transcendence serves as a way to break down the mystery of the organization (or hierarchy) and the actions of the organization.

Medicine’s “original sin” is the medical mistake. Medical mistakes, as discussed in a previous theme, stand in the face of the belief that the practice of medicine is the practice of perfection. Physicians inherit the belief that they are not supposed to make mistakes in the practice of “perfect” medicine. This particular view of medicine positions medicine as a science, and thus, supposedly free of error (Montgomery, 2006). In the traditional medical hierarchy, even though mistakes are a common part of the medical process, physicians are prohibited from completing the redemption cycle. Sin occurs, but purification and redemption does not.

Conversely, the disclosure and apology program at the VAMC provides VA physicians the opportunity to work through the redemption cycle. The disclosure and apology program serves as an *embodied* expression of the emotions traditionally hidden or silenced by the medical system. The guilt and shame VAMC physicians experience are embodied in the physicians’ discussions of fear and failure. VAMC physicians also experience both mortification and victimage. As Burke (1954, 1970) explained, individuals who sin and wish to be purified have to either symbolically offer up the self or identify a victim. Burke even suggested that mortification and victimage work together
as a pair, where victims can be identified and an individual can symbolically offer his or herself up for absolution (Burke, 1970). Bobbitt (2004) argued that many scholars have separated mortification and victimage, but that if a scholar wants to truly understand a redemption experience, then the scholar must identify mortification and victimage. The disclosure and apology program allows physicians to perform mortification through the act of disclosing to patients or patients’ families. The physicians also perform victimage by re-envisioning the physicians as second victims in the medical mistake experience. VAMC physicians still engage in the emotional expressions of guilt, but are now given the opportunity to complete or attempt to complete the redemption cycle through the discursive act of the apology.

_Fear and Failure as Embodied Guilt and Shame_

After the medical “sin” of the mistake, physicians may experience guilt and shame. Guilt is the failure to live up to one’s own picture of oneself, whereas shame is a reaction to criticism by other people (Shultz, 2000). Guilt manifests because an individual believes that he or she has “injured, unjustly hurt, or failed to help someone (Andersen & Guerrero, 1998). Conversely, shame focuses on others’ perceptions of the individual who has erred. Shame is unequivocally tied to embarrassment because attention is focused on the individual (Andersen & Guerrero, 1998). Both guilt and shame highlight the interpersonal relationship inherent in human activity. Additionally, guilt and shame force an individual who has erred to question his or her existence and beliefs. “Whereas, feelings of guilt emphasize the importance of one adjusting themselves so as to fit into the larger society in which one lives, the encountering of shame if confronted full in the face may throw an unexpected light on who one is and point the way toward who one
may become” (Shultz, 2000, p. 256). In the case of medical mistakes, VAMC physicians, guilt manifests because physicians have inflicted unjust injury or death on a patient. Shame appears as a result of the mistake being reported and exposed to patients and other physicians. For VAMC physicians, guilt and shame manifests itself in the recognition of failure to a human being and in fear of the unknown future because of the mistake.

VAMC physicians spoke to the fact that medical mistakes inherently represent a failure to patients and to the practice of medicine. During the interviews, many of the VAMC physicians explained that they went into medicine because they wanted to help people. For the VAMC physicians, the practice of medicine is the practice of helping people. A mistake, then, means that the physician has failed to help patients. Failing to help a patient may result in guilt over the failure. For many of the VAMC physicians, these feelings of failure result if there is a bad outcome, not just a mistake, because the physician caused an unjust injury to the patient. Dr. Anderson explains how guilt can manifest, even when there is no mistake.

Number one, you feel sorry and bad for any bad outcome, and you do that regardless of whether a mistake is made. For example, when I would deliver a baby that did not do well, and I certainly have delivered babies that haven’t done well, and I had no involvement in terms of causing that, for example, I delivered children with very severe congenital anomalies, and obviously there’s nothing you can do about that. You just feel sorry, you can feel the emotion and the pain that the patient has. And most health care deliverers are pretty emphatic people, otherwise I don’t think they would go into health care. There’s exceptions, of
course. So, you feel that way. The other thing is, if it’s a medical error, then you feel guilt. And you feel that you failed the patient in some way.

Dr. Anderson highlights a key element of the cause of guilt for physicians: empathy. Although physicians are encouraged to emotionally detach in order to practice medicine, empathy is still expected from physicians. This empathic connection to patients means that physicians place blame on the self. Dr. Vaughn expresses his feelings of failure as a result of mistakes.

Depression. Failure. You feel like you are worst doctor. I mean, my first cataract, it went bad. I was a first year resident and I felt like I was never going to be able to make it as a doctor. Probably the worst emotion, it was probably the worst day of my life. I felt like, you know, I had harmed somebody that I was trying to help. I put someone through something, and I don’t know, I just felt like a complete failure. That’s the easiest way I can say it. I felt like a complete and utter failure. For Dr. Vaughn, failure resulted in his thinking that he is the “worst doctor.” Not only has Dr. Vaughn failed the patient, but he feels that he has also failed himself. The day he made his first mistake, was the “worst day of his life.” Dr. Vaughn goes on to explain, “I got a massive headache. I felt sick to my stomach. I couldn’t get the sickness to stop.” Dr. Williams expresses a similar feeling, stating, “It’s horrible. You’re stomach sinks. I get physically nauseous just thinking about the mistakes I’ve made.” For Dr. Vaughn and Dr. Williams, guilt was physically embodied through sickness. Many of the physicians interviewed said they experienced stomach pain and headaches; Dr. Patterson reported getting an ulcer as a report of a malpractice case that stretched on for years.
Part of the reason that VAMC physicians experience physical pain as a result of feelings of failure is that the physicians constantly play the mistake moments over in their heads. This means that the physicians continue to relive the moment, thus, never getting over the guilt of the mistake. Dr. Sampson highlights how thinking about a mistake can continue to manifest guilt.

Generally, anything like that you get very self-critical. I do at least. I chastise myself for you know, I should have been more careful, I should have done an X-ray. I always look through the retrospective-scope and say well, what would I or could I have done differently? And so, you generally go through those questions several times. The outcome of that process is often very different. Sometimes you realize that there’s not really anything else that I could have done and that was just one of those things. Sometimes, you say, well maybe if I’d thought a little differently or done something a little differently. Ultimately, I think some good comes out of it because you grind through the process. I probably do it more than I should. That self-critique is probably the first thing that you do. I get mad at them a little bit. It’s not mad at the patient. It’s mad that I did or something didn’t go the way I wanted. Again, that’s just part of being a little bit of perfectionist, I think.

Other VAMC physicians express a need to have this kind of self-critique, even though it can be dangerous. Dr. Sampson went on to explain, “It can be dangerous, though, to think about it. Eventually, you have to stop or it will eat you alive.” The self-critique and constantly thinking through the experience can be a learning process, as Dr. Johnson sees it, because then the physician thinks about how the experience could have gone.
I think it depends on the mistake and how serious it is. If it’s a mistake, a fairly trivial mistake, there’s probably a mental don’t do that again, that’s not good, kind of reaction. I think if it’s a mistake that causes harm to a patient, there is a lot of anguish that goes with that. A lot of playing it over and over in your mind. What you did, what you could have done differently, how did it happen? Those kinds of things.

Ultimately, the rethinking of experiences forces physicians to question what needs to be done as a doctor. As Dr. Nelson explains, he must balance between being empathic to the patient and figuring out how to work through the mistake.

You empathize with the patient and you try then to be as supportive to the patient and their family as you can. Now, in the back of your mind, you are still going through things. You know, I would have not operated or we will fix the problem in pharmacy, or I will give a course to the nurses. You may still be going through all those things. But, I think it’s very difficult, you know, I can remember as a young surgeon and would do complicated cases. And you would lose some. And I think it’s a very difficult thing to deal with families when you lose patients. Particularly if you lose them in the operating room. It’s devastating. At the same time, you kind of have this balance between you know not an arrogance, but it’s sort of a confidence level that tells you to get back on the horse. Even if you’ve made a mistake and you’ve got to learn from it and move on through it.

Many of the physicians reported always thinking about the “first one,” the first case in which a physician kills or severely injures a patient. As Dr. Pope, one of the program creators explains, “You never forget the first person you kill.” It is this type of language
of “killing” a patient that continues to feed guilt. In the previous theme that focuses on the narrative expression of mistakes, the stories physicians tell are clearly emotionally laden. During two of the interviews, the physicians had to stop the story because they started crying during the telling of mistake narratives. Retelling the potentially traumatizing medical mistake narratives means that physicians relive traumatic medical mistake events. Through the constantly reliving of mistake experiences, physicians constantly experience guilt.

A second emotional element of failure as the embodiment of guilt and shame is that VAMC physicians see the failure as a test of ego. Several of the physicians reported becoming defensive because failure forces the physician to question his or her competence and ability. In the case of VAMC physicians, ego is linked to expressions of shame.

Shame involves exposure, particularly unexpected or involuntary exposure which leads to a desire to hide, cover up, or sink into the ground; forces us to recognize our own incongruity or inappropriateness within the social situation; shatters our trust in the world in which we live and those who are in authority when reality contradicts what we have been led to expect; is all consuming and therefore can only be transcended in so far as there is some change in our whole self; reveals the tragedy of life (ours and everyone’s) which when confronted can lead to transcendence; and is difficult to communicate, because it is essentially an isolating experience so that only if it is shared and a language developed to express the experience can it be overcome. (Shultz, 2000, p. 256)
Shultz’s understanding of how shame manifests in communicative action. Failure as a test of physicians’ egos echoes many of Shultz’s manifestations, especially how shame forces individuals to recognize incongruity in a social situation and how it can shatter trust in the world and authority.

Failure as a test of ego calls into question the incongruity of making mistakes in medicine as well as how physicians are not “supposed to” make mistakes. Many of the physicians felt that this ego questioning highlighted that he or she was supposed to know something. Dr. Campbell illustrates this point and highlights how this leads to guilt about failing the patient.

You feel dumb in terms of “Gee, I’ve been doing this a long time, how in the world could I have done that?” There’s always reasons. It’s usually that there is something a little bit different about their anatomy. You feel bad, bad for the patient.

For Dr. Campbell, the failure is impacted by the fact that the mistake might have been prevented because he had been practicing for a long time. Physicians have so much knowledge that must be learned and retained that it can be difficult to make sense of all the information. Additionally, it can be difficult to connect all of the information together to make a diagnosis. Dr. Daniels uses a computer analogy to make sense of the difficulty in sifting through knowledge, pointing out how easy it can be to make a mistake about something that he does know.

Well, the first one is kind of a feeling of being down because you either didn’t know about it or you failed to recognize it. You don’t feel good. You know, there are some things that we learn that as you’re going about your daily work, you
have to pull out of the computer, the computer being your brain, information
while you are doing all kinds of other different things at the same time. The things
that bother you the most if you make mistakes are those things that you do in fact
know, and you just made a mistake while you were doing them because you
weren’t paying attention or were being distracted or whatever the circumstance
may be.

Dr. Daniels’ comment about mistakes being a result of not remembering something that
he already knew highlights a frustration in the ease in which mistakes can happen. This
ease, which leads to an affront to ego, results in the VAMC physicians sometimes
becoming defensive about their medical ability as well as attempting to place blame on
another party.

Like Dr. Young, many of the VAMC physicians discussed the difficulty in
admitting that a mistake was actually made because it forces the physicians to recognize
that they will make mistakes. Admitting that one can make mistakes breaks down the
confidence a physician has in his or her ability to practice medicine.

But there’s comes a time even if you do all that, you realize that either you made a
mistake or even if someone in the team made a mistake, in many ways you are
captain of the ship. One of the emotions you go through is an ego thing. It’s an
affront to your ego, it’s a dent in your confidence. Then I think you kind of, if you
intrinsically have compassion for the patient, then I think you work through that.

As Dr. Young stated above, VAMC physicians have to admit that admitting to mistakes
challenges physician ego. If the physician is the “captain of the ship,” then ultimately, the
physician is the one that must take responsibility for the mistake. Dr. Sydney has a
similar concern with taking responsibility for the guilt and shame of medical mistakes, and discusses the defensive ego-saving tactic that comes with blaming others.

I think it is a real human tendency to look for blame in others, as I said, it’s the nurse’s fault, we don’t have the right equipment, it’s was the patient’s fault, they are too sick, it’s their fault, how dare they die on me or how dare they get this complication. You know, I think there’s always those things that we go through and particular as surgeons, I don’t think we have evolved or genetically developed as a profession like some other professions. For instance, I’m using airline pilots as an example, where, you know they get routinely tested on simulators or someone will come in and sit in on their performance. If you said to most surgeons, you know, the chief of surgery or some outside surgeon is going to come in and watch you do cases every 3 months or 6 months, I mean, they would be up in arms. And I think they would be partially up in arms because I think their assumption is that they are doing the best they can and they are well-qualified. If you ask surgeons, there is no such thing as an average surgeon. No surgeon would ever say “I’m average.” And, maybe that’s a good thing. So, there’s that immediate affront to your ego, to you confidence, that this has been a failure.

Dr. Sydney’s comment highlights two key elements of guilt and shame as an affront to physician ego. The first element is that his statement shines a light on the ease of identifying a “scapegoat” in the medical mistakes experience. There is tremendous pressure on physicians to care for and treat patients; part of the VAMC’s mission statement is that patients should not leave the hospital worse than when they entered. The pressure associated with that amount of responsibility can push physicians to point the
blame at another party. By suggesting that another party is responsible for the mistake, the physician is attempting to remove feelings of guilt and the shame that will come with a mistake. It is easier to put the blame elsewhere than to admit that the mistake may be of one’s own making.

Interestingly, even though the physicians may have initially pointed the blame at other parties, they are quick to point out that in the end, it is the physician who is responsible for the mistake. Dr. Montgomery points out this struggle in his discussion of admitting to mistakes.

I think, trying to think of ways to verbalize it, but I think for all of us there’s a tendency to be, you know, almost to take, to become defensive about it because it’s hard at any time, when anyone makes a mistakes, in any conversations, in any sort of discussions, we all have trouble as human beings to say, you know, I made a mistake, you know, I screwed up. And, you know, even as kids we sort of learn not to do that, although we would then learn to do it because you knew at least you would get into twice as much trouble if you didn’t admit it. So, I think there’s always, and it’s a very, there’s a confidence in the profession that is required that mitigates any tendency to admit error. We want to do the right thing. We are dedicated. We hate to think that disease can beat us.

At the end of Dr. Montgomery’s comment is another frustration with mistakes: admitting to mistakes ultimately means admitting to not being able to “beat” the disease. Guilt and shame are easier to manifest in cases of medical mistakes because physicians can point to a particular reason for the mistake and attempt to prevent it from happening again.

Ultimately, the affront to ego shines a light on the frustration that physicians feel because
they cannot “beat” every disease. The affront to ego highlights the shame physicians feel because they cannot save every patient.

Finally, shame is embodied through physicians’ fear of the unknown. The earlier discussion of failure as affront to ego and a failing of patients ultimately lead to the fear of what is going to happen to the physician. Dr. O’Malley eloquently highlights the questions that may race through physicians’ minds as they attempt to negotiate guilt and shame.

It was a sense of fear. What are people going to think about me? My peers; am I going to be embarrassed among my peers? Fear of failure in that my referring doctors are going to lose confidence in me. Is this family going to talk to other families and say that I’m not a surgeon? So, that fear is another emotion. And embarrassment, which comes out of that. And then, you worry, anxiety, you are anxious about having to discuss among your peers and about potentially getting sued. But, I think fear of failure and embarrassment are much more stronger emotions than fear of lawsuit. And I think it is for most physicians.

This fear of the unknown is a painful expression of shame because it is unknown. Burke (1954, 1961) does not discuss whether or not exposure and the consequences of mistakes are known to individuals. For the VAMC physicians, there is a fear of not knowing how peers are going to react to mistakes. Thus, there is an unknown element associated with shame. Dr. Kendall further explains that it is this fear of not knowing what is going to happen that forces many physicians from not admitting to mistakes. She questions, “Why would you tell someone if you didn’t know what was going to happen to you?” It is clear from previous themes that the VAMC physicians are extremely concerned about the
consequences of making mistakes (which comes in the form of “black marks” in the national tort databank and medical malpractice claims).

Ultimately, the guilt and shame associated with medical mistakes may force some physicians to question whether medicine really is the right profession. Dr. Xavier, the only first year resident interviewed, talks about his constant questioning of whether being a physician is the right profession for him.

But honestly, I shouldn’t have missed any of this. In my mind, there are things that I shouldn’t miss as a first year, second month intern. I feel miserable. I was all these feelings that we’ve talked about. Sick and disgusted with myself. To be honest, faith is a very important part of my physicianhood. To be honest, I went home questioning, God, am I in over my head? Have I bit off more than I can chew? Were you really involved in me becoming a physician? I thought you were, but now I’m like, can I even handle the basic stuff. He ended up recovering and doing okay, but I will honest, I was scared to death that because of my mistake he was going to die. There wasn’t anything that I could do about it because I had made the mistake. You know, down the road, it made my hyper vigilant, hyper-vigilant to check everything. It made me grow as a person, but at the same time, I wish I could have had that growth without the pain. So, it was very tough to deal with. For a week or two there, with the stress of an intensive care unit bearing down, I questioned my decision to become a physician. And there are still nights, in the middle of the night when you are just feeling this stuff, I still do. I believe I’m where I’m supposed to be, and I believe I’m doing that I’m supposed to be doing, but even still. We are dealing with people’s lives, with things that are vital
to them. They are strangers to you, but they are entrusting you. You don’t want to make a mistake. When you do, you chew on it for a little while.

Dr. Xavier’s comment illustrates all of the elements of guilt and shame that are embodied through failure and fear. Like Dr. Montgomery above, Dr. Xavier must come to terms with the fact that there are limits to what he, as a physician, can do for patients. All of the VAMC physicians at some point in the interview talk about or admit to feeling frustrated with the fact that they cannot save all patients. Patricia, one of the co-creators of the program, serves as the initial program contact for physicians who make a mistake. She highlights all of the elements of failure and fear as the represent guilt and shame.

The first one is horrible guilt. I will go back to the first resident with Mrs. Potassium Overdose and the one who called last week about the wrong surgery. They are vastly sort of different, I mean this lady died, this one got the wrong mole taken off. But the experiences that they have, the emotions they go through are, I won’t say that this guy was as devastated as this one was, but he was angry at himself, he was angry at the system, worried, guilty because this person whose, you know, in his 80s is now going to have to come back for another surgery. I think there is, there’s anger. There’s guilt. The things they say to me, like the guy who called and said I think I killed a woman [this story is shared in the medical mistake narrative theme]. Lori, who was the potassium overdose, she said, “I don’t know if I can be a doctor or not.” And then, you know, the surgeon who has taken off he wrong lesion said “I can’t believe this happened. I’ve been doing this for seven years. I’ve never taken off the wrong lesion. And so now, what does that mean? Because I’m finishing this fellowship, am I going to be
reported to the databank? I’ve got this new baby of the way.” So, I mean, it’s
guilt, it’s fear, it’s anger, it’s sorrow. There’s a lot of sorrow in their hearts. It
hurts their hearts to make mistakes, even though they know up here, I’m just a
human being, as long as I’m a human being, I’m going to make mistakes because
I’m not perfect. But, then you transfer that to the heart where they don’t exactly
always believe that to be true. If I’m vigilant, if I’m safe, I will not make
mistakes. I will not hurt somebody. Even the most vigilant, safest, with an
infrastructure that allows the Swiss cheese to line up, the mistake will happen. It’s
not their mistake. It’s a mistake. Sometimes, there are mistakes that are the
individual’s, but they are very sorrowful, feel very guilt. I’ve never ever had one
that didn’t. Never.

Patricia explains that this questioning of whether a physician has made the “right”
decision to become a physician is one that is exacerbated by making a mistake. During
the retelling of the first medical mistake that was the impetus for the program, she
explains how she witnessed the physician who made the mistake question her ability.

Patricia’s comment shows that the guilt and shame physicians feel may never truly end,
regardless of whether or not physicians have the opportunity to express remorse, ask for
redemption, and be redeemed.

The Second Victim as Embodied Internalization

A key element of Burke’s narrative form of redemption is the act of identifying
victims, or scapegoats, and villains. In traditional medical mistake narratives, the
physician and hospital are cast as villains and the patient as the victim. This naming
process logically makes sense because the patient’s body is where the mistake happens,
the patient is the one the mistake happens to. The physician, then, is cast as the villain because he or she is the one who made the mistake. VAMC physicians have to negotiate the guilt and shame he or she experiences as a result of making medical mistakes. VAMC physicians negotiate the guilt and shame by internalizing the emotions.

Internalizing guilt and shame can have a devastating effect on physicians because physicians do not get a chance to work through and talk about the emotions and the experience. VAMC physicians, as mentioned earlier, have the opportunity to enact and embody mortification and victimage. For the VAMC physicians, the internalization of emotions serves as a kind of victimage act. The VAMC physicians enact victimage in a different way; instead of turning the blame outward and identifying a victim, the VAMC physicians turn the blame for the mistake inward. This turning of blame inward re-envisions the idea of the victim and villain in medical mistake narratives. Rather than positioning the physician as the villain who made the mistake, VAMC physicians re-envision the physician as the “second” victim in the medical mistake narrative. Now, there is no villain on which to blame the mistake. Instead, there are only multiple victims in the tragedy. Rather than strategically placing the blame on another individual, the VAMC physicians place the blame on him or herself. Dr. Davis explains how he makes sense of the fact that a patient, a human being, died as a result of his actions.

You feel internally, very bad about yourself. You look into yourself what could have I done differently. This person died on my watch. You feel really bad about it, you beat yourself a lot. Everybody does this. And people stuff it. Physicians especially, stuff it.
Dr. Davis’s comment highlights how physicians “stuff” the emotions, or internalize the emotions associated with the mistake. This act of internalization means that physicians are not given the opportunity to work through the emotions of mistakes.

Part of this internalization and “stuffing” of emotions is based on the belief that physicians should rise to a level of excellence. This struggle between perfection and humanness has been discussed in a previous theme; however, its saliency resonates through the emotional experience of mistakes. Dr. Patterson reflects on how this tension influences the way he emotionally makes sense of mistakes.

Of course you feel bad. I mean, you feel terrible because we all do. We aren’t perfect but we all expect perfection in ourselves. This is not a profession that accepts mediocrity. It just doesn’t. I live by that standard and try to practice by that standard. But, it’s hard. Yes, it’s hard to take. I don’t like it when it happens.

Obviously, I don’t feel good about it. And I’m hard on myself.

Dr. Patterson’s comment is interesting, not only because it harkens back to the overarching tension in medicine that physicians experience, but also because it emphasizes an almost inherent trait in physicians to practice medicine. Dr. Xavier explains this idea in more detail, stressing the role of his personality in the way he makes sense of mistakes.

It’s so hard to not take this job home. It’s so hard to separate yourself from this.

We are all Type A personalities. We are trying to do the best job that we can.

Most of us have gotten into medicine because we enjoy working with people and want to help people. When that breaks down, and, you just, you know, at least with my personality, and I’m pretty sure working with these guys [other
opthalmologists], that they are the same way, it’s all your fault. There could have been a breakdown with the nurses, but it’s still my fault. I take it home. My family tells me that.

Like Dr. Xavier, many of the physicians referred to a difficulty is reconciling mistakes with a drive to be perfect. The “type A” personality that Dr. Xavier refers to makes it difficult to accept the fact that a mistake has been made at all, which means that it is difficult to work through the emotions. Dr. Davis’ and Dr. Patterson’s reflections shines a light on the difficulties associated with making sense of the emotions associated with medical mistakes. They must deal with the knowledge that they have injured or killed another human being, and the recourse they seek is often to internalize the emotions. As Dr. Xavier expressed above, this internalization can be difficult at times, and physicians may not be able to detach the emotions experienced at work from the rest of their lives.

Because the VAMC physicians place the blame on the self rather than on the patient or another outside force and because these physicians, like most physicians have been socialized to keep these emotions inside, the VAMC physicians internalize the act of victimage. Dr. Young explains how the organizational socialization and processes of medicine lead to physician victimage.

There is no place to get this out and to have a debrief, have some processing of what happened. Surgeons don’t do it with each other, morbidity and mortality conferences are not like that at all; they are very business like, very cordial. Oh, it’s too bad that happened. They don’t even say that. You just, it’s very matter of fact. A patient died. Let’s talk about why that patient died, and how you did the operation, how you cared for the patient. You are taught as a physician to be
emotionally detached, or affectively neutral was the word they used in medical school. It’s hard to do that. That’s the way we are taught. But, I internalized it, felt very bad about myself.

Interestingly, Dr. Young’s comment highlights two ways in which physicians are victimized in the medical mistake process. First, physicians become second victims through the socialization process, where physicians are taught to “emotionally detach” from the entire medical experience. Dr. Vaughn echoes this sentiment, explaining, “That’s where I think being a professional, there’s a level of professionalism where you have to kind of separate yourself from your emotions and go about your business. It eats at you.” The grand narrative of what it means to be a physician encourages physicians to separate from the experience. Inherently, then, physicians will attempt to emotionally detach from the mistake experience, and like Dr. Davis, internalize the emotions. Second, Dr. Young’s comment shows how the organizational processes and rituals associated with medical mistakes, while a learning tool to identify where the problem occurred and how to prevent it, does not provide physicians space to work through the emotions of guilt and shame.

Many of the VAMC physicians talked about the need to detach and separate in order to make sense of mistakes. Dr. Kendall puts this succinctly when she explains, “Well, you deal with it and move on.” “Moving on,” as Dr. Kendall frames it, can be difficult because, even though the physician may detach him or herself from the experience, another patient or event may trigger emotional feelings. Dr. Johnson reflects on how he tries to compartmentalize mistake experiences.
I guess I compartmentalize them. But they will resurface when you come into a situation that’s similar or that’s…There was a particular instance, not uncommon, not infrequently, come into contact with a relative of the patient that may have suffered from a mistake. And, there’s just kind of an emotional wrenching of I wish I could go back and do it differently.

Dr. Johnson’s comment really highlights another important aspect of the internalization: the physician still has other patients to see and still has to practice medicine. For the VAMC physicians, detaching from the experience almost serves as an attempt to move past being a victim. If the physician does not think about it the failure or work through the emotions, then, logically, he or she is no longer the victim of the experience.

Detachment and compartmentalizing are not only a way for the physician to move away from victimage, but many of the VAMC physicians felt it was also beneficial for patients. Dr. Tanner explains how focusing on his successes helps him to detach from the mistake experience.

I think, ultimately, time takes care of that. You have to think of all the, you know, you may have one failure measured against 100 successes, so you have to kind of balance it. You say, okay, this was one individual, things didn’t go according to plan, but think about all the other people where things did work out well. You have to put things in perspective and kind of get back into the saddle. One of the hardest thing to do is if you’ve had a complication is to, you know, go into the OR and operate on your next patient. You have to put that one behind you and say, okay, you’ve got to concentrate on the task that you are working on at that moment.
Dr. Tanner’s comment points out an important aspect the practice of medicine. Even though a physician may make a mistake, he or she still has to see patients and care for others, including the patient who was one of the victims of the mistake. Dr. Nelson explains the importance of detaching in terms of providing care to patients.

Well, you have to realize that I spend most of my career in critical care, so, and pulmonary medicine, which includes some pretty bad diseases, many of them terminal. So, I was pretty experienced in delivering bad news and what happens when you become a doctor and you have to do that, you immediately learn how to stand back emotionally from it. You can’t stand too close because then you get sucked up in it and you can’t be effective and you don’t want to be too far back and be cold. So, it’s sort of a middle ground.

Interestingly, it is this detachment for the patients’ sakes that further victimizes the physician. Rather than internalizing mistake emotions because of socialization or organizational norms, physicians internalize emotions for the patient. VAMC physicians still have to provide care for patients, including the patient that was the other victim of the mistake. By placing the patient’s needs and care first, physicians are further victimized. Many of the VAMC physicians used the excuse of care to justify internalizing the mistake emotions.

VAMC physicians become second victims of the medical mistake narratives because the physician is part of the mistake experience. Like patients, the physician experiences the mistake as the primary actor in the mistake. The physician who makes a mistake must deal with the emotions associated with that mistake, often choosing to internalize the emotions. Confession of the sin and the emotions associated with a
medical mistake is not encouraged by hospital administrators or other physicians (Wu, 2000). One of the unstated goals of the disclosure and apology program at the VAMC is to address the emotional frustration and isolation that physicians feel as a result of medical mistakes. Dr. Pope, one of the co-creators of the program explains the idea of the second victim.

The negative, which is what I kind of referred to be, you feel bad for what happened. You feel bad actually from two perspectives. You can feel bad for what happened to what happened to the patient. But kind of an underlying mood, and I’ve written a paper on what’s called the second victim, and that’s the individual emotional aspect of the person that causes the medical error. Now in my role of a person that’s taking care of the incident, not the one that has committed it, you know, people go into medicine to help people, not to hurt people. So, they actually, kind of like the oncologists, they beat themselves up more than anybody else can. You need to be sensitive about that. The paper that I went over detailed the process used in aviation after an accident called critical incident stress debriefing. You’ve probably heard about it. It’s used after aircraft accidents, where basically skilled professionals, you know, psychologists, psychiatrists, social workers, work with the victims and the families of the victims to minimize the impact. It’s actually very structured. I could send you a copy of the paper if you are interested. So, you need to be aware that it’s not just the incident that you are involved in taking care administratively, but the people themselves. You need to be very aware of the second victim.
The internalization of emotions is an important part of the embodiment of the second victim because the internalization helps to make sense of the physical manifestations of the victimage. Dr. Shepherd explains the physical expression of guilt and shame that he experiences as a result of medical mistakes.

I’m very hard on myself. I don’t go home with it, crying about it all the time. But I think about it a lot, and I go, as I said, I try to look at it. It hurts. If somebody, if I really made something bad for somebody, I mean, I don’t know. I think, I just pride myself on the relationships that I build with patients.

The VAMC physicians, because of the socialization and organizational forces that promote internalization, often experience mistakes in an intense physical way.

Along with crying, many of the physicians relayed feelings of headaches, chest pains, and nausea. These intense physical symptoms highlight the ways in which the emotional experience of medical mistakes is an embodied experience for physicians. In some cases, the constant internalization of emotions may lead to feelings of suicide.

Patricia reflects on one such experience that she and Dr. Pope, one of the other co-creators, had to carefully negotiate.

This happened to us together. I got a call from the UK paging operator and she said, “I have a physician on the line for you. Could you hold on?” I said sure. Dr. Pope and I were getting ready to go to a meeting together and we were going over the data which we were going to present, which was probably something about this program. So, I said, “Hello” and the phone cut off. The operator called back and said, “That was a resident. He said for you to meet him on the roof of the clinic building at UK.” And I said, “On the roof?” She said, “Yes, and he sounded
really upset.” I said, “Okay, I’m on my way.” Dr. Pope said, “Are you going by yourself?” I said, “No. Come on. I’m not going by myself.” So we went over and searched high and low. I had my pager. I didn’t have my cell phone that day. So, the operator paged me back and I called from Dr. Pope’s phone. The operator said, “He called back and he left the door to the stairwell open on the fifth floor behind the medical records department.” Or something like that. I went, okay. I said, “Wait just a minute.” I said, “Dr. Pope, do you know where that is?” He said, yeah. So, we went and the door was propped open. There was, I can’t remember, a book or something, because it’s a restricted access door because it goes out to the roof. And it was open. So, we went up the stairwell, took a look around, there was nobody up there. We came back down. Dr. Pope’s phone rings again. It’s the operator. Now, he’s at such and such and I went, okay. So, at that point, Dr. Pope and I were worried about somebody who was on the roof. You know it was shortly after the new academic year and the year before we had a resident commit suicide within the first month. And so we both got worried and we split up to find him. We couldn’t find him. Could not find him. So, one of the chief residents came over to talk to me about something else, and I said, “Bill, is anybody on medicine having trouble right now? Emotional trouble?” He said, “Why?” And I said, “I got one of those calls.” We went through it. He said, “You went to the wrong building.” I said, “What building is it?” He said, at that time I was over there at the window, and he said, “It’s that building right there.” And I said, well shit. He said, “Well, you don’t need to go. I’ll get Dr. Pope and we’ll go.” I said, “No, I’m going. They called me and I’m going.” He said “Well I’m
going with you.” So, we went to the roof of the research building, not the clinic building. There were two chairs, two lawn chairs sitting out there and one of those stand-up ashtrays. Bill said, “Don’t come over here”, so I didn’t go over. He went to the chair and he said, “This is a direct view into your office.” So, you know, they called for help. They’re really just kids.

Patricia’s and Dr. Pope’s comments highlight the danger inherent in internalizing emotions. VAMC physicians are reframed as victims through the actions of the organization as well as the actions of the self. This internalization can result in intense emotional and physical reactions to the mistake experience, making internalization an embodied emotional experience.

Disclosure and Apology as Embodied Redemption

For many physicians, the redemption cycle abruptly ends before it can be completed because physicians are not encouraged or legally allowed to disclose and apologize for medical mistakes. Physicians at the VAMC, however, are offered the opportunity to complete the redemption cycle. Redemption occurs in two ways. First, redemption and purification is achieved for physicians because they have the chance to disclose mistakes to patients or patients’ families. Second, the VAMC, as a medical institution, also has the opportunity to complete the redemption cycle by disclosing and apologizing for mistakes. As discussed in the first theme, physicians do not actually have the opportunity to apologize for mistakes. Instead, the Chief of Staff does the apologizing.

For VAMC physicians, the opportunity to disclose mistakes to patients serves as the embodied expression of mortification. As mentioned earlier, mortification requires a
sinned individual offer something to society that publicly acknowledges the mistake. VAMC physicians offer up the disclosure of mistakes as the mortification act. Disclosing mistakes to patients or patients’ families inherently means that physicians acknowledge that a mistake was made. Many of the VAMC physicians highlighted patients’ or patients’ families’ appreciation of honesty. Dr. Lovin reflects on a disclosure experience and the warm reaction she received.

I think probably in the beginning, I dreaded it. But now that’s I’ve been doing this a little longer, I try to keep things very professional instead of extremely personal. And I have found that when you work with patients and you are very honest and direct with them and you really give them the sense that you have nothing to hide, they’re actually very forgiving. And I don’t know if that’s every group because this is a VA population, but I feel like I have a forgiving population here and they are very understanding, you know that no one is perfect. They appreciate it. And like I said, thankfully it has never been anything severe, generally it was something that could be corrected quite simply.

Dr. Lovin’s comment shines a light on an important element of redemption: forgiveness. Many of the VAMC physicians interviewed commented on how the VA population was extremely forgiving and understanding of mistakes when physicians attempted to a mistake.

The patient’s or patient’s family’s ability to forgive is intrinsically tied to whether a physician feels redeemed for the mistake. Patricia, one of the co-creators, comments of the responses that she has seen during formal disclosure and apologies. She explains, “I have never, after explaining what happened, I’ve never had a patient seem angry about it,
even though they are hurting.” Not only is redemption tied to forgiveness, but overall acceptance of making mistakes is tied to this forgiveness. Dr. Vaughn talks about difficult it can be to accept a mistake when patients respond negatively to disclosure.

Sometimes the patient’s response to what you say helps or hurts because if the patient really understands what you are saying and they give you this sense of forgiveness, than they understand and they forgive you. That makes you feel like, you know, it makes you accept it a little bit easier than if they get bitter and angry at you. You are already angry at yourself. Not that there should be a course for how patients should deal with doctors and their mistakes, but if the patient, I will say this, if a patient is understanding and gives you that, it makes it a lot easier to accept and move on.

Dr. Vaughn places a lot of emphasis on the patient’s response to his disclosure. This emphasis serves as a reminder that the medical mistake experience is a co-accomplishment and the narratives associated with mistakes are multifaceted and multivocal. The patient’s response to a disclosure is just as important as the disclosure in the purification act.

Another important element of the mortification act is that the act must also be equal to the sinful act. In essence, the physician’s disclosure must be seen as equal to the sinful act of committing the mistake. If the medical mistake is medicine’s “original sin,” then disclosing and apologizing for the mistake is an extension of the sin. Since physicians are not supposed to make mistakes, then attempting to a mistake is not acceptable. In this sense, the mortification act of disclosing mistakes is equal to making the mistake. Disclosure as a mortification act stands in the face of the sin of mistakes
since physicians are socialized or mandated to keep silent about the mistake. Breaking the silence and talking about the mistake is discursively equal to the mistake. VAMC physicians are also able to seek redemption through disclosure of mistakes because disclosing mistakes offer physician the opportunity to demystify the sin. As discussed earlier, an important part of redemption is the counter-order, or transcendence, of hierarchy. The entire purpose of disclosing mistakes is that physicians want patients or patients’ families to know what happened. By disclosing to patients or families, physicians are demystifying the mistake experience. Patients or families find out what happened during the procedure, when and how the mistake occurred, and have the chance to ask questions about the mistake. This helps to demystify not only the mistake but also medicine, since physicians have to explain medical terms and procedures so that patients or families understand.

For the VAMC physicians, the redemption cycle ends with mortification and partial counter-order. Redemption of the mistake continues through the organizational mortification and counter-order process of the institutional closure or disclosure. Up to this point, the VAMC physicians have been focusing on medical mistakes, not known complications. As discussed in the first theme, not all bad outcomes are mistakes. Some bad outcomes are known complications, risks associated with the practice of medicine. Although known complications are not mistakes, the hospital has a redemptive ritual for complications as well as mistakes. This is because until a review of the bad outcome has occurred, the bad outcome is treated as a mistake. As discussed in the first theme, when a bad outcome is reported, the clearinghouse determines if the bad outcome is a mistake or a known complication. If it is known complication, a closure is in order. If the bad
outcome is determined to be a mistake, a disclosure is performed. Regardless of whether a patient is invited to a closure or a disclosure, disclosure and explanation of the mistake or known complication is performed. Both events are meant to be a positive, redemptive experience, either because an apology is offered or because it has been discovered that no organizational redemption is needed.

Closures and disclosures, as embodied expressions of redemption, are meant to foster warm and positive emotions, such as forgiveness in all parties involved. These meetings serve as a chance to replace the feelings of guilt and shame. Patricia, one of the co-creators, explains how closures and disclosures can be an extremely emotional experience.

So, you know, it has a lot of emotions. It is almost like a happy ending. We all cry. Can’t tell you how many cases I’ve sat in and cried in when we have a disclosure. Even in closure. Because you do feel, you feel so sad for people who have a loss. It’s nice to have some kind of closure for the mistake.

Closure and disclosure meetings are redemptive in the attempt to provide some kind of ending to the medical mistake experience, even though the actuality of the mistake may reverberate in physicians’ and patients’ lives long after the meeting has ended. Patricia’s comment also highlights the fact that an individual does not have to be personally involved in the mistake to feel the emotions of the mistake. The Chief of Staff, like Patricia, is not personally involved in the making of a mistake. He reflects, however, on the positive and redemptive feelings he associates with disclosures.

You know, one thing, and this may sound kind of funny, to me, these are very positive experiences. The prominent emotion that I feel is positive. We are
helping somebody and we are doing to right thing. So, you know, doing the right thing, of course, is self-actualization, because that’s our inner driven thing that we want to do. I always feel good about those. There are some negative emotions that I will go over in just a minute. We are helping somebody. We went into the health care profession to help people. So like this gentleman we arranged for some appropriate mental health care. We did some other things. We made sure he got an appropriate nutritional medicine consult to help him with nutritional problems that came up when he had problems.

The Chief of Staff highlights a unique redemptive element of the disclosure and apology program: offering some kind of support. Regardless of whether patients or families participate in a closure or disclosure, some kind of support is always offered, either in the form of monetary support (for those in disclosures) or in the form of other medical assistance.

Closures and disclosures are also redemptive because, like the disclosure the physician does after a mistake, they break down the mysterious hierarchy of the mistake and the hospital. During closures and disclosures, the Chief of Staff explains in more detail the mistake experience, focusing on what happened in the procedure to cause the mistake or complication. This explanation can be particularly distressing for patients and families because it is a chance to relive the mistake or complication. Dr. Pope, who used to perform the apologies when the program started, explains how the closure or disclosure experience, which is meant to be one of forgiveness, can easily become one of mistrust.
I didn’t find it particular emotionally draining. It was sometimes, it didn’t go terribly smoothly. Usually it did. As a matter of fact, much more than I would have thought. Very often, within 15 minutes, you know, when the family, you know, was leaving, they would shake hands or even hug. They felt that what they wanted was, almost everyone understands that people make mistakes, but they don’t understand a doctor or a hospital at that point abandoning the patient, covering its own rear end, you know, just to save some money. So, we never acted that way. We made it clear that we were giving them all of the information, answering all of their questions, we had the record right out there. They want to see X-rays, we would put X-rays up. We didn’t hold back anything. And they saw very quickly that that was the case. Occasionally, there were people who came in with a chip on their shoulder, expecting to be snookered. And, it took no longer than 5 minutes for them to realize that that wasn’t the case. So, it was generally a good experience.

Once patients or families realized that the hospital was not out to “hide” or silence the experience, patients and families became more open about the process. Dr. Pope’s comment highlights the mortification element in the closure and disclosure process, showing how the hospital is open to explain the process and answer questions that patients or families have about the mistake or complication. This does not mean that patients or families always see the closure or disclosure as an act of redemption. Gina, one of the co-creators, remembers a particular case where the patient’s family was not convinced that a complication had occurred.
We were in a disclosure, well actually it was a closure meeting. The patient, it was a non-risk management case at the beginning, but it became a risk management case because these people came here because they knew we had a law office and said that this had occurred. It was a feeding tube that had nicked the liver of a very elderly, very sick patient, who subsequently died. And they believed that the placement of the feeding tube caused his death. They had an attorney, and the man was 87, bless his heart. I had a lot of feelings about this case because I felt heartsick about the veteran who probably hadn’t been very well cared for at home. And then they bring him in at the last minute and they had been manipulating, oh it was just awful. He was a little, bitty fellow. The family, the son especially, who had been caring for him, was mean. And I got very angry and I got concerned that it was son. He’d gone home after the placement of the feeding tube. When he came back in, the feeding tube had been moved around and the son had done it. I think the son was feeling guilty. I was feeling concerned that the son had probably not, didn’t really have the necessary mental skills to care for this man. Then he became (slams hand on desk) belligerent and threatening and got in my face. I had doctors who had come down to spend their time going for hours through the records with the attorney and this family, explaining what happened. And, explaining it. And to have this guy just continually, you lie! You know, and just, it was just horrible for all of us, including their attorney, who understood the facts, understood what our doctors were saying. He was calling me, saying, I don’t know how I’m going to handle my client, but we don’t have a case, and I know it, and thanking me for providing
all of this information. At first blush, it looked like a case. It looked like this feeding tube perforating this liver might have caused a bleed. It didn’t. When the feeding tube went through the liver, the liver just sealed around it. There was no blood around the liver at all. The poor man was just so ill. Ultimately, the lawyer in Gina’s story convinced the family that the hospital was not liable of a medical mistake. Gina’s story and Dr. Pope’s comment, however, shine a light on the fact that the patient or patient’s family, as the other victim in the medical mistake narrative, is a key factor to whether or not redemption can occur. These comments highlight the fact that the medical mistake experience and the redemption cycle is one of co-ownership. During her reflection of disclosures, Gina sums up the entire redemptive reason for the disclosure and apology program.

Most of them [patients] believe something happened and don’t know who to trust. If we shoot straight with them, then they begin to trust us and we begin to care about them. I guess a feeling of I want to do the right thing, a kind of moral heartache.

It is this moral heartache that drives physicians and hospital administration to attempt redemption. Although the VAMC physicians do not have the opportunity to participate in the final redemptive act of the apology, the physicians do have a change of counter-order by disclosing the mistake to patients or families. The disclosure and apology program, however, does not always complete the redemptive cycle. Although an apology is offered by the Chief of Staff, patients or families may choose to reject the apology and offer of compensation. Disclosing and offering an apology does not automatically mean the physician or hospital is granted absolution.
Summary

The disclosure and apology program at the VAMC allows physicians the opportunity to work through the “sin” of the medical mistake and attempt to be redeemed for the mistake. The disclosure and apology program also serves as the embodied emotional experience of medical mistakes. The VA physicians interviewed discussed not only the emotions they experience as a result of medical mistakes, but also the physical experience of the emotions by re-envisioning the physician as a “second” victim of the medical mistake experience. Physicians, like patients, have to navigate the tenuous terrain of continuing to practice medicine after a mistake.

The disclosure and apology program also serves as a way to demystify the medical experience by explaining how a mistake happens. Additionally, the apology aspect of the program serves as a chance to enact mortification to the patient or the patient’s family for the mistake. Interestingly, the mortification is somewhat circumvented because the physician who made the mistake is not the person who offers the apology. The organization’s circumventing of the mortification act turns the apology into an apology-by-proxy (Harter, Stephens, & Japp, 2000). People who did not make mistakes are asking for redemption. Mortification and redemption cannot be truly achieved for physicians because they do not get a chance to complete the redemption cycle. The program serves more as a way for the VA to achieve redemption rather than the physician. Ultimately, because mistakes are a process of medicine and will continue to happen, VA physicians will constantly go through this embodied cycle of redemption.
CHAPTER FIVE

Discussion

Narrative, by its nature, is disruptive. Unlike lists or formulas, narrative is not clean, predictable, or obeisant. Narrative makes its own paths, breaks its own constraints, undercuts its own patterns. As it does in dreams or in Beckett, narrative anywhere can make new out of old, creating chaos out of linearity while, subversively, exposing underlying fresh connections among the seemingly unrelated. Not only through its ordering impulses but also through its disordering ones, narrative can help one see newly and for the first time something concealed, something overlaid, something buried in code. (Charon, 2006, p. 219)

Charon’s (2006) comment underscores the importance of narrative in challenging the ways in which we attend to and represent disruptive life experiences. Inherent in Charon’s comment is the acknowledgement that disruption is part of life experiences, or what Burke (1954) calls Trouble with a capital T. There is no way to live without disruption. We use narrative as a way to make sense of those disruptions. We also use narrative as a way to recognize the disruptions for others and appreciate how others work through crisis. The disclosure and apology program at the VAMC seeks to challenge and disrupt the traditional medical mistake grand narrative by re-envisioning the health care system’s approach to medical mistakes. The program recognizes that medical mistakes are a part of the health care process and that the program will not prevent medical mistakes from happening. Rather, the program seeks to restory the experiences after the medical mistake for the physician, patient, family members and the hospital.
This dissertation began as a way to make sense of the “hidden epidemic” in medicine that communication scholars have relegated to the shadows of research. The health care system is a complex web of experiences, and the medical mistake experience is just one of those experiences. Interestingly, as I argue at the beginning of the dissertation, the medical mistake experience has been an experience disciplined through silence and denial. As many of the physicians indicated in their interviews, this is still true to an extent. One program at one hospital is not going to change the culture of silence and denial in which physicians are socialized in medical school. The program, however, can re-socialize physicians to approach medical mistakes differently by eliminating silence and denial. This does not mean that program completely eradicates silence and denial or the fear associated with the discursive and material consequences of mistakes. But, I believe that it is a start. It is this belief, the belief that the health care system can change, which drives the co-creators and Chief of Staff to continue this program and to work to bring it to hospitals across the country.

The lived connection between the discursive, material, and corporeal forces that influence how physicians and other VAMC stakeholders make sense of medical mistakes, disclosure, and apology emerged as the driving force for this dissertation journey. In particular, I sought to understand how multiple VAMC stakeholders make sense of the disclosure and apology program situated within a larger medical mistake experience. I included discussions of medical mistakes and the consequences of mistakes as a way to appreciate the larger social problem of medical mistakes. Focusing on the VAMC program allowed me to explore how policies enable and constrain physicians in the ways
they talk about medical mistakes as well as the ways they enable and constrain physicians as they practice medicine in a culture of patient safety.

Narrative and structuration theories afforded me a useful vocabulary to make sense of the multitude of experiences, especially when these experiences diverged from each other. Narrative theory allowed me to explore how multiple stakeholders make sense of the entire medical mistake experience, as medical mistakes are disruptions to the practice of medicine. Even though I believe that the VAMC physicians understand that medicine is an artful practice full of ambiguity and uncertainty, I also believe that they, like any physician, are not comfortable with admitting when they have failed the system. Structuration theory provided me the additional vocabulary to make sense of how individuals and structures interplay together in the medical mistake experience. Because the medical mistake experience is a multifaceted and multivocal experience situated in an organizational setting, as well as, I would argue, in the entire health care system, I needed to appreciate how individuals and institutions work with and against each other through the program.

Each theory brought something to the theoretical table that the other was missing; together, these theories provided me with the tools to uncover the multiple layers and discourses of the program and stakeholders. Overall, the insight garnered from observations and interviews with multiple stakeholders of the VAMC disclosure and apology program, informed by narrative and structuration frameworks, contribute new understandings to the communication discipline regarding medical mistakes, organizational structuring of experiences, apology, corporeal and material exigencies, and the marriage of structuration and narrative theories.
Theoretical Implications

The interpretations presented in the analysis of the medical mistake experiences of VAMC stakeholders are significant for both communication scholars and medical practitioners. I will first explore the theoretical implications of my findings by reflecting on the research questions on an individual basis. I will highlight themes, issues, concepts, and theoretical extensions that are important for each question.

Research Question One

The first research question asked: How do VAMC physicians narratively make sense of medical mistakes? Three themes speak directly to this particular question: “Bearing Witness to the Ethics of Practice: Narrative Expression of Medical Mistakes,” “Black Marks and Money: Corporeal and Material Constraints and Negative Sanctions in Medical Mistakes,” and “From Failure to Forgiveness: Disclosure and Apology as Embodied Emotional Redemption.”

VAMC physicians have to consider several different aspects of the medical mistake experience in order to make sense of mistakes. The VAMC physicians, along with the co-creators, considered both the restorying of the medical mistake itself as well as the discursive and material consequences that happened as a result of the mistake. My research question was guided by my desire to understand the complexity of the medical mistake experience situated as a process of medicine, and not the product of a procedure (Paget, 2004). This research question was equally driven by my desire to include mistakes and failures in health care as equally important to the health care experience (Allman, 1998; Eisenberg, et al, 2005; Paget, 2004). Considering both the actual mistake narrative and the consequences that occur is important because it appreciates the
narrativity of the experience and the fact that the mistake narrative’s conclusion is not the mistake itself. Positioning medical mistakes as a process and part of the medical experience rather than the end product helps to reorient how all stakeholders make sense of mistakes.

Moreover, as I argued in several of the themes, medical mistake narratives are multi-vocal experiences. As argued in the “Bearing Witness” theme, repositioning medical mistakes as a process helps to highlight the fact that there are multiple actors involved in medical mistakes. No longer is the mistake solely owned by the physician; no longer is the patient just a pathology or a body to cut open. Tied to this, “Bearing Witness” underscores the fact that physicians are not alone in the mistake. Many of the rituals associated with medical mistakes are designed to bring physicians together to attend to and represent each others’ mistakes. Attending to and representing others’ mistakes are inherently reflexive acts (Charon, 2006). By bearing witness to others’ mistakes, VAMC physicians appreciate their place in many medical mistake narratives.

Tied to this reflexivity, VAMC physicians use medical mistake narratives as a learning opportunity. Sharing medical mistake narratives with others opens up a space for physicians to learn from each other and from the self. Morbidity and mortality conferences are designed to be a narrative pedagogical tool. Physicians share medical mistake stories, and together, the group of physicians work through how the mistake happened and how to prevent a similar mistake from happening again. Narrative rituals like morbidity and mortality conferences are designed for physicians to attend to, represent, and take action to prevent future mistakes. What is interesting, however, about morbidity and mortality conferences is that, even though they are narrative pedagogical
tools, they are still rituals of shame and blame. Many of the VAMC physicians discussed how morbidity and mortality conferences can become space for blame and challenging knowledge. Additionally, the pedagogical element of medical mistakes is bounded since VAMC physicians cannot take notes during the morbidity and mortality conference for fear that information about a case could be used by outside lawyers. Although VAMC physicians take a narrative approach to medical mistakes, the narratives are bounded.

Looking at all three of the themes together highlights the importance of emplotment. As I argue in these themes, medical mistake narratives do not end with the mistake. There is more to medical mistake stories than just the medical mistake. As the “Black Marks and Money” and “Emotional Redemption” themes underscore, physicians have to deal with the discursive and material consequences of mistakes. In the case of VAMC physicians, they still have to worry about litigation and being reported to the national tort databank. Moreover, VAMC physicians have to deal with the emotions of making a mistake. These experiences are not unique to the VAMC physicians. What is interesting, however, is that the re-envisioning of the medical mistake grand narrative does not diminish the presence of these other issues. What re-envisioning the medical mistake grand narrative does is allow us to appreciate the material and institutional exigencies that were silenced in the traditional medical mistake narrative.

VAMC physicians, in the re-envisioning of the medical mistake grand narrative, also attempt to restory what it means to be a physician. The discussions present in “Black Marks and Money” and “Emotional Redemption” highlight the tension VAMC physicians face between being humans who make mistakes and practicing “perfect” medicine free of mistakes. VAMC physicians struggle with these two ontological
positions. It is important to note that the narrativizing of the medical mistake experience shines a light on the ontological nature of medical mistakes. For VAMC physicians, the bigger struggle with medical mistakes is not just about the medical mistake and its impact on the patient. More importantly, medical mistakes make physicians question whether medicine is the right profession for them after making a mistake. Narrativizing medical mistakes, then, makes it an ontology of possibility. Physicians not only question, ontologically, if they should be a “human” physician or a “perfect” physician, but whether they should be a physician at all. This is just one of many different tensions that emerge for physicians in the narrative presentation of medical mistakes.

An important element of this research question is the recognition that the medical mistake experience is a discursive and corporeal experience. The body affects medicine. For patients, the body is the scene on which the mistake happens, and the place where healing happens. For physicians, the body is the enabling and constraining agent in the practice of medicine. Physicians are both enabled by what their bodies have been trained to do and bounded by the limits of the human body. For medical mistake narratives, the body is the both the medium and the outcome; the agent and the scene of medical mistakes. The limited communication research that has been done on medical mistakes has only appreciated medial mistakes from a discursive perspective (Allman, 1998; Petronio, 2002, 2006). This dissertation calls into question the fact that the medical mistake experience is both discursive and corporeal.

The literature on narrative in medicine focuses on illnesses in patients and how patients and physicians narratively present illness (Charon, 2006; Hunter, 1992; Mattingly, 1998; Mattingly & Garro, 2000; Montgomery, 2006). Health communication
scholars, likewise, have used narrative to explore illness (see, for example, Harter, Japp, and Beck’s 2005a edition on narrative and health). Frank (1995) even said that illness is a “call for stories.” Medical mistakes are not illnesses or diseases that can be treated, but it is still a health experience that calls for narrative. Medical mistake narratives are similar to illness narratives in that they are a disruption to health. My dissertation inherently calls for the discipline to not only consider this “hidden epidemic” as an important social problem, but also to reconsider how we as scholars define health illness narratives and the use of the narrative in our scholarship.

Research Question Two

Research question two probed even further into the sense-making VAMC physicians engaged in, asking: How do VAMC physicians narratively make sense of the VAMC’s apology and disclosure program? Together, two themes provide insight into this question: “The Right Thing To Do: VAMC Disclosure and Apology Program as (Un)Ethical Action” and “From Failure to Forgiveness: Disclosure and Apology as Embodied Emotional Redemption.” Since the major goal of the dissertation was to explore the disclosure and apology program, how VAMC stakeholders make sense of the program is key to understanding perceptions of the program.

First, as discussed in the dissertation, there is a definitional difference between adverse events, mistakes, and complications. These definitions are the first “hole” in the Swiss cheese analysis of determining whether or not closure or disclosure is warranted in a case. VAMC physicians are concerned with these differences, seeing these differences as key to the patient-physician relationship. These definitions are important for VAMC
physicians because the program is designed to provide information to patients and family members, eliminating secrecy from medical mistake narratives.

VAMC physicians generally fell into two camps regarding the ways in which they make sense of the disclosure and apology program. VAMC physicians saw the program as either a moral imperative or as the dehumanization of medicine. This tension focuses on whether the program is the “right” way to handle medical mistakes. What is important is that tension is not concerned with whether disclosure and apology is the “right thing” to do; all of the stakeholders I interviewed believed that disclosure and apology are appropriate responses to medical mistakes. The concern here is whether the program is the “right” approach to re-envision the medical mistake narrative. The disconnect for VAMC physicians is whether the program serves as the moral answer to mistakes or if the program dehumanizes medicine by telling physicians how to practice medicine. As Kirby and Krone (2002) argued organizational policies are not enough to encourage change if there are not broader social and cultural changes. This is what Dr. Montgomery was talking about when he refers to “process” changes and “culture” changes. The VAMC program is a “process” change in an institution that need a larger “culture” change. The program may be the ethical response to re-envisioning medical mistakes, but it has unintended consequences of physicians questioning who gets to make decisions about medical mistakes.

Tied directly to this tension is the fact that many of the VAMC physicians see a difference between disclosure and apology. All of the VAMC physicians interviewed believe in the idea of disclosure to patients and families. For these physicians, however, there is a difference between open communication, embodied by disclosure, and the
emotional redemptive values of apology. Ultimately, the distinction is concerned with the definitions between mistakes and complications. For some of the VAMC physicians, emphasis on apology is misguided. Apology sets the wrong tone for patients, and these physicians worry that patients will think mistakes are intentional and wrong. Even Dr. Pope, one of the co-creators, felt that the emphasis on apology is misguided. The tone that this emphasis sets is that mistakes are acts of wrongdoing, rather than part of the process.

Finally, the program’s positioning of disclosure and apology as an emotional redemptive act aids physicians in making sense of emotions associated with mistakes. As mentioned in research question one, the emotional aspect of medical mistakes is part of the medical mistake experience. The program affords multiple VAMC stakeholders the opportunity to emotionally work through mistakes. However, the program highlights some interesting elements of redemption. First, physicians are not able to complete the redemption cycle. Burke (1970) assumes that individuals are either redeemed or not by an audience. For Burke, the redemption cycle is between the rhetor and the audience. His cycle does not account for the chance that a third party, like an organization, circumvents redemption. As mentioned in the analysis, because physicians are excluded from the institutional disclosure, they are excluded from the final redemptive act. The program re-visions medical mistakes as an organizational failure, not an individual failure. Second, even though the program re-visions the medical mistake grand narrative, physicians still experience the same emotions regardless of the program. This is important because it suggests that there might be limits to restorying an experience.
Research Question Three

The third research question inquired: How does the VAMC’s apology and disclosure program enable and constrain physicians in practicing medicine in a culture of patient safety? Two different themes can be brought together to answer this question: “Ensuring Trust, Respect, and Excellence: The Bureaucratization of the Medical Mistakes Experience Through the Disclosure and Apology Program” and “The Right Thing To Do: VAMC Disclosure and Apology Program as (Un)Ethical Action.” 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 bureaucratization of the medical mistake experience, reveals what was previously hidden about the medical mistake experience. The program is designed to eliminate the ambiguity associated with the VAMC’s organizational approach to medical mistakes. The program created a very clear policy that outlines a clear hierarchy and rules for stakeholders. This, in turn, fosters the feeling for some VAMC physicians that they can practice medicine in an open and welcoming environment. In the theme “(Un)ethical Action,” the VAMC physicians who see the program as a moral imperative see the program as a way to develop patient-physician relationships.
Conversely, the program constrains physicians in their practice of medicine by bureaucratically determining who makes decisions in the practice of medicine. As mentioned above, bureaucratization enables physicians by revealing information that was previously hidden. Interestingly, it is this bureaucratization that constrains physicians, as well. The bureaucratic nature of the policy dictates who gets to make decisions about medical mistakes and how the hospital handles mistakes. The bureaucratic policy, in conjunction with the “service line” organizational structure, places all the decisions in the hands of a small number of administrators, not physicians.

Tied to the constraining feature of the bureaucratization of the medical mistake experience is how some VAMC physicians feel the program constrains medical practice through the dehumanization of medicine, as discussed in the “(Un)ethical Action” theme. For these physicians, the program’s emphasis on control and definition constrain their ability to practice. The program not only has control over medical mistakes, but the program also dictates how physicians should practice medicine. Here, the VAMC physicians see the program as constraining because it forces physicians to be open and honest about adverse events. The hospital should not tell physicians to be open and honest with patients. Moreover, for physicians who see the program as the dehumanization of medicine, the program is constraining because it attempts to define the role of the physician. As mentioned in the theme, these physicians see a conflict with the program mandating disclosure and apology, which they feel are decisions that must be made by the physician.

Finally, and connected to all of the other constraining elements of the program, the program is constraining because it ultimately takes the decision-making of medical
mistakes and medicine out of the medical arena and places the control with the legal department. Interestingly, it is the multi-disciplinary nature of the program, the connection between the medical and legal worlds, which creates this constraint for physicians. Regardless of whether physicians see the program as enabling or constraining, many of the VAMC physicians see a conflict with having the legal department actively involved in medical mistakes. A major reason for the conflict is tied to the emphasis on apology versus compensation. Another reason for this conflict is physicians’ disappointment with the legal consequences. For many of the VAMC physicians, policing should be handled by the medical community, not outside individuals with no or limited knowledge of medicine.

Research Question Four

Finally, the fourth research question asked: How do the policies and procedures of the VA’s apology and disclosure program contribute to and challenge the practice of ethical and responsible medicine? A sub-question of research question four probed even further, questioning: How, if at all, do these policies and procedures discipline physicians and the ways they practice medicine? Four themes combined help to answer this question: “Ensuring Trust, Respect, and Excellence: The Bureaucratization of the Medical Mistakes Experience Through the Disclosure and Apology Program,” “The Right Thing To Do: VAMC Disclosure and Apology Program as (Un)Ethical Action,” “Black Marks and Money: Corporeal and Material Constraints and Negative Sanctions in Medical Mistakes,” and “From Failure to Forgiveness: Disclosure and Apology as Embodied Emotional Redemption.” This research question is concerned with specific elements of policy and the ways in which physicians are disciplined by the program.
As mentioned throughout Chapter 4 and various theoretical implications, issues of control are a major concern for physicians. The program, although it provides physicians the security to clinically disclose to patients and families, the program disciplines physicians by taking away their ability to be present in the institutional disclosure or closure. Restorying the medical mistake experience as an organizational failure rather than an individual behavior disciplines physicians by taking away their ownership of the mistake. This disciplining raises an interesting question. In a health care organization, who has the authority to make decisions? This question of authority is complicated by the governmental aspect of medicine at the VAMC. Moreover, managed care further complicates this question. Moreover, this discussion of ownership and authority shines a light on the concern about who should have control over the redemptive process. This idea was initially raised in the discussion of research question three. If the program is meant to serve as a chance for individuals to openly talk about and apologize for mistakes, then not allowing physicians to be present for the act means that the program disciplines physicians. The program, in not allowing physicians to be present at the institutional disclosure or closure, unintentionally punishes physicians for making a mistake.

The program further disciplines physicians through the continued use of “black marks” on physician records through the national tort databank. The program does not protect physicians from being marked; in fact, Gina even admitted to assisting physicians with filing to the national tort databank. Although physicians get the chance to write a short narrative about the event, the databank still marks the physicians. What is extremely interesting about the national tort databank is that marks against physicians never go
away. Physicians are continually disciplined by the databank because there is no time limit to the mark. Litigation is still a disciplinary concern for VAMC physicians because many of them jointly practice medicine at the university hospital. The VAMC protects physicians not only from being named individually in a lawsuit but also from being sued for complications and mistakes. That protection disappears when they cross over into the university hospital. Moreover, litigation, even in the VA, disciplines physicians through time because malpractice cases can go on for years. Giddens, in his discussion of discipline, never discusses whether there is a time limit on the discipline. This dissertation demonstrates that time and space is an important factor for disciplining individuals in an organization.

Finally, the program disciplines VAMC physicians’ emotional journey. As discussed in the analysis of the redemptive nature of the disclosure and apology program, VAMC physicians experience a wide range of emotions as a result of making a medical mistake. Although many of the VAMC physicians indicated that they felt remorse and guilt for the mistake, the program assumes that all physicians feel remorse and guilt. The program disciplines physicians by suggesting that all physicians want to do the “right thing.” The program is predicated on the belief that there had to be a way to do right for the physician and the patient, and the program co-creators assume that disclosure and apology will address these emotions. Although the program does not explicitly discipline physicians’ emotions, the program disciplines through assumptions about physicians wanting a way to address medical mistakes in a better way.
Practical Implications

In 2005, the disclosure and apology program at the VAMC went “nation-wide,” meaning that all VA facilities had to implement the program by 2010. As of 2008, none of the other VA facilities in the United States had implemented the program. Because the program is still trying to find a place outside of the VAMC, I offer practical implications for the program. Specifically, I offer three practical implications for the disclosure and apology program as the program becomes nation-wide in the VA as well as how to aid the program in transitioning to the private, non-governmental health arena.

First, I suggest that the program co-creators reconsider the exclusion of physicians in the institutional disclosure process. As mentioned in the first theme, physicians and other medical practitioners are systematically excluded from the disclosure process, normally excluded after they are interviewed by Gina. Physicians do get the chance to do the clinical disclosure of events to patients or families immediately after the adverse event, but they are not included in the actual institutional disclosure or closure process. If, as is suggested in theme five, the disclosure and apology program is a redemptive program where physicians can work through the emotions associated with making mistakes and offer an apology, then physicians are prevented from achieving redemption. The logic behind excluding the physicians is warranted; the program wants to take the onus of responsibility for the mistake away from the physician and place it on the organization. In doing this, the program co-creators assume that responsibility is re-envisioned. Moreover, as Dr. Pope pointed out, the emphasis of the meeting should be on compensation, which has to be done by the administration. In theme two, however, many of the physicians indicated that they felt they should have the chance to apologize for
making mistakes if a policy was going to exist that says disclosure and apology are the VAMC’s response to mistakes. At the very least, the program could invite the physician or other medical practitioners to be present at the institutional disclosure or closure. Including the individual or individuals who did make the mistake is a first step to appreciating the closure that is needed by both patients and families and the physician. This applies not only to the VAMC but to all of the VA facilities that will have to comply with the program by 2010.

The second practical implication is concerned with the tensions that exist as a result of hospitals changing to a culture of patient safety. First, the VAMC, as well as any hospital with a program like the disclosure and apology program, may have to rethink the definitions of mistakes, complications, and adverse events in the light of new governmental changes to compensation policies. Dr. Montgomery, a general surgery attending and Chief of General Surgery, mentioned during his interview that there is a large disconnect between process and culture. For Dr. Montgomery, many hospitals create programs that attempt to change culture but really are just changing the process. Regarding medical mistakes, hospitals will now have to deal with culture changes as opposed to process changes. Beginning October 1, 2008, in an attempt to foster patient safety, Medicare will no longer pay for certain hospital errors that are considered preventable (Neergaard, 2008). Additionally, the new policy prevents hospitals from billing the patient for the extra costs. This new policy is a process change, not a culture change. This new governmental policy will inevitably change the program because the new policy will prevent the program from offering compensation for those mistakes. If, as Dr. Pope argued, compensation is the most important part of the program, then the new
policy will certainly influence what the Chief of Staff and Gina can offer to patients. Although this policy is meant to discipline hospitals for not preventing some kinds of errors, it does not necessarily mean that it will reduce errors. Moreover, since the new policy rests in tension with the program, the patient or family will ultimately be the ones who are disciplined. The co-creators and Chief of Staff need to consider this new policy and the potential impact it will have on future disclosures.

Finally, the co-creators are actively trying to get the program integrated into non-governmental hospitals across the country. Two hospitals have already implemented the program (in Michigan and California). One of the reasons that the program was able to be successful at the VAMC is that the physicians are protected by the Federal Torts Claim Act and cannot be individually named in litigation suits. This protection is only afforded to physicians who practice in the VA or other governmental setting. In order for private non-governmental hospitals to implement the disclosure and apology program, the double punishment of being reported to the national tort databank and being named individually in litigation suits needs to be rethought. These consequences were named by all of the VAMC stakeholders interviewed as the major barriers to accepting the program outside of the government. For the program to be truly embraced by hospitals, the fears associated with litigation need to be removed. This is not something that the co-creators at the VAMC can do; rather, this action requires both private hospitals, insurance companies, and the federal government to rethink policies and laws. One of the reasons that medical mistakes remain a set of complicated topics is because there are so many other actors involved in the process. For non-governmental hospitals and physicians to embrace and enact this program, insurance companies and hospitals need to rewrite their
existing adverse event policies. The federal government, in conjunction with state
governments, needs to rewrite litigation laws and offer that extra layer of protection to
physicians and hospitals. If the medical and legal communities wish to truly change the
vision of health care, then they must turn to their own policies and laws as a starting
place.

Limitations

The in-depth interviews and observations I conducted at the VAMC were
extremely fruitful in terms of understanding how the multiple stakeholders in the VAMC
make sense of the medical mistake, disclosure, and apology experience. The VAMC
physicians, the co-creators, and the Chief of Staff were extremely welcoming to my
presence and open to answering all of my questions, even when those questions asked
them to reflect and recount medical mistake experiences. Knowing that they were
comfortable with my presence enough to talk candidly about the program and invite me
to witness very personal patient-physician experiences (in the form of ethics board
meetings and an active potential mistake case) proves that the VAMC is open to the
presence of this “outsider.” However, there are several specific limitations that, given
another chance, I would pursue in a different manner.

First, the observations that I did conduct on-site at the VAMC were, in some
instances, a bit diverse. I was able to observe many different aspect of patient care, such
as two ethics committee board meetings, internal medicine morning rounds, risk
management meetings, and an institutional closure. The diversity in my fieldnotes
assisted me in understanding the complexity of the VA system. My main concern is my
lack of observations having to do with the rituals of medical mistakes, disclosures, and
apologies. Along with not being able to observe disclosures, the hospital would not let me attend any of morbidity and mortality conferences that occurred during my time at the VAMC. One primary reason for that was because the hospital does not allow physicians to take notes about cases presented at the M & M conferences, and the Chief of Staff knew I would be writing notes about the experience. Moreover, because I was an “outsider” and not an actual employee of the hospital, I could not attend the conferences. Even though I was in the field from July until December, my fieldwork was not constant. Because of my teaching commitments, I could only be at VAMC half of the week. Moreover, driving back and forth to Kentucky every week was not always possible. I do not believe that being constantly in the field would have resulted in more in-depth observations; rather it just resulted in less observations hours.

Gina and the Chief of Staff, by law, would not allow me to witness an institutional disclosure. There were five institutional disclosures made during my time at the VAMC. Not being able to legally witness the actual disclosure process through an institutional disclosure meant that I was not able to bring that information to the dissertation and the presentation of the program. Moreover, I was only able to witness one closure meeting. During my time at the VAMC, there were only two closures made, so I was able to witness one of those two closures. I was able to observe the closure meeting because the legal “threat” of litigation was not present in the case. I was also able to observe the legal team working on an active case. Although I was asked and did sign a confidentiality form in order to protect the privacy of the patient and nurses involved in the case, I was witnessing information that would be open to the public. The main difference between the case and closure versus disclosure has to do with what
information is open to for public consumption and what is protected by the government. The lack of observations of the rituals of medical mistakes and the program certainly hindered my ability as a researcher to fully immerse myself in the workings of the program. However, I completely respect the hospital’s concern with patient confidentiality and the legal underpinnings guiding these decisions. For future projects, I need to be aware of all of the laws and hospital policies that will prevent observations at a specific health care facility.

Second, I was able to talk to multiple stakeholders involved with the medical mistake experience and disclosure program at the VAMC. I talked to all of the program co-creators and the Chief of Staff, who is the chief apologizer and is involved with all adverse event cases. The limitation of the interviews rests with the third group of stakeholders: the VAMC physicians. I believe that 30 physicians is a good number of individuals, given the difficulties in negotiating physician schedules. The limitation lies not in the number of physicians but in the type of physicians I interviewed. I attempted to equally represent all of the different departments at the VAMC; however, the vast majority of physicians who agreed to be interviewed were surgeons. There are two reasons that most of the interview participants were involved in surgery. First, my main informant, Debra, used to be the head scrub nurse in the surgery department and is now the NSQIP Officer. As the NSQIP Officer, she is still actively involved in the surgery department and is familiar with many of the VAMC surgeons, meaning that many of the surgeons knew about my project. Second, surgeons are the group of physicians most likely to be involved in an adverse event case that leads to a medical mistake (Kramen & Hamm, 1999). At the VAMC, many of the surgery department heads are actively
involved in program. The internal medicine, ambulatory care, and obstetrics/gynecology departments were also welcoming and volunteered. I did contact physicians in the all of the VAMC’s major departments. Some departments, such as the emergency department and oncology department, did not respond or declined to participate. Any of my future studies of medical mistakes and hospital-wide programs need to be more diverse in an attempt to provide a well-rounded representation of physicians.

Finally, as I point out throughout the dissertation, the medical mistake experience is a multi-voiced experience, and in this study, there is one particular group of stakeholders whose voices were not included: patients. For this dissertation, tracking down and interviewing patients was impractical. HIPAA (Health Insurance Portability and Accountability Act) protects patients’ information from leaving the hospital or being seen by anyone who is not an employee of the hospital. The VAMC is extremely protective of their patients and providing me information about patients who had been involved in cases of medical mistakes was not feasible. Having worked in the medical field where I personally handled medical records, I greatly admire the VAMC’s commitment to maintaining the anonymity of patients involved in cases of mistakes. Moreover, this dissertation project was concerned with understanding how the program works within the VA system as well as how physicians make sense of the program. Exploring patients’ views regarding medical mistakes and the ideas behind disclosure and apology is an important element of the complex medical mistake experience. Future research could focus on the patient’s understanding of medical mistakes, disclosure, and apology.
Directions for Future Research

Delving into the complexity of medical mistake experiences answered many questions, but fostered even more theoretical and practical questions about the role of communication in medical mistake experiences. From this, I expand on the need for communication scholars to spend time wrestling with issues surrounding medical mistakes. I also propose some additional research projects that can begin answering many of my unanswered questions. This dissertation is one of the first communication dissertations (save for Allman’s 1995 dissertation on physicians’ boundary management of medical mistakes) that explores the issue of medical mistakes and the role of communication in the process. As this dissertation underscores, medical mistake experiences are extremely complicated and multifaceted. Moreover, this complicated experience is situated within a larger, even more complicated structure that is the American health care system. As communication scholars, we need to explore the discursive nature of social problems like medical mistakes. I would argue that part of the reason we have not explored medical mistakes is because medical mistakes are a “hidden epidemic” that continues to be silenced by the traditional medical mistake master narrative. This dissertation serves as a beginning step to implore communication scholars to start exploring these issues.

Secondly, communication scholars need to be involved in social issues and problems that have a uniquely communication base. The Joint Commission (JCAHO) even identified communication as a central element of the new patient safety culture, as well as the key to dealing with medical mistakes (2007). Communication scholars have much to offer the ongoing discussions of hospitals and advocacy groups regarding
medical mistakes. Medical mistakes reform, however, is situated within a larger health care cultural shift to a culture of patient safety. The culture of patient safety does position communication as an important aspect of health care. Communication scholars interested in advocacy of social issues have an obligation to contribute their knowledge to these discussions.

Specifically, I have identified several research projects that can contribute to our discussions of medical mistakes and patient safety. First, this dissertation only looks at one approach to medical mistakes that was created by a hospital policy. In most cases, medical mistake cases play out in the legal arena. A project that explored the ways in which medical mistakes are discussed in the space of the courtroom would shine a light on what happens when the medical mistake moves out of the realm of medicine. A recent case involves the death of television actor John Ritter. As a contemporary case claiming that his death was a result of misdiagnosis and mistreatment, the John Ritter case is an excellent way to explore the medical-legal presentation of medical mistakes. A second project, related to the first project, explores current medical mistakes unfolding in the media. Over the past two years, there have been several high profile medical mistake cases in the media. Exploring these cases shines a light on how public discourses discuss medical mistake cases.

A third direction for research that would explore the multifaceted nature of medical mistakes is talking with patients about their medical mistake experiences. Ideally, this project would talk with patients who have been involved in cases at the VAMC so they could discuss their experiences with disclosures and apologies. However, exploring how patients narratively make sense of medical mistakes is just as important in
order to understand the complex nature of the medical mistake experience. A fourth direction for research would be to explore the training programs that are offered by insurance companies and apology advocacy coalitions. What are the contradictions inherent in training people who to apologize? What are the organizational conflicts that exist when an insurance company offers training versus training provided by coalitions? Finally, a fifth project could explore the health community’s transition to a culture of patient safety. This project would explore how physicians define and see patient safety in relation to the Joint Commission’s definition of patient safety.

Final Reflections

My time at the VAMC was an eye-opening experience. I gladly accept Gina’s call for me, as one of the “young ones” to “continue to bring this program to others.” The VAMC welcomed me as an “outsider” into their facility. Never once did I feel that I was not welcome, and many of the physicians treated me as if I was an employee. Many physicians were even comfortable enough with my presence to include me in the teaching process, either by inviting me to attend patient rounds or by including me in teaching activities with other medical residents. The excitement of me being at the VAMC was palpable and everyone I interviewed was genuinely interested in reading the completed dissertation and executive summary. My key informant, Debra, worked with me to track down physicians to interview and provided me with valuable information about the workings of the hospital and VA health care system. I was humbled by this warmth and willingness to include me and my project in the day-to-day workings of the hospital.

I was equally humbled by all of the participants’ willingness to talk to me and tell me their personal stories of medical mistakes. These stories were haunting and chilling. I
was touched by the vulnerability present in these stories and glad to see that for many of the physicians, these stories stayed with them years after they happened. Engaging in narrative research means that the researcher is attending and representing the storied experiences of participants. As a narrative researcher, I attended to and tried to represent these stories and the physicians’ experiences. This commitment to narrative research, however, did create a level of stress previously unknown to me as a scholar. The participants did share very detailed and often very gruesome medical mistake narratives with me. Moreover, for many of the physicians, these stories are very present in their lives and medical practice. During several of the interviews, physicians had to stop to compose themselves or cry (this can be heard on the tapes). Several wiped away tears as they told their stories. Not only did I bear witness to these stories during the interviews, but I also continually bear witness to these narratives through the transcription of and working with the transcriptions.

As the individual listening to these stories, I had a responsibility to attend to these stories, as well as a responsibility to represent these stories in the dissertation. I bear witness to the medical mistake experiences of physicians just as they bear witness to each others’ experiences. The emotional connection required for bearing witness can be emotionally wearing. Moreover, actively witnessing nurses talking about the death of a patient and witnessing a patient’s difficult and heart wrenching decision to end his cancer treatment asked me to bear witness to these medical experiences. Being an active participant through attending to and representing these narratives was also an emotionally challenging experience. Because of my connection with multiple stakeholders at the
VAMC who opened up their offices, stories, and experiences to me, I feel an enormous obligation to represent their experience with grace and humility.

Although I have completed my field work and interviews at the VAMC, I have an open invitation from the Chief of Staff to return to the facility to continue work or to start new research projects involving VA physicians and patients. I was even offered a patient safety fellowship at the VAMC (which I graciously refused). I have cultivated several research relationships that I hope I will be able to continue to foster. The VA system is so complex and has so many different programs across the country that I would only be scratching the surface with my research. Moreover, the program co-creators are extremely excited about the idea of a communication scholar joining the ongoing dialogue about medical mistakes, disclosure, and apology. As a scholar, I know that this research and my interest in medical mistakes and patient safety can be used by a variety of scholars and practitioners in other disciplines to change the traditional approach to medical mistakes. I left the VAMC with just as many questions as I entered and I am grateful for the fact that I will have been offered the chance to explore those questions. As a teacher, I have the opportunity to integrate this program and the theoretical connections I have made into the classroom, informing students and encouraging them to wrestle with complex social issues. Finally, as a patient in health care, this project reminds me of the ambiguity and uncertainty of medicine. Hearing the physicians' stories, the stories that are often silenced, underscored the fact that every person involved in the medical mistake experience is just that: human.
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Table 1

Dimensions of Structuration

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<th>Interaction (Modality)</th>
<th>Communication</th>
<th>Power</th>
<th>Sanctions</th>
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<tr>
<td>Interpretative schemes</td>
<td>Facility</td>
<td>Norm</td>
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<td>Structure</td>
<td>Signification</td>
<td>Domination</td>
<td>Legitimation</td>
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Table 2

Connections between Structuration and Narrative Theories

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<th>Interaction (Micro-level)</th>
<th>Storytelling</th>
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<tr>
<td>Structure (Meso-level)</td>
<td>Policies and procedures, organizational documents</td>
</tr>
<tr>
<td>System (Macro-level)</td>
<td>Organizational narrative and discourse</td>
</tr>
<tr>
<td>Structuration (Meta-level)</td>
<td>Institutional/historical narratives</td>
</tr>
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Appendix A

VAMC Research Access Approval Letter

Department of Veterans Affairs

Date: July 30, 2007

From:

Research Proposal entitled, "UK/VA: How to Say I'm Sorry: A Study of the Veteran's Administration Hospital Association's Apology and Disclosure Program"

To: Research and Development Committee

TO BE SIGNED BY THE CHIEF OF EACH SERVICE INDICATED IN #5 ON COVER MEMORANDUM

I have read the proposal listed above and will provide the assistance/resources required.

Walter A. O'Keeffe, Jr., MD, MHSA
Chief of Staff

Mall code: 11A-CDD
Location: A121 Cooper Drive
Ext: 4902

7/3/07
Title of Research Proposal: How to Say I’m Sorry: A Study of the Veteran’s Administration Hospital Association’s Apology and Disclosure Program

Investigator(s) Information

Primary Investigator
Name Heather J. Carmack Department: Communication Studies

Address 006 Lasher Hall, Ohio University
(If off-campus, include city, state and zip code)

Email hc200403@ohio.edu Phone 740-593-4837

Training Module Completed? X Yes □ No (Attach Certificate as Appendix H)
(www.vp-res.ohiou.edu/cbt)

Advisor Information (if applicable)

Name Lynn M. Harter, Ph.D. Department: Communication Studies

Address 109 Lasher Hall, Ohio University

Email harter@ohio.edu

Training Module Completed? X Yes □ No (Attach Certificate as Appendix H)

Anticipated Starting Date August 2007 Duration 9 mos yrs
(Work, including recruitment, cannot begin prior to IRB approval. This date should never precede the submission date)

Funding Status

Is the researcher receiving or applying for external funding? □ Yes X No
(Note – This refers to funding from entities outside of Ohio University)

Is there a payment of any kind connected with enrollment of participants on this study that will be paid to persons other than the research participants?
□ Yes X No
Review Level

Based on the definition in the guidelines, do you believe your research qualifies for:

X_ Exempt Review Category 2

___ Expedited Review Category _____________

___ Full Committee Review

Final determination of review level will be determined by Office of Research Compliance in accordance with the categories defined in the Code of Federal Regulations

Prior Approval

If this or a similar protocol been approved by OU IRB or any other, please attach copy of approval and label as Appendix E.

Recruitment/Selection of Subjects

Estimated Number of Human Participants ___________ 30-40

Characteristics of subjects (check as many boxes as appropriate).

Minors ___ Physically or Mentally Disabled ___ Elementary School Students

Adults ___ Legal Incompetency ___ Secondary School Students

Prisoners ___ Pregnant Females ___ University Students

Others (Specify) _______________________

Briefly describe the criteria for selection of subjects (inclusion/exclusion). Include such information as age range, health status, etc. Attach additional pages if necessary.

Participants must meet the following criteria:

1. Participants must be licensed physicians practicing medicine in Kentucky

2. Participants must have active practicing privileges at the Lexington, Kentucky VA hospital system.

3. Participants must be at least 18 years of age.

How will you identify and recruit prospective participants? If subjects are chosen from records, indicate who gave approval for the use of the records. If records are "private" medical or student records, provide the protocol, consent forms, letters, etc., for securing consent of the subjects for the records. Written documentation for cooperation/permission from the holder or custodian of the records should be attached. (Initial contact of subjects identified through a records search must be made by the official holder of the record, i.e. primary physician, therapist, public school official.)

Participants are recruited by the lead investigator through snowball sampling and phone calls. The Lexington, KY VA hospital’s Chief of Staff’s office will be providing a contact list of practicing physicians. No other records will be used in the recruiting of
participants. Participation is completely voluntary and interviews are conducted face-to-face during times convenient for participants.

Please describe your relationship to the potential participants, i.e. instructor of class, co-worker, etc. If no relationship, state no relationship.

Participants have no relationship with the lead investigator. The lead investigator does not have a relationship with the Lexington, Kentucky VA hospital.

Attach copies of all recruitment tools (advertisements, posters, etc.) and label as APPENDIX B

Performance Sites

List all collaborating and performance sites, and provide copy of IRB approval from that site and/or letters of cooperation or support.

The Lexington, Kentucky VA hospital system

Project Description

Please provide a brief summary of this project, using non-technical terms that would be understood by a non-scientific reader. Attach an additional page, if needed, but please limit this description to no more than one typewritten page.

This project explores how physicians narratively make sense of medical mistakes experiences and the act of apologizing for those mistakes. In particular, this study explores how physicians not only make sense of medical mistakes and apologizing, but also how they do this in light of hospital policy and procedures regarding mistakes and apologies. Communication research has yet to truly explore the (mis)communication of medical mistakes and the apology program at Lexington offers a window into this world.

Please describe the specific scientific objectives (aims) of this research and any previous relevant research.

The specific aims of this study are:

1. To explore how physicians make sense of medical mistakes
2. To explore how physicians make sense of the act of apologizing for medical mistakes
3. To understand how physicians work with and against hospital policy and procedures regarding medical mistakes and apologies.

Relevant research:

See Appendix F
Methodology: please describe the procedures (sequentially) that will be performed/followed with human participants.

1. Participant observations by the lead investigator will take place at the hospital site. Observations include sitting in on legal team meetings, risk management meetings, attending morbidity and mortality conferences, and shadowing physicians and administrators.
2. Participants will be interviewed face-to-face following the semi-structured interview protocol.
3. Interviews will be transcribed by the lead investigator, using pseudonyms and numbers to identify participants and interviews.
4. The transcriptions will be read for emergent themes.

Describe any potential risks or discomforts of participation and the steps that will be taken to minimize them.

Participants may experience some emotional discomfort discussing medical mistakes. Participants have the right to discontinue the interview during any point and to skip questions in which they feel may cause discomfort. There are no legal, employment, or economic risks associated with this study because the VA keeps a very detailed tort/medical mistake database which records all instances of medical mistakes in the hospital. Additionally, the hospital will not have access to raw data or transcripts.

Describe the anticipated benefits to the individual participants. If none, state that. (Note that compensation is not a benefit, but should be listed in the compensation section on the next page.)

No known benefits are associated with this study.

Describe the anticipated benefits to society and/or the scientific community. There must be some benefit to justify the use of human subjects.

1. This study brings the previously under explored issue of medical mistakes to the forefront of communication research, highlighting the ways in which physicians make sense of events not normally talked about.
2. This study will help multiple stakeholders in the medical realm understand how hospital policies and procedures impact how physicians negotiate the act of apologizing for medical mistakes.
3. This study will provide more evidence for patient safety stakeholders (both medical and non-medical) as they attempt to change policies and legislation regarding medical mistakes.

Describe procedures in place to protect confidentiality. Who will have access to raw data? Will raw data be made available to anyone other than the Principal Investigator and immediate study personnel (e.g., school officials, medical personnel)? If yes, who,
how, and why? Describe the procedure for sharing data. Describe how the subject will be informed that the data may be shared.

*Only lead investigator will have access to raw data. Raw data will not be made available to anyone other than the lead investigator. Data will not be shared. Pseudonyms will be entered during the transcription process to protect participant names and any other identifying information. There will not be a master list connecting names to pseudonyms. Signed consent forms will be kept separate from interviews and no codes be used to connect interviews and signed consent forms.*

<table>
<thead>
<tr>
<th>Will participants be: Audiotaped?</th>
<th>X Yes</th>
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</thead>
<tbody>
<tr>
<td>Videotaped?</td>
<td>□ No</td>
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</table>

If so, describe how/where the tapes will be stored (i.e. locked file cabinet in investigator office), who will have access to them, and at what point they will be destroyed.

*The audiotapes will be stored in lead investigator’s office in a locked cabinet. Only the lead investigator will have access to the tapes. The tapes will be destroyed after transcription of audiotapes have been completed and compared with tapes to verify the accuracy of the material.*

Provide details of any compensation (money, course credit, gifts) being offered to participants, **including** how the compensation will be prorated for participants who discontinue participation prior to completion.

*No compensation is being offered to participants.*

**Instruments**
List all questionnaires, instruments, standardized tests below, with a brief description, and provide copies of each, labeled as APPENDIX C.

1. Interview protocol for practicing physicians
2. Interview protocol for program creator

How will the data be analyzed? State the hypothesis and describe how the analysis of the data will test that hypothesis.

*Data will be transcribed and analyzed for emergent themes to explore the following research questions:*

*RQ1: How do VA physicians narratively make sense of medical mistakes?*
*RQ2: How do VA physicians narratively make sense of the VA’s apology and disclosure program?*
RQ3: How does the VA’s apology and disclosure program enable and constrain physicians in practicing medicine in a culture of patient safety?

RQ4: How do the policies and procedures of the VA’s apology and disclosure program contribute to and challenge the practice of ethical and responsible medicine?

RQ4a: How, if at all, do these policies and procedures discipline physicians and the ways they practice medicine?

**Informed Consent Process**
Attach copies of all consent documents or text and label as APPENDIX A.

Informed consent is a process, not just a form. Potential participants/representatives **must** be given the information they need to make an informed decision to participate in this research. How will you provide information/obtain permission?

The lead investigator will attend a hospital staff meeting to initially meet with physicians and explain the aims and purpose of the study. Initial verbal consent will be acquired from participants when they arrange their individual interview time. Participation is completely voluntary.

How and where will the consent process occur? How will it be structured to enhance independent and thoughtful decision-making? What steps will be taken to avoid coercion or undue influence?

A written informed consent form will be given to participants at the beginning of the interview to read over and sign. The lead investigator will also verbally explain the consent form to participants. Participants will also receive an additional copy of the consent form to keep for their records. In order to avoid coercion or undue influence, participants may stop the interview at any time they feel uncomfortable or wish not to continue.

Will the investigator(s) be obtaining all of the informed consents? X Yes □ No

Will all adult participants have the capacity to give informed consent? If not, explain procedures to be followed.

All adult participants have the capacity to give informed consent.

If any participants will be minors, include procedures/form for parental consent and for the assent from the minor.

N/A

Are you requesting a waiver or alteration of Informed Consent? □ Yes X No

An IRB may approve a consent that does not include, or alters, some or all of the elements of informed consent. Provide justifications below for the waiver.
a. Describe how the proposed research presents no more than minimal risk to participants.

N/A

b. Why will a waiver of informed consent not adversely affect the rights and welfare of participants?

N/A

c. Why is it impracticable to carry out the research without a waiver or alteration of informed consent?

N/A

d. How will pertinent information be provided to participants, if appropriate, at a later date?

N/A

Even if waiver of written informed consent is granted, you will likely be required to obtain verbal permission that reflects the elements of informed consent (if appropriate). Please specify below information to be read/given to participants.

N/A

Will participants be deceived or incompletely informed regarding any aspect of the study?  □ Yes  X  No

If so, provide rationale for use of deception.

Attach copies of post-study debriefing information and label as APPENDIX D.

Investigator Assurance

I certify that the information provided in this outline form is complete and correct.

I understand that as Principal Investigator, I have ultimate responsibility for the protection of the rights and welfare of human subjects, conduct of the study and the ethical performance of the project.

I agree to comply with Ohio University policies on research and investigation involving human subjects (O.U. Policy # 19.052), as well as with all applicable federal, state and local laws regarding the protection of human subjects in research, including, but not limited to the following:

- The project will be performed by qualified personnel, according to the OU
approved protocol.

- No changes will be made in the protocol or consent form until approved by the OU IRB.
- Legally effective informed consent will be obtained from human subjects if applicable, and documentation of informed consent will be retained, in a secure environment, for three years after termination of the project.
- Adverse events will be reported to the OU IRB promptly, and no later than within 5 working days of the occurrence.
- All protocols are approved for a maximum period of one year. Research must stop at the end of that approval period unless the protocol is re-approved for another term.

I further certify that the proposed research is not currently underway and will not begin until approval has been obtained. A signed approval form, on Office of Research Compliance letterhead, communicates IRB approval.

Principal Investigator Signature______________ Date _______

Co-Investigator Signature________________________ Date __________

Faculty Advisor/Sponsor Assurance

By my signature as sponsor on this research application, I certify that the student(s) or guest investigator is knowledgeable about the regulations and policies governing research with human subjects and has sufficient training and experience to conduct this particular study in accord with the approved protocol. In addition:

- I agree to meet with the investigator(s) on a regular basis to monitor study progress.
- Should problems arise during the course of the study, I agree to be available, personally, to supervise the investigator in solving them.
- I assure that the investigator will report significant or untoward adverse events to the IRB in writing promptly, and within 5 working days of the occurrence.
- If I will be unavailable, as when on sabbatical or vacation, I will arrange for an alternate faculty sponsor to assume responsibility during my absence.

I further certify that the proposed research is not currently underway and will not begin until approval has been obtained. A signed approval form, on Office of Research Compliance letterhead, communicates IRB approval.

Advisor/Faculty Sponsor Signature________________________ Date _______

*The faculty advisor/sponsor must be a member of the OU faculty. The faculty member is considered the responsible party for legal and ethical performance of the project.
Checklist:

X Completed and Signed IRB-1 (this form)
X Appendix A - copies of all consent documents (in 12 pt. Font)
X Appendix B - copies of any recruitment tools (advertisements, posters, etc.)
X Appendix C – copies of all instruments (surveys, standardized tests, questionnaires, interview topics, etc.).

N/A Appendix D - Copies of debriefing text
X Appendix E - Approval from other IRB, School District, Corporation, etc.
X Appendix F - Any additional materials that will assist the Board in completing its review

N/A Appendix G – Copies of any IRB approvals
X Appendix H – Copies of Human Subjects Research Training Certificates (for all key personnel involved in non-exempt research)

All fields on the form must be completed, regardless of review level. If a field is not applicable, indicate by inserting n/a. Incomplete forms will result in delayed processing. Forward this completed form and all attachments to:

Human Subjects Research
Office of Research Compliance
RTEC 117

Questions? Visit the website at www.ohio.edu/research/compliance/ or email compliance@ohio.edu
Ohio University Consent Form

Title of Research: How to Say I’m Sorry: A Study of the Veteran’s Administration Hospital Association’s Apology and Disclosure Program.
Principal Investigator: Heather J. Carmack
Department: Communication Studies

Federal and university regulations require signed consent for participation in research involving human subjects. After reading the statements below, please indicate your consent by signing this form.

Explanation of Study
The purpose of this study is to explore how physicians make sense of medical mistakes and the act of apologizing for mistakes. Moreover, this study explores how physicians make sense of hospital policies and procedures regarding medical mistakes and apologies.

Participants will be interviewed following the interview protocol. Interviews will take approximately 60-90 minutes and will be audio recorded. After data has been analyzed and emergent themes have been extracted, interview tapes will be destroyed.

Risks and Discomforts
Participants may experience some emotional discomfort discussing medical mistakes. Participants have the right to discontinue the interview during any point and to skip questions in which they feel may cause discomfort. There are no legal, employment, or economic risks associated with this study.

Benefits
No individual benefits are associated with this study. However, this study does add to our understanding of the ways in which physicians and hospital administrators understand and talk about medical mistakes, apologies, and how hospital policy influences those understandings.

Confidentiality and Records
All records will be kept in the principal investigator’s office and only the principal investigator will have access to the files. All names will be replaced with pseudonyms and each interview will be given a code number. After transcription, thematic analysis, and member checking, all data will be destroyed.

Compensation
No compensation will be given for participation in this study.

Contact Information
If you have any questions regarding this study, please contact Heather Carmack at hc200403@ohio.edu or Dr. Lynn Harter at harter@ohio.edu or at (740) 593-4830.

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. I certify that I am 18 years of age or older. My participation in this research is given voluntarily. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled. I certify that I have been given a copy of this consent form to take with me.

Signature_________________________________________ Date____________

Printed Name________________________________________
Name of Principal Investigator:
Heather Carmack

Title of Research Project:
UK/VA: How to Say I’m Sorry: A Study of the Veteran’s Administration Hospital Association’s Apology and Disclosure Program

Applicability

(A) Research activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the following categories, may be reviewed by the IRB through the expedited review procedure authorized by 45 CFR 46.110 and 21 CFR 56.110. The activities listed should not be deemed to be of minimal risk simply because they are included on this list. Inclusion on this list merely means that the activity is eligible for review through the expedited review procedure when the specific circumstances of the proposed research involve no more than minimal risk to human subjects.

(B) The categories in this list apply regardless of the age of subjects, except as noted.

(C) The expedited review procedure may not be used where identification of the subjects and/or their responses would reasonably place them at risk of criminal or civil liability or be damaging to the subjects’ financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.

(D) The expedited review procedure may not be used for classified research involving human subjects.

(E) IRBs are reminded that the standard requirements for informed consent (or its waiver, alteration, or exception) apply regardless of the type of review—expedited or convened—utilized by the IRB.

(F) Categories one (1) through seven (7) pertain to both initial and continuing IRB review.

Please indicate whether or not your protocol involves more than minimal risk*:  ___YES  ___X__ NO

*“Minimal risk” means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves from those ordinarily encountered in daily life or during the performance of routine physical or psychological examination or tests. 45 CFR 46.102(i)
Research Categories

Please indicate which of the following categories are applicable to your research.

1) ____ Clinical studies of drugs and medical devices only when condition (a) or (b) is met.
   (a) _____ Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review.)
   (b) _____ Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

2) ____ Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:
   (a) _____ From healthy, nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or
   (b) _____ From other adults and children considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

3) ____ Prospective collection of biological specimens for research purposes by noninvasive means. Examples: (a) Hair and nail clippings in a nondisfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue; (f) placenta removed at delivery; (g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor; (h) supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings; (j) sputum collected after saline mist nebulization.

4) ____ Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications.) Examples: (a) Physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject’s privacy; (b) weighing
or testing sensory acuity; (c) magnetic resonance imaging; (d) electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electoretinography, ultrasound, diagnostic infrared imaging, doppler blood flow, and echocardiography; (e) moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

5) ____ Research involving materials (data, documents, records, or specimens) that have been collected or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis). (Note: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(4). This listing refers only to research that is not exempt.)

6) ____ Collection of data from voice, video, digital, or image recordings made for research purposes.

7) ____X__ Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (Note: Some research in this category may be exempt from the HHS regulations for the protection of human subjects 45 CFR 46.101 (b)(2) and (b)(3). This listing refers only to research that is not exempt.)

8) ____ Continuing review of research previously approved by the convened IRB as follows:
   (a) _____ Where (i) the research is permanently closed to the enrollment of new subjects; (ii) all subjects have completed all research-related interventions; and (iii) the research remains active only for long-term follow-up of subjects; or
   (b) _____ Where no subjects have been enrolled and no additional risks have been identified; or
   (c) _____ Where the remaining research activities are limited to data analysis.

9) ____ Continuing review of research, not conducted under an investigational new drug application or investigational device exemption where categories two (2) through eight (8) do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

*THE CATEGORIES OF RESEARCH THAT MAY BE REVIEWED BY THE INSTITUTIONAL REVIEW BOARD (IRB) THROUGH AN EXPEDITED REVIEW PROCEDURE BECAME EFFECTIVE NOVEMBER 9, 1998.

In Kentucky, “child/children” refers to all individuals less than 18 years of age unless the individual(s) is/are legally emancipated. (See Informed Consent SOP for discussion of “Emancipated Individuals” under Kentucky state law.) Individuals less than 18 years of age who are not emancipated meet the federal definition for “child” (e.g., DHHS, FDA, and U.S. Department of Education). Children are defined in the HHS regulations as “persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted.” 45 CFR
If conducting research outside the state of Kentucky, you are responsible for complying with applicable state law.

Medical IRB Research Description

In approximately 7 typed pages (excluding attached appendices) of font size 10 or larger, describe your protocol using the outline below. Each response should be numbered or labeled to correspond to each of the following items. If an item does not apply to your research project, simply indicate that the question is "not applicable." For the following sections: 1. “Background”; 2. “Objectives”; 3. “Study Design”; and 4. “Study Population,” you may provide a photocopy of the relevant passages from the sponsor’s full protocol or grant application. *Note: In the Research Description, please make reference to the page number and section and in the appended materials reference the IRB Research Description question and mark the passages (“Background, Objectives, etc.). Attach the relevant passages in order as an appendix to the Research Description. The Research Description should be intelligible to all of the IRB members, professional and lay.

1) Background:

To err is human. The practice of medicine is no exception—health care providers engage in interpretative and ambiguous work as they adjust scientific abstractions to individual cases, engage in diagnostic reasoning, and offer up treatment protocols. Indeed, Hunter (1991) described medicine as “the exercise of practical wisdom in the face of uncertainty” (p. xix). Even so, providers and patients alike remain bound by what Lupton (2004) described as “certainty scripts” and “god-like” expectations for providers. The belief that physicians are omniscient is supported by a long tradition in which doctors are socialized to understand themselves as infallible. Physicians’ expectations for their own careers and abilities are often distorted by unrealistic and narrow understandings of medicine as a realm of knowledge that is or can be as certain as chemistry or physics (see critiques by Hunter, 1991; Montgomery, 2006). Health care contexts must be re-envisioned as uncertain arenas—contexts characterized by medical mishaps woven through role performances among characters who act toward others with the best of intentions.

Just as adverse events have been linked to vulnerable communication processes (see Allman, 1998; Eisenberg, Murphy, Sutcliffe, Wears, Schenkel, Perry, & Vanderhoef, 2005; Petronio, 2002), the (mis)management of adverse events is a communication accomplishment. Health communication scholars have focused primarily on the successes of health communication, generally ignoring failures in health. Failure typically denotes a breakdown, defeat, or mistake in the communication process. However, failure can be seen as a productive part of the communicative process, one that provides space for opportunity and change (Chang & Butchart, 2007). Failure is a lived communicative experience because humans tend to fail more than succeed (St. John, 2006). If we are to understand human communication, then we have to explore the failures as well as the successes. In the medical arena, the highest echelon of failure is the adverse event. Moreover, understanding the failures in communicating about adverse events may
provide a window to understanding the changes hospitals are implementing to reduce failure.

The Discursive Terrain of Medical Mistakes

The general public is relatively unaware of mistakes in medicine. In 1999, however, the Institute of Medicine (IOM) released its landmark report, *To err is human: Building a safer health system* (Kohn, Corrigen, & Donaldson, 1999). This report shared staggering statistics and stories of adverse events that had, up to this point, been silenced within hospital walls. The explosive statistics, including the shocking conclusion that between 44,000 and 98,000 people die annually from adverse events, sparked a nationwide debate in the medical community concerning how to begin to rebuild a safer health care system (McLaughlin, 2005). Part of the controversy associated with the IOM report was the suggestion of new hospital policy about physicians’ and administrators’ responses to adverse events. Covering up mistakes, not informing the patients, altering medical charts, denying mistakes, or simply keeping the mistakes secret are not uncommon practices, and in some cases, are acceptable hospital policy (Duff, 2002; Green, 2003; Kalra, Massey, & Mulla, 2004).

The IOM report called for alternative approaches to handling adverse events, encouraging open and honest communication about mistakes and patient safety. These ideas were further suggested in the Joint Commission on Accreditation of Healthcare Organization’s (2005) report and recommendations and the U.S. Agency for Healthcare Research and Quality. Specifically, JCAHO calls for healthcare facilities to pursue patient safety initiatives that prevent medical injury, to foster open communication between patients and providers, and to create an injury compensation program that is patient-centered. Likewise, the U.S. Agency for Healthcare Research and Quality has placed a special emphasis on adverse events (Lammers, Barbour, & Duggan, 2003). Inherent in these recommendations is the disclosure of medical mistakes. In order to foster open communication, pursue patient safety initiatives, and create patient-centered programs, the disclosure of medical errors is essential (See Appendix A for a more complete list of literature on adverse events).

Although the push for a culture of patient safety started in the late 1990s (Wachter & Shojania, 2004), one hospital system has been creating that culture since the late 1980s. In 1987, the Department of Veteran’s Affairs Medical Center-Lexington-Lexington in Lexington, Kentucky created an apology and disclosure program. This program is a mandatory hospital policy that discloses adverse events to patients and families as well as offers an apology for the event. The Lexington program began after the hospital lost two high-profile malpractice cases. The program, co-created by VA attorney Ginny Hamm and Dr. Sampsonetve Kraman, then Chief of Staff at the hospital, provides a space physicians, patients, and families to reflect and talk about the event (Gebhart, 2005).

The program brings together the physician, patients, families, and hospital administrators to an apology and disclosure meeting. At the meeting, the hospital and physician offers an apology, answers questions, and offers a monetary settlement (Gebhart, 2005). Since its inception in 1987, the Department of Veteran’s Affairs Medical Center-Lexington-Lexington has seen a decrease in lawsuits, settlement costs, and defense costs; in fact, only three cases have gone to trial in the 17-year period (“Why Sorry Works! works,” 2005).
The purpose of this project is to explore how Department of Veteran’s Affairs Medical Center-Lexington physicians make sense of adverse events as well as the socio-historical and institutional shifts surrounding the management of human error in health contexts generally, and the apology and disclosure program specifically. Through a case study of the Department of Veteran’s Affairs Medical Center-Lexington Apology and Disclosure Program, this project is an attempt to bring adverse events to the forefront of health communication theory and practice. Moreover, the communicative exploration of apology has traditionally been relegated to rhetorical scholarship, focusing on interpersonal, corporate, and social apologies through the presentation of case studies (see for example, Benoit, 1995, 1997, 2000; Benoit & Brinson, 1994; Harter, Stephens, & Japp, 2000; Hearit, 1995, 1997; Rowland & Jerome, 2004; Takaku, Weiner, & Ohbuchi, 2001; Tyler, 1997; Yamazaki, 2004). See Appendix A for a more complete list of literature on apology. Health communication scholarship has also generally ignored to role of apology in the practices of health and healing (Phillips, 1999) although apology is a part of health and healing. This project serves as a space to begin to introduce apology and failure to the communication canonical dialogue.

2) **Objectives**: The research objectives for this study are as follows:

a) To explore how physicians at the Department of Veteran’s Affairs Medical Center-Lexington make sense of adverse events from a communication standpoint.

   i) This objective is concerned with the exploration of how Department of Veteran’s Affairs Medical Center-Lexington physicians talk about instances of adverse events. Physicians do not need to have experienced or been involved in an adverse event in order to talk about adverse events.

b) To explore and understand how Department of Veteran’s Affairs Medical Center-Lexington physicians make sense of the act of disclosing and apologizing for adverse events from a communication standpoint.

   i) This objective is concerned with how Department of Veteran’s Affairs Medical Center-Lexington physicians talk about the ideas of disclosing and apologizing for adverse events to patients, families, and/or hospital administrators. Participants do not need to have experienced or been involved in acts of disclosure and/or apology in order to talk about disclosing and/or apologizing for adverse events.

c) To explore and understand how Department of Veteran’s Affairs Medical Center-Lexington physicians make sense of hospital policies and procedures regarding adverse events, disclosing, and apologizing for the events from a communication standpoint.

   i) This objective is solely concerned with how hospital policies and procedures regarding adverse events influence the ways in which physicians talk about adverse events, disclosing, and apologizing in the face of an adverse event.
d) To examine how, if at all, hospital policies and procedures regarding adverse events influence the ways in which Department of Veteran’s Affairs Medical Center-Lexington physicians think about and talk about medicine.

   i) This objective is concerned with how hospital policies and procedures potentially influence how ideas of medicine are communicated. In particular, this research objective is concerned with how policies that encourage patient safety and patient-centered care influence if and how physicians talk about medicine from a patient-centered language.

3) Study Design:

   The research design for this study is a qualitative approach that utilizes in-depth interviews. The dissertation relies on qualitative interviews of physicians who are employed and have active medical duties at one of the VA sites. I am also planning on interviewing Ginny Hamm, one of the founders of the program, who is still employed at the Department of Veteran’s Affairs Medical Center-Lexington as a risk management attorney. Qualitative interviews are used in order to understand a social actor’s experiences (Lindlof & Taylor, 2002, p. 173). More importantly, the qualitative interview is used when observing in a social setting is not possible or fruitful (Warren, 2002). Specifically, I will be engaging in respondent and narrative in-depth interviews. These two interview types are appropriate because I am asking interviewees to reflect on their experiences and the influence an organizational change had or did not have on the ways in which they practice medicine and think about medical mistakes. In-depth interviewing allows individuals the opportunity to describe how they make sense of the world and how they convey their experiences to others. By eliciting narrative experiences from respondents, I can highlight the personal and organizational narratives surrounding apologies and medical mistakes. I will be able to explore the web of collective realities that are embodied and enacted by organizational members (Czarniawska, 2002).

   The interview protocol will include open ended questions focusing on how physicians make sense of adverse events; how they talk about adverse events; if they have been involved in an adverse event how they felt about the event and subsequent apologies; and how they make sense of the organizational process of adverse events and apologies. The interview sessions will be semi-structured to allow participants to talk about their individual experiences and insights, with recognition that the interview process is a fluid co-constructed event (Heyl, 2001) and other experiences may emerge during the course of the interview.

4) Study Population:

   Participants for this study will be active physicians who have practice privileges at the Department of Veteran’s Affairs Medical Center-Lexington. For this study, only physicians who actively practice medicine at the hospital will be interviewed because they will be familiar with the hospital’s policies regarding adverse events and apology. The anticipated number of participants is between 30-40 physicians. Participants should be between 21 and 75 years of age. 21 was selected because physicians are not likely to have completed medical school before the age of 21. 75 was selected as the cutoff age because most individuals will have retired by this age. There is no exclusion of
participants based on race, gender, or nationality because race, gender, and nationality are not important for this study or the study’s objectives. Participants begin to be contacted via phone by the end of July or beginning of August (the beginning of enrollment). See Appendix B for phone message. Contact and enrollment of participants will continue until October, 2007. Interviews will be completed by October, 2007.

5) Subject Recruitment Methods and Privacy:

Participants will be identified based on their registration to practice medicine at the Department of Veteran’s Affairs Medical Center-Lexington. The Chief of Staff’s office will provide the names and phone numbers of practicing physicians to the research team. A FOI (Freedom of Information) form will be completed by the researchers in order to obtain this information. Only the researchers will have access to the names and phone numbers of potential participants. Participants will interact with an investigator in two ways: over the phone via the initial participation discussion and any subsequent calls to confirm participants and interview times, and during the interview.

6) Informed Consent Process:

Informed consent will be obtained by the study personnel in two different ways. First, the participants will be contacted about participating in the study and will either accept or decline the offer to participate. Once a participant has accepted the invitation to participate, the study personnel will schedule an interview time with the participant that coordinates with their schedule. At the scheduled interview time, the study personnel will present the participants with the informed consent forms and go over the consent forms with each participant, ensuring that the participants understand the project and purpose of the interview. Participants must sign all of the informed consent forms in order to participate in the interview. Participation and consent is completely voluntary and participants may decline to participate or stop the interview at any time. Signed consent forms will be kept in a separate file with no identification that connect the signed consent form to an interview code number or pseudonym.

7) Research Procedures:

Individuals will be contacted by the study personnel inviting them to participate in the study via phone. If participants verbally consent to participate, interview times will be arraigned by the researchers that are compatible with participants’ schedules. Participants will receive a reminder phone call about the interviews to confirm participation. Participants will arrive at the pre-arranged meeting place at the University Inn Motel or the W. T. Young Library. The interviews will be conducted in private rooms at the specified locations. The study personnel will read over the informed consent forms with participants, answering any questions and making sure the participants understand the purpose of the interview. Participants will sign the informed consent forms necessary to complete the interviews. Once the informed consent forms have been signed, the interviewer will begin the interview, following
the pre-established interview protocol (see Form M). The interviews will take approximately between 60-90 minutes, depending on the length of answers given by the participants. Once the interview is completed, the participants can leave the interview room. Interviews will be downloaded from the audio recorder each night and will be immediately transcribed by the researchers.

8) **Resources:**

The interviews will be conducted by the study personnel. The study personnel consist of one individual with extensive training and experience in conducting in-depth qualitative interviews. The interviews will take place in a private conference room at the University Inn Motel or in a private conference room in the W. T. Young Library. The interviews will be audio recorded and participants will sign informed consents forms at the beginning of the interview. No psychological, social or medical services or monitoring is required for these interviews.

9. **Potential Risks:** There are no known risks associated with this study.

10. **Safety Precautions:** All interviews will be conducted in a neutral setting to ensure confidentiality and privacy of participants. Only the research team will have access to raw data. Raw data will not be made available to anyone and raw data will not be shared. During the interview, respondents will not be identified by name. All names and places will be replaced with pseudonyms and interviews will be given a code number. Once audio recorded interviews have been transcribed, the audio recordings will be destroyed. Signed consent forms will be kept separate from interview transcriptions to prevent identification. All data will be kept locked in the office of Lasher 006 at Ohio University. Only the researchers will have access to this data. Once interviews have been transcribed, data files will be destroyed.

11. **Benefit vs. Risk:** There are no known individual benefits to participants. There are no known risks to participants. There are, however, several potential benefits for research communities and the general public. These benefits are:

   1. This study brings the previously under explored issue of medical mistakes to the forefront of communication research, highlighting the ways in which physicians make sense of events not normally talked about.

   2. This study will help multiple stakeholders in the medical realm understand how hospital policies and procedures impact how physicians negotiate the act of apologizing for medical mistakes.

   3. This study will provide more evidence for patient safety stakeholders (both medical and non-medical) as they attempt to change policies and legislation regarding medical mistakes.
12. **Available Alternative Treatment(s):**

This study does not provide treatments to participants. There are no available alternative treatments for this study.

13. **Research Materials, Records, and Privacy:**

This study relies on audio recorded interviews following the interview protocol (see Appendix C or Form M). Responses to the interview protocol will be recorded. No existing data will be used in this study. Interviews are needed for this study because the objectives and aims of the research to explore how physicians make sense of and talk about adverse events. These kinds of research objectives require a qualitative research methodology. As stated below in the confidentiality section, all records will be kept private and any identifying information will be changed in the transcription process.

14. **Confidentiality:**

Confidentiality is of the utmost importance to the research team. Only the research team will have access to raw data. Raw data will not be made available to anyone and raw data will not be shared. During the interview, respondents will not be identified by name. All names and places will be replaced with pseudonyms and interviews will be given a code number. Once audio recorded interviews have been transcribed, the audio recordings will be destroyed. Signed consent forms will be kept separate from interview transcriptions to prevent identification.

15. **Payment:** Payment for participation is not offered in this study.

16. **Costs to Subjects:** There are no costs to subjects associated with this study.

17. **Data and Safety Monitoring:**

The data for this study is not of greater than minimal risk. However, all data will be kept locked in the office of study personnel. Only the researchers will have access to this data. Once interviews have been transcribed, data files will be destroyed.

18. **Subject Complaints:**

Subject complaints, problems, or concerns will be directed to Debra Jo Barrett, NSQIT (National Surgery Quality Improvement Program) Clinical Reviewer. You can contact Debra Jo Barrett at (859) 608-9600 anytime. Debra Jo Barrett is the PI for which this research is being collected. Any questions or requests for information about the research can be directed to Heather Carmack, Doctoral Candidate in the School of Communication Studies at Ohio University at hc200403@ohio.edu.
19. **Research Involving Non-English Speaking Subjects or Subjects from a Foreign Culture:** This study does not involve non-English speaking subjects. Additionally, a subject’s nationality is not pertinent to the objectives of the study.

20. **HIV/AIDS Research:** This study does not focus on HIV/AIDS research.
Consent to Participate in a Research Study

UK/VA: How to Say I’m Sorry: A Study of the Veterans Administration Hospital Association’s Apology and Disclosure Program

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about adverse events and apologies. You are being invited to take part in this research study because you are a licensed, practicing physician at the VAMC in Lexington. If you volunteer to take part in this study, you will be one of about 40 people to do so.

WHO IS DOING THE STUDY?

The person in charge of this study is Debra Jo Barrett (PI) of Veteran’s Affairs. Interviews will be conducted by the study personnel, Heather Carmack.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to explore how physicians make sense of adverse events and the act of apologizing for the events. Moreover, this study explores how physicians make sense of hospital policies and procedures regarding adverse events.

By doing this study, we hope to learn how physicians understand and talk about adverse events, apologizing, and the hospital policies that influence these events.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

The research interviews will be conducted at a conference room at the University Inn Motel or the VA Medical Center depending on the convenience for participants. You will need to come to the decided upon location for your pre-scheduled interview. You will only need to be interviewed one time during the study. This interview will take about 60 to 90 minutes.

WHAT WILL YOU BE ASKED TO DO?

You will be asked to answer interview questions regarding adverse events, apologies, and hospital apology and disclosure policies. All answers are voluntary and you can refuse to answer any question you do not feel comfortable answering. You can also end the interview at any time. You will be asked general information questions about your interest in medicine and your particular specialty. You will then be asked questions regarding adverse events, followed by questions about apologizing for adverse events.
The interviews will end with questions about general hospital policies about disclosing and apologizing for adverse events.

There are no experimental procedures in this study. There are no randomization procedures in this study as participation is voluntary.

**ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?**

You can participate in this study if you are a licensed, practicing physician (MD or DO) in Kentucky with privileges at the VAMC- Lexington.

**WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?**

There are no known risks or discomforts associated with this study. You may, however, experience a previously unknown risk or side effect.

**WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?**

You will not get any personal benefit from taking part in this study. However, this study does add to our understanding of the ways in which physicians and hospital administrators understand and talk about adverse events, apologies, and how hospital policies influence those understandings.

**DO YOU HAVE TO TAKE PART IN THE STUDY?**

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

**IF YOU DON’T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?**

If you do not want to be in the study, there are no other choices except not to take part in the study.

**WHAT WILL IT COST YOU TO PARTICIPATE?**

There are no costs for you to participate in this study.

**WHO WILL SEE THE INFORMATION THAT YOU GIVE?**

We will keep private all research records that identify you to the extent allowed by law.
Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. For example, your name will be kept separate from the information you give, and these two things will be stored in different places under lock and key. All names and places will be replaced with pseudonyms and each interview will be given a code number. After the interviews have been transcribed, all voice recordings will be destroyed.

The VA Medical Center and Government Accounting Office (GAO) may look at or copy pertinent portions of records that include your pseudonym and code number.

**CAN YOUR TAKING PART IN THE STUDY END EARLY?**

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to withdraw you from the study. This may occur if you do not meet the participant requirements.

**WHAT HAPPENS IF YOU GET HURT OR SICK DURING THE STUDY?**

If you believe you are hurt or if you get sick because of something that is due to the study, you should call Debra Jo Barrett at Debra.Barrett@va.gov immediately. She will determine what type of treatment, if any, that is best for you at that time.

It is important for you to understand that the University of Kentucky does not have funds set aside to pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. Also, the University of Kentucky will not pay for any wages you may lose if you are harmed by this study.

If you are eligible for Veterans Affairs medical benefits, the VA provides medical care if you get hurt or get sick as a result of taking part in this study. The necessary care must be provided in a VA medical facility unless an exception is granted. In cases of exceptions, the VAMC Director may contract for such care. Exceptions include: situations where a VA facility is not capable of furnishing economical care, situations where a VA facility is not capable of furnishing the care or services required and situations involving a non-veteran research subject. The VA does not provide medical treatment for a research-related injury in cases where injuries result from noncompliance by a research subject with study procedures.
A co-payment from you may be required for medical care and services provided by the VA.

**WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?**

You will not receive any rewards or payment for taking part in the study.

**WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?**

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the study personnel, Heather Carmack at hc200403@ohio.edu or 740-438-0469. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428. We will give you a signed copy of this consent form to take with you.

**WHAT ELSE DO YOU NEED TO KNOW?**

You will be told if any new information is learned which may affect your condition or influence your willingness to continue taking part in this study.

_____________________________________________                 ____________
Signature of person agreeing to take part in the study            Date

_____________________________________________
Printed name of person agreeing to take part in the study

_____________________________________________     ____________
Name of [authorized] person obtaining informed consent            Date

_________________________________________
Signature of Investigator
Appendix C

IRB Approvals

The following research study has been approved by the Institutional Review Board at Ohio University for the period listed below. This review was conducted through an expedited review procedure as defined in the federal regulations as Category(ies):

Project Title: How to Say I'm Sorry: A Study of the Veteran's Administration Hospital Association's Apology and Disclosure Program

Researcher(s): Heather Carmack

Faculty Advisor (if applicable): Lynn Harter

Department: School of Communication Studies

Jeff Vancouver, Ph.D., Chair
Institutional Review Board

Approval Date 08/14/07
Expiration Date 08/13/08

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

Adverse events must be reported to the IRB promptly, within 5 working days of the occurrence.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.
Approval Ends
September 10, 2008

Project Ends
December 31, 2007

IRB Number
07-0381-P3H

TO:
Debra J. Barrett, M.S.N.,
c/o Heather Carmack
006 Lacker Hall
Ohio University
Athens, OH 45701
Phone #: (839)233-4511 ext. 4769

FROM:
Chairperson/Vice Chairperson
Medical Institutional Review Board (IRB)

SUBJECT: Approval of Protocol Number 07-0381-P3H

DATE: September 12, 2007

On September 12, 2007, the Medical Institutional Review Board approved your protocol entitled:

"UK/VA: How to Say I'm Sorry: A Study of the Veteran's Administration Hospital Association's Apology and Disclosure Program"

Approval is effective from September 12, 2007 until September 10, 2008. This approval extends to any consent/assent document unless the IRB has waived the requirement for documentation of informed consent. If applicable, attached is the IRB approved consent/assent document(s) to be used when enrolling subjects. [Note: subjects can only be enrolled using consent/assent forms which have a valid "IRB Approval" stamp unless special waiver has been obtained from the IRB.] Prior to the end of this period, you will be sent a Continuation Review Report Form which must be completed and returned to the Office of Research Integrity so that the protocol can be reviewed and approved for the next period.

In implementing the research activities, you are responsible for complying with IRB decisions, conditions and requirements. The research procedures should be implemented as approved in the IRB protocol. It is the principal investigator's responsibility to ensure any changes planned for the research is submitted for review and approval by the IRB prior to implementation. Protocol changes made without prior IRB approval to eliminate apparent harm to the subject(s) should be reported in writing immediately to the IRB. Furthermore, discontinuing a study or completion of a study is considered a change to the protocol's status and therefore the IRB should be promptly notified in writing.

For information describing investigator responsibilities after obtaining IRB approval, download and read the document "PI Guidance to Responsibilities: Qualifications, Records and Documentation of Human Subjects Research" from the Office of Research Integrity's Guidance and Policy Documents web page [http://www.research.uky.edu/ori/humaniguidance.html#PPIps]. Additional information regarding IRB review, federal regulations, and institution policies may be found through ORI's web site [http://www.research.uky.edu/ori]. If you have questions, need additional information, or would like a copy of the above mentioned document, contact the Office of Research Integrity at (859) 257-6428.

Chairperson/Vice Chairperson

University Veterinarians, IRB, RDRG, IACUS
315 Kinkaid Hall - Lexington, Kentucky 40506-6057
(859) 257-6428 - Fax (859) 257-8095
www.research.uky.edu/ori
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<th>Activities</th>
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12/12/07  10:00 am-12:00 pm  2.0  Observations with legal team  N  Y  N
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12/12/07  4:00 pm-5:00 pm  1.0  Interview  Y  Y  N
12/13/07  8:00 am-10:00 am  2.0  Risk management meeting  N  Y  N
12/13/07  11:00 am-12:30 pm  1.5  Interview  Y  Y  N
12/13/07  2:00 pm-5:00 pm  3.0  Observations with legal team (closure)  N  Y  N
Appendix E

Interview Protocol—Physicians

Time of interview: ____________________  Date: _________________________

Place: ______________________________  Pseudonym: ___________________

**General Questions:**

Tell me how you came to practice medicine.

   What drew you to the medical profession?

   How did you decide to practice your medical specialty?

Tell me how you came to be at the Lexington, KY VA hospital.

   What drew you to this particular hospital?

   How long have you practiced medicine here?

**Medical Mistakes Questions:**

Tell me about your experiences with medical mistakes.

   Tell me the story of your first mistake.

   What were the rituals or consequences that happened as a result of the mistake?

   What did you take away from the experience?

How do you feel about making mistakes in medicine?

   Based on your experiences with medical mistakes, what have you learned about the way that the institution of medicine sees mistakes?

   How do you think other physicians see medical mistakes?

   How do you think, in general, hospitals see medical mistakes?

What do you think about the rituals of medical mistakes, such as malpractice litigation and morbidity and mortality conferences?
**Apologizing for Mistakes Questions:**

Medical mistakes and apologies are emotionally charged experiences. How do you handle the emotional nature of mistakes and apologizing?

   How do you manage or negotiate your emotions when you have committed a mistake and must continue to see and treat patients?

What, if any, barriers exist that you think prevents the medical community from embracing apologies?

   What, if any, barriers exist that you think prevents the legal community from embracing apologies?

How do you feel about state and national legislations that mandate apologies?

   How, if at all, do you see these as disciplining or empowering physicians in wake of medical mistakes?

   How, if at all, do you see these as disciplining or empowering patients in the wake of medical mistakes?

**The VA Apology and Disclosure Program Questions:**

Tell me about the apology and disclosure program here at the VA.

What do you see as the stated purpose(s) of the program?

What, if any, are the unstated purpose(s) of the program?

How do you feel the policy enables or constrains your ability to practice medicine?

Tell me about your experiences with disclosing and apologizing for mistakes.

   How did you feel about apologizing?

   How, if at all, did it change the way you practice medicine?

   How, if at all, did it change the way you think about medical mistakes?

What does the term “patient safety” mean to you?

What does the term “social responsible medicine” mean to you?

   How, if at all, do you think disclosing and apologizing for medical mistakes accomplishes or does not accomplish this?
Are there any other important questions or issues about the program, medical mistakes, or apologizing that I have not talked about that you think are important for me to know?

Do you have any questions for me?
Appendix F

Interview Protocol—Administration

Time of interview: ____________________  Date: _________________________

Place: ______________________________  Pseudonym: ___________________

**General Questions:**

Tell me how you came to practice health law.

  What drew you to the legal profession?

  How did you decide to practice your legal specialty?

Tell me how you came to be at the Lexington, KY VA hospital.

  What drew you to this particular hospital?

  How long have you practiced law here?

**Medical Mistakes Questions:**

Tell me about your experiences with medical mistakes.

  Tell me the story of your case of a medical mistake.

  What were the rituals or consequences that happened as a result of the mistake?

  What did you take away from the experience?

How do you feel about making mistakes in medicine?

  Based on your experiences with medical mistakes, what have you learned about the way that the institution of medicine sees mistakes?

  How do you think physicians see medical mistakes?

  How do you think, in general, hospitals see medical mistakes?

What do you think about the rituals of medical mistakes, such as malpractice litigation and morbidity and mortality conferences?
**Apologizing for Mistakes Questions:**

Medical mistakes and apologies are emotionally charged experiences. How do you handle the emotional nature of serving as counsel in cases of mistakes and apologizing?

What, if any, barriers exist that you think prevents the medical community from embracing apologies?

What, if any, barriers exist that you think prevents the legal community from embracing apologies?

How do you feel about state and national legislations that mandate apologies?

How, if at all, do you see these as disciplining or empowering physicians in wake of medical mistakes?

How, if at all, do you see these as disciplining or empowering patients in the wake of medical mistakes?

**The VA Apology and Disclosure Program Questions:**

Tell me about the apology and disclosure program here at the VA.

How did the program come into being?

What were the driving forces behind the program?

Since its inception, how many apologies have you witnessed?

What do you see as the stated purpose(s) of the program?

What, if any, are the unstated purpose(s) of the program?

How do you feel the policy enables or constrains physicians’ ability to practice medicine?

How, if at all, did it change the way you think about medical mistakes?

What does the term “patient safety” mean to you?

What does the term “social responsible medicine” mean to you?

How, if at all, do you think disclosing and apologizing for medical mistakes accomplishes or does not accomplish this?

Are there any other important questions or issues about the program, medical mistakes, or apologizing that I have not talked about that you think are important for me to know?

Do you have any questions for me?
## Appendix G

### Physician Code List

<table>
<thead>
<tr>
<th>Physician</th>
<th>Practicing Service</th>
<th>Rank</th>
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<tbody>
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<td>Anderson</td>
<td>OBGYN</td>
<td>Attending</td>
</tr>
<tr>
<td>Burke</td>
<td>Anesthesiology</td>
<td>Attending, Chief of Anesthesiology at VAMC</td>
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<tr>
<td>Campbell</td>
<td>Anesthesiology</td>
<td>Attending</td>
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<tr>
<td>Davis</td>
<td>Cardio-thoracic surgery</td>
<td>Attending</td>
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<tr>
<td>Earhart</td>
<td>Ambulatory care/outpatient care</td>
<td>Attending</td>
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<tr>
<td>Ferris</td>
<td>Ambulatory care/outpatient care</td>
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<td>Grey</td>
<td>Optometry</td>
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<td>Resident</td>
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<td>Quality Improvement Officer</td>
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<tr>
<td>Gina</td>
<td>Legal counsel, co-creator</td>
<td>Head of Legal Services at VAMC</td>
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<tr>
<td>Chief of Staff</td>
<td>Chief apologistizer</td>
<td>Chief of Staff</td>
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