The news media cleaning up "dirty" hospitals?

Exploring the effects of the news media on the establishment of organized professionalism

MASTER THESIS

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NOVEMBER 2013

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Thesis defense: 15 November 2013, Utrecht School of Governance (USG/USBO), Utrecht

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[1] Image cover: http://www.fransveugen.nl/nl/files/Test%20schaaltjes.jpg

Preface

"Though the road's been rocky it sure feels good to me."

— Bob Marley

It probably is surprising to find a quote from a famous reggae legend in the preface of an scientific research report. However, this might not turn out to be as striking as it seems. This quote not only perfectly expresses my feelings about doing this research and writing a thesis, hopefully it also reflects the feelings of professionals who encountered intense media attention and consequently struggled with these pressures to improve patient safety.

I got interested in this research topic as I was watching the news and saw all these fragments about 'failures' and incidents in health care pass by. I thought of what it would do to me personally, and whether it would affect the way I work. That was when I realized that this topic is not only present in health care, but also in my own field, academia. Recently there have been several news items reporting about failures in academic research, and I do think it affected 'how we work'. People are aware of the fact that we are held accountable for what we publish, just as medical specialists who are held accountable for the care they deliver. This all the more underlines the relevance of the topic. Because I have had a fascination for health care since I was a little child, and we all are to some extent dependent from that service delivery, I decided to dive into this topic to find out how the news media affect medical professionals and their organizing activities.

This hadn't been possible without the help of many people. First, I want to thank all the respondents who were willing to tell me their stories, even though it wasn't always easy to talk about what has happened. Your openness has really been inspiring to me. Next, I want to thank Liesbeth Rensen, who was willing to help me find those people. A special 'thank you' goes to Mirko Noordegraaf and Lars Tummers, who inspired me, puzzled me, and motivated me to improve my work all the time. Further, I want to thank Arjen Boin, who stimulated me to dive into this research master in the first place, and acted as second supervisor in this final project. Finally, I want to thank my family and friends for their support in so many ways.

By finishing my master thesis, I made it to the end of this road. Luckily, there is a new road ahead of me. And it will be rocky for sure. But every time I get lost somewhere along the way, I will definitely play a song by Bob Marley and say "Though the road is rocky, it sure feels good to me"

Marlot Kuiper

October 2013

Executive Summary

This research project was performed in the context of a Research Master in Public Administration and Organizational Science to obtain the degree of Master of Science from the Universities of Utrecht, Rotterdam and Tilburg.

Research focus and set-up

The past few decades, professional organizations like schools, law courts and hospitals have come under an increasing challenge. In for example health care, the control of clinical practices has undergone considerable change; medical specialists have extensively been exposed to management control instruments that have affected the nature of medical professionalism. These developments appeared in reaction to several challenges that threatened the medical healthcare sector in Western countries, such as the welfare state and financial crisis, reinforced market requirements, more demanding and well-informed clients, and last but not least, publicly exposed medical failures.

The introduction of an organizational logic in reaction to these pressures and the public demand for accountability were at odds with a former dominant professional logic, in which professional autonomy served as a basis for health care service delivery. This research project explored changes in the organization of patient safety to with a special focus on how health care professionals (medical specialists) are affected by these pressures and whether the news media make professionals feel the need to change and take on *organizational roles* to deal with these challenges, and what mechanisms affect the identified responses. This led to the following central research question:

How do news media affect organizational actions by medical professionals and what mechanisms affect these actions?

In many studies that focused on the reconfiguration of professionalism, a perspective in which professionals and managers were approached as opponents dominated. This perspective often led to a research set up from an isolated focus, in which there was an emphasis on either professionals *or* managers. To overcome these dichotomies, this research applied a more holistic approach in order to unravel how these actors can work together to face contextual change. Varying contextual empirical analyses have shown that more hybrid forms rather than only clashes, hegemony and resistance exist. This study facilitated the demand for the investigation of these subtle reactions by applying a qualitative comparative case study which specifically focuses on bacteria outbreaks in hospitals, in which in all the three researched cases respondents from different hierarchical levels were included in order to get a rich understanding of how actions by professionals can be positioned in their organizational context. A theoretical framework was constructed to provide a focus for this study in which after a separate analysis of the main concepts, media attention and organized professionalism were connected in a theoretical model. Subsequently, 13 interviews were

conducted (5 in Hospital I., and 4 in both Hospitals I. and II.). The data collection was complemented by documents and observations.

Research outcomes and implications

The empirical results demonstrate that media attention does have an effect on organizing actions by professionals. There are clear differences in how the media attention is processed within the organization. For the outcome, it proves important how the media attention reaches the professional; if professionals are directly affected by media attention this seems to urge them more to adopt organizing activities than if they are protected by their managers and a sense of urgency if more indirectly forwarded to them. In other words, organizational pressures are more 'soft' than direct media attention. It has to be noted however, that although it did lead to the implementation of new practices, 'assaulting' media attention can also cause fear for public shaming.

The perceived picture of 'professionalism' in the organization seems to matter in how managers estimate the organizing capacities of professionals; if professionals are considered recalcitrant towards change, administrators are more likely to take on initiating roles. If professionals are not involved in the creation of new measures, a focus on compliance and sanctioning possibilities prevails. However, if there are less systematic efforts by staff departments or managers to improve patient safety, professionals demonstrated to take on these roles themselves. These initiatives reach further than demands for what is needed to live up to protocols; professionals can also arrange work arrangements in which patient safety efforts are incorporated, for example in the form of safety rounds and work meetings.

In short; media attention does have an effect on organizing actions by professionals. Direct media attention is a stimulus for adapting work processes. Explicit media attention can cause fear, but this does not directly cause apathy, but even motivate professionals to take on new roles. Examples of new organizing actions by professionals are safety checks, safety rounds and the inclusion of bacteria as a structural topic on the agenda of work meetings. If organizations have strong mechanisms to control media content, a sense of urgency to improve patient safety is not directly transferred to professionals by media organizations, but more indirectly by managers. A strong role for administrators in carrying out patient safety as a top priority may help to improve the safety climate, but overwhelming activities initiated by staffing members may also reduce the stimulus for professionals to transform their ways of working.

The research findings have some implications for both health care practice and academic research and theories that focus on the reconfiguration of professionalism and the adaptation of organizing activities by professionals, and raise some new questions. In many studies that focus on the reconfiguration of professionalism and the creation of patient safety a focus on *individual* competencies prevail (e.g. CanMEDS framework). I argue that these approaches do not explain how different actors can act together in their organizational environment and thus more studies that focus on *system* capacities rather than *individual*

capacities are needed. Further a tradition in which managers are concerned with *protecting* their professionals at the operating core does, despite efforts to transform management in healthcare into more businesslike approaches, still partly exists. Managers act as a 'heat shield' in which they protect professionals from external pressures. Since this protection lowers the probability that professionals take on organizing roles, this paradigm might be revised.

Theoretically, safety culture has been illustrated as a requisite for other safety improvement strategies to work. The results of this study imply that this assumption also works the other way around; the implementation of concrete, physical measures, can create greater *awareness* of patient safety issues and herewith a just safety culture.

To conclude; this study wondered if 'the news media are cleaning up dirty hospitals'. With hindsight it can be stated that 'dirty hospitals' indeed is terminology that fits the repertoire of news organizations. The image is sketched that a bacteria outbreak certainly implies a dirty hospital. Although this reality constructed by the news media is highly debatable, it is something health care organizations have to deal with. It has shown that media attention can be a stimulus for adopting new (organizing) practices that prevent 'filthyness' and improve patient safety.

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1. Introduction

1.1. "Named and shamed"

"Lack of hygiene persevering problem", "Hospital immediately closes surgery section" and "Patients victim of conflicts between medical specialists[2]" are just a few of the very many headings that recently appeared in Dutch national newspapers and report failures in hospitals. Concerns about patient safety are rising worldwide; the past few years brought a growing public realization that health care organizations are often 'dangerous places', in part caused by high-profile failures reflected in the news media (Walshe and Shorthell 2004). The issue of patient safety has already been repeatedly identified in the medical literature since the 1950s onwards, but these earlier revelations about patient harm caused by treatment in hospitals did not lead to sufficient changes in the actual practice of medicine (Millenson 2002). Nowadays, health care professionals are coming under increasing pressures, since their failings are now publicly being "named and shamed" in the news media.

1.2. Changes in Service Delivery

In the traditional 'professional logic' which has been dominant in health care service delivery for a very long time, core values such as autonomy, expertise and status role became highly institutionalized and served as a basis for individual behavior (Scott 2000; Redmond 2003). Because of the lengthy socialization processes of medical specialists in which knowledge and values became internalized, ways of working became *taken-for-granted* [3](e.g. Noordegraaf 2007; Scott 2000; Witman et al. 2011). The traditional paradigm characterized by professional values discouraged action aimed at improving patient safety in at least one powerful way; a domination of autonomy and *human intuition* lacks a tradition of system thinking and herewith an understanding of complex high-risk systems (Perrow 1999). After all, professionals were well intentioned and "nobody wants to kill a patient"; the errors that reached the public were attributed to a few 'rotten apples', not in the least by physicians themselves (Reason 1997). Furthermore, in the public consciousness there was little if any

[2] "Hygiëne in ziekenhuis blijft probleem", De Stentor, 22 September 2012; "Ziekenhuis sluit afdeling hartchirurgie", De Volkskrant, 27 March 2013; "Patiënten slachtoffer van conflicten tussen medisch specialisten", Nu.nl 21 aug 2012

[3] This study specifically focuses on what is labeled 'classic' medical professionals. Although there are academic debates about the 'professionalism' of nurses and newer hybrid forms of professionalism (e.g. nurse practitioners), In this study professionals are defined as *medical specialists*, following the classic professionalism literature in which physicians are often considered exemplary.
Wilensky (1964) for example described in 'The professionalization of everyone?' two characteristics of professionals; the possession of technical knowledge acquired during a process of education and socialization (1), and behavior following professional values and standards (2). In 'The third logic', Freidson (2001) distinguishes three characteristics of the professional; specialized knowledge (1), the existence of professional associations (2) and professional autonomy, norms and values.

awareness of the uncertainties in healthcare delivery, and a certain faith in the ability of healthcare professionals and institutions to provide safe and high quality care existed for a very long time.

However, the welfare state which characterized the Dutch political landscape for many years caused rising costs which finally led to an untenable situation, not in the least generated by the organization of the health care system. The health care reform act from 2006 shifted the system towards a more market-oriented system (Helderman et al. 2005). Health care organizations since then thus increasingly embody an organizational logic that focuses on (cost) control and bureaucratic regulations, at the expense of professional autonomy (Scott 2000; Muzio and Kirkpatrick 2011; Pollitt and Harrison 1994). These developments can be attributed to broader (international) trends which are well documented in the literature, such as changes in capitalist markets, technologies and forms of regulation and management (Muzio and Kirkpatrick 2011:393). Due to the rise of the New Public Management (NPM) from the 1990s onwards, the idea to reform the public sector into a more efficient and effective system, while maintaining the volume and quality of services, became dominant in Western economies (Hood 1991; Pollitt and Bouckaert 2011; Ferlie et al. 1996). In order to achieve this, various private sector management techniques were introduced in the public sector. Further, like other professional practices, the delivery of healthcare work became increasingly dominated by large-scale organizations.

Because of increasingly dynamic environments, organizations are continually confronted with the need to implement changes in strategy, structure, process, and culture. Health care systems are starting to recognize and use ideas and techniques from safety science, which were developed in other commercial settings where safety and reliability are critical concerns (Walshe and Shorthell 2004). The values of organizational effectiveness, efficiency and system safety, were at odds with the former dominant logic of autonomous professional service delivery, since traditionally professions were considered as groups of workers who control themselves (e.g. Freidson 2001, 1994, 1970). Wynia et al. (1999) stated that *"a gulf has been developed between the medical profession and the society it serves"* (p.1612). Society demands accessible and safe care and asks for accountability, transparency and sound professional standards (Dunning 1999), while medical professionals feel restricted in their autonomy because of shrinking budgets, bureaucracy, and quality concerns (Plochg et al. 2009).

1.3. Learning from Blame?

Balancing "No Blame" and Accountability

Although society has tremendously benefited from physician autonomy, for example regarding the use of innovative therapies and medication (Pronovost 2010), there is a widespread agreement on the need for public accountability (Chassin and Galvin 1998; Brook,

McGlynn and Cleary 1996; Bovens 1998; 2007). Autonomy and innovation need to be continued, but stated firmly: *"too often autonomy is mindless and driven by arrogance. When placing a catheter, reliability not autonomy is needed"* (Pronovost 2010:205).

The "no blame" culture which had been tightly embraced for a long time started to break-down when pioneers in the patient safety movement began to question this paradigm. Leape for example described the need for a more 'aggressive' approach to poorly performing medical doctors (e.g. Leape 1994; Leape et al. 2002). Goldmann (2006) described the urgent need to create accountability for lacking hand hygiene, and Marx (2001) promoted a 'just culture' rather than a 'no blame culture'.

News media are often claimed to play a crucial role in the accountability of public organizations by illustrating news organizations as 'watchdogs': *"..the press remains uniquely situated to act as a watchdog to hold the medical profession accountable for improved safety and quality of care"* (Millenson 2002: 62). Wachter (2004) evaluated the forces that have promoted patient safety efforts after the publication of the report *To Err is Human* by the American Institute of Medicine (IOM) in 1999. After listing for example the increased reporting of adverse events, growing implementation of new technologies and skill-building support by organizations he concludes that: *"But, by serving as an essential catalyst for all of these forces, media coverage of patient safety might well be the most crucial element of all (…) medical errors occur once at a time, generally hidden from public view. The problem of patient safety needed to be brought into sharper focus if it was going to receive the attention and resources required for change. This focus was provided in large measure by the media."* [4]

However, the second edition of Wachter's bestselling book *Understanding Patient Safety* (2012) provides a new perspective on the role of the news media. Wachter states that people often look to the media to 'shine a light' on the problem of patient safety and ensure accountability; the thinking goes that media coverage of safety incidents will force hospitals and care providers to change *"and there is no doubt that such scrutiny can have precisely this effect"* (Wachter 2012:353). Nonetheless, Wachter warns that *"media scrutiny can also tap into institutional and individual fear of public disclosure and spur an atmosphere of silence"* (ibid). Although the author does not further elaborate on this issue, it is an extremely important issue for the patient safety discussion as a whole that needs further (empirical) exploration.

In short, there is a *probability* that news media indeed help improving patient safety, but there are also hypotheses that media scrutiny leads to quite the opposite. There remains a clear gap in the understanding of how media pressures are translated within public organizations and what mechanisms determine the responses towards this public exposure.

[4] Wachter, R.D. (2004). The Media: An Essential, If Sometimes Arbitrary, Promoter of Patient Safety. <accessible via: http://webmm.ahrq.gov/perspective.aspx?perspectiveID=80> assessed 22-5-2013

1.4. Isolated research foci; "Occupations versus Organizations"

Professional service organizations are extensively researched within public administration (e.g. Noordegraaf, van der Steen and van Twist 2013; Tummers, Steijn, and Bekkers 2012; Ackroyd, Kirkpatrick, and Walker 2007). The overwhelming popularity of the topic is well illustrated by Bernard Barber who already aimed to define *Some Problems in the Sociology of Professions* in 1963. In the introduction of his article he states that: *"Although it is still only a partly developed field of specialized knowledge, the sociology of the professions is already too large a body of theoretical analysis and empirical research to be more than sketched in this paper"* (Barber 1963:669).

The academic literature on the sociology of professions has long been dominated by traditional distinctions as 'occupations versus organizations' and 'managers versus professionals'; *"Occupations are usually considered to be weakened by organizations, and managers are seen as adversaries of professionals"* (Noordegraaf 2011:1350). Organizational and professional logics thus are mostly considered as conflicting (see for example Marquis and Lounsbury 2007; Lounsbury 2007; Reay and Hinings 2009; 2005; Kirkpatrick et al. 2005).

In empirical research, this often leads to a clear distinction between occupations and organizations in which these are approached as opponents (e.g. Krause 1996). Research projects are set up from for example a professional *or* managerial angle. In a more normative way, this reinforced distinction between organizational and professional logics leads to claims to either return to 'classic professionalism' and protect professional values *or* go beyond professionalism in order to focus on managerial control (Noordegraaf 2011). This illustration of intrinsically conflicting values and behaviour however, does not lead to a clarification whether and how organizations and professionals can work together to adjust to new pressures, for example executed by news media (Noordegraaf 2011:1350).

Organized professionalism

Things have started to change, however. In addition to the aforementioned 'clashes' between paradigms, new patterns have been documented in the academic literature (e.g., Waring and Currie 2009; Muzio and Faulconbridge 2012; Noordegraaf 2011; 2007). Instead of divides and dichotomies, the focus shifts to more dynamic and hybrid approaches of logics. Many studies dealt with the impact of management on professional control. Waring and Currie (2009) state that the dynamics between management and professionalism can result in five different ideal typical outcomes on a continuum; compliance, co-optation, adaptation, circumvent and resistance. A process of co-optation for example, in which the utility of some management tools is recognized by professionals and included within their jurisdictions was described by Waring and Currie (2009); medical specialist from obstetrics and gynecology departments in the United Kingdom adopted reporting techniques into their daily clinical practice. An example of strategic adaptation was provided by Van Herk et al. (2001), who demonstrated how professionals maintained their autonomy by gaining control over the

development and implementation of regulatory tools. Another strategy to management measures is a *selective* approach to the use of these measures. Different modalities and hybrid forms are thus empirically documented.

Noordegraaf (2011) introduced a new perspective, by not only describing coping mechanisms of professionals towards managerialism, and herewith the (strategic) adoption or refusal of managerial measures, but the possibility that professionals start organizing *themselves*. The notion of *organized professionalism* refers to professional practices that embody organizational logics; *"professionals might take up organizing roles and professional workers might develop organizational capacities in order to face changing circumstances"* (Noordegraaf 2011:1351).

A new focus towards professional boundaries aims to overcome the mentioned dichotomies such as "occupations and organizations" and "managers versus professionals", by *connecting* research strands that formerly focused on isolated aspects such as professional recalcitrance, coping mechanisms or managerial techniques. The aim of this project is to get an understanding of what role news media play in the reconfiguration of health care professionalism. I will therefore not only focus on *what* reactions follow on public exposure of incidents, or more specifically; bacteria outbreaks (see also chapter 3), but I will even more focus on *who* sets up new practices. To go beyond clashes of paradigms, both managerial and professional actors are included in the design (see also chapter 4).

1.5. Scope and Research Questions

With structures and practices strengthened by the power of professionals (Tummers 2013), they do not easily adapt to new ideas and ways of working. In other words, change is far from 'on the spot' in these social systems; these structures exhibit much recalcitrance and inertia (Scott 2000). However, the pressures of a constructed reality by the news media create new ongoing challenges for health care organizations (Noordegraaf 2001). As a result, new patterns to deal with these challenges may occur and professionalism might be *reconfigured*.

Different roles of the news media in improving safety are hypothesized and documented in the literature (see paragraph 1.3). Some scholars state that the transparency generated by the media driven by public reporting of errors ensures accountability and forces hospitals and providers to enforcing rules and standards and generate the recourses to catalyze needed system change (Wachter 2004; Millenson 2002). But while some argue that media attention for incidents indeed might initiate change, it is also claimed that media scrutiny can lead to quite the opposite response by tapping into institutional and individual fear of public disclosure and create an atmosphere of silence (Wachter 2012).

Although the response towards media incidents is a complex process which might be influenced by other contextual factors, the way the media chooses to handle errors is likely to influence the way healthcare organizations respond to the prospect of media attention

(Wachter 2012). Naturally, these pressures by the media vary in intensity and form. By analyzing different variations in media attention for a specific type of incident (bacteria outbreaks), this research project explores how health care professionals are affected by these pressures and whether the news media make professionals feel the need to change and take on *organizational roles* to deal with these challenges and what mechanisms affect the identified responses. This leads to the following central research question:

How do news media affect organizational actions by medical professionals and what mechanisms affect these actions?

This research question breaks down in the following theoretical and empirical research questions:

Theoretical questions

1. What are incidents and what is media attention?
2. What is reconfiguration of (public) professionalism and what is organized professionalism?
3. How can media attention for safety incidents in hospitals affect organized professionalism?

Empirical questions

1. Which incidents and media attention have taken place in various cases?
2. How are medical professionals affected by media attention and does it affect organizational actions?
3. What mechanisms affect responses towards media attention?

Implications

1. What are theoretical and practical implications?

1.6. Relevance

This study is highly relevant for scholars in public management and media studies, as well as for health care workers, both at the management level and on the working floor.

Theoretically, this research provides an innovative perspective by connecting popular bodies of literature. This interdisciplinary approach suits the complex nature of the research topic; subtle reactions in the organization of patient safety after media incidents. I used insights from Public Management (for example Hood 1991; Ferlie et al. 1996), the Sociology of Professions (for example Freidson 2001; Barber 1963), Media Studies (for example Bennett 2012; Cook 2005; Altheide and Snow 1979) and Patient Safety Studies (for example Altman et al. 2005; Leape et al. 2002; Nieva and Sorra 2003).

Professionalism and management are frequently considered as contradictory and conflicting. However, varying contextual empirical analyses have shown that more hybrid

forms rather than only clashes, hegemony and resistance exist. This study facilitates the demand for the investigation of these subtle reactions. By empirically building upon the concept of organized professionalism, this research further explores the synergies between management and professionalism pressured by media attention. Regarding media studies, effects on politics have already extensively been researched. However, there remains a gap in the understanding of what media do for public organizations and especially professionals; this study aims to fill that gap.

Most empirical research on the hybridization of professionalism so far has been based on single case studies (e.g. Waring and Currie 2009; Waring 2007; Adler et. al 2008; Kitchener 2002), with only few analyses based on comparative case studies (e.g. Farrell and Morris 2003; Lozeau et al. 2002). In this regard, this comparatively driven research provides insights into the diffusion of management principles and their impact on professional practice across different medical specializations and organizational settings. Furthermore, a first effort is made to explain what causal mechanisms lead to certain outcomes. The inclusion of different hierarchical levels of the organizations aims to overcome the often present problem of an isolated research focus.

Practically, this study helps to generate a better understanding of how safety management practices disseminate in hospitals. Further, the results might help to get a 'grip' on news organizations and translate the pressures executed by these organizations into sound safety practices. Last but not least, the participating hospitals were willing to open their glass-houses, which enables others to look into them. In other words, the stories illustrated in the result sections function as an 'exclusive' possibility to learn from others.

1.7 Outline of the thesis

Drawing on this perspective of organized professionalism, I seek to understand the transitions in the organization of professional work and the rise of more hybrid forms of professionalism in which organizing tasks become incorporated. The substantive focus of this study is the media attention for bacteria outbreaks in Dutch hospitals. The report is structured as follows. First, the theoretical framework pays attention to both media attention and the reconfiguration of professionalism. After an extensive exploration of both research fields and their main concepts, the closing chapter will illustrate how the two are linked. To sketch the broader context of the problem, chapter 3 will provide a contextual framework which will generate a better understanding of bacteria outbreaks in their embedded context. Chapter 4 presents the research design. The foundation for both case selection, data collection, and data analysis will be explained. Chapter 5 gets to the result section, in which separate chapters are set up for the three cases. Chapter 8 closes the result section with a cross-case comparison. The results are followed by a conclusion, in which the research questions will be answered. This chapter also pays attention to the discussion and suggestions for future research.

2. Theoretical Framework

2.1 Introduction

The question 'why study media attention?' was already implicitly answered in the introduction; that is, 'just scan the content of newspapers' and 'watch the news on television'. As stated, the issue of patient safety has already been identified in de medical sector decades ago, but the changes in the news sector finally generated (negative) publicity and herewith new challenges for public organizations. The professional status as such no longer guarantees legitimacy; professionals have to develop capacities to *organize* safety while they are performing their core tasks (Noordegraaf 2011). The functioning of the news media is of significant value for health care organizations since they play a significant role in the framing of societal problems and attracting public and political attention to them (Bekkers et al. 2008). The activities of the news media are crucial for public organizations, since both positive and negative publicity affect the *legitimacy* of the organization, and hereby its right for existence (Vibert 2007).

In this chapter, first, a further theoretical exploration of the news media will be presented, in which questions as 'how do news media operate?' 'what role do news media play in society?' and 'what are hypes?' will be answered. In part two, the focus shifts towards the reconfiguration of professionalism, in which an endeavor is made to illustrate and explain the changes in professional work from a theoretical angle. Special attention will be paid to the concept of 'organized professionalism'. The closing part will bring the two sections together by answering 'How can media attention for safety incidents in hospitals affect organized professionalism?

PART I: THE NEWS MEDIA

2.2. Media as political institution: agenda setting and gate-keeping

The past few decades, more and more political scientists have turned to the study of news, convinced that the media are an increasingly significant and autonomous force in politics. Fundamental to this perspective is the observation that the news media are not neutral organizations reflecting the factual events of the day. Like other institutions, media are shaped by various organizational, political and cultural forces that influence the selection and content of the news (Andrews and Caren 2010). However, academic consideration of the production of news goes back to Max Weber, who already labeled the journalist as a 'political person' (Weber, 1946 [1921]). Nowadays, most reflections of the news media as "fourth estate" are based on cases in the United States. A modern classic is *Governing with the News* (1998, 2005 2nd ed), in which Timothy E. Cook goes beyond the claim that the American press is impartial by arguing that the news media are in fact an political institution integral to the daily working of the American government.

Walter Lipmann is considered the first in academia who nominated the media as an institution worthy to study. In his classic *Public Opinion* (1922), Lippmann was the first to describe the agenda setting process of the news media, without yet labeling it that way. In the opening chapter 'The world outside and the pictures in our heads' Lipmann argues how public opinion does not respond to the environment, but to the *pseudo-environment* constructed by the news media. A few decades later, Theodore White analyzed the 1960 election of John F. Kennedy as President of the United States and illustrated an immense power of the news media:

> *"The power of the press in America is a primordial one. It sets the agenda of public discussion; and this sweeping political power is unrestrained by any law. It determines what people will talk and think about – an authority that in other nations is reserved for tyrants, priests, parties and mandarins"* (White 1973:23).

The agenda setting role of the news media has been confirmed by various scholars throughout the years. The concept of gate-keeping has been central since it was introduced in the 1950s (Schoemaker and Reese 1996, 2nd ed.); news agencies act as gate-keepers who determine what is, and what is not, an important story (newsworthiness). Scholars have identified various mechanisms through which gate-keeping operates (Andrews and Caren 2010). McCombs (2004) confirms the ability of the news media to influence our perception; *"Newspapers (…) do considerably more than signal the existence of major events and issues (…) This ability to influence the salience of topics on the public agenda has become to be called the agenda-setting role of the news media"* (McCombs 2004:1).

2.3. Media logic: "People like you could die"

The agenda-setting function illustrates that the news media can operate in different modes; they can not only follow, but they can also lead (Peters 1994). Regarding incidents, they can report the event and disseminate (official) information to the public. But they can also play a significant role in the social construction of a problem or incident, for example by creating a newswave based on a specific, fragmented perspective (Vasterman et al 2005). Therefore, *framing* has become one of the main topics in media studies (e.g. Entman 1993; Schuck and De Vreese 2006). After the occurrence of an incident, many different social actors, among whom the news media, are struggling to define *what* happened, *why* it happened, and *what* can be expected for the future. In order words, the media are in a position to not only play an agenda-setting role, but also a frame setting role (Vasterman et al 2005; Murdock et al. 2003). Journalists decide what to include in the story and what not; they decide which words, which tone, but also the interpretation of the news facts. In the news coverage, news stories can be presented by a balanced frame by sketching the incident in its useful context. However, a dramatized, simplified, one-sided frame can also be applied.

As for health care organizations, a lot has changed for the news sector too. In previous decades, the journalistic 'mission' was to factually report the news; balanced and with integrity. However, the same cost control challenges faced by hospitals have become reality for news organizations. News has become a 'money making industry' (Benett 2012; Serani 2008). The journalistic focus shifts from 'getting the facts right' to acquiring customers in order to get advertisers. Altheide and Snow (1979) were the first who referred to *media logic* to identify the specific frame of reference of the production of media culture. Media logic is defined as 'a way of seeing and interpreting social affairs' (Altheide and Snow 1979). This interpretation consists of how the material is organized, the style in which it is presented, the focus and emphasis, and the applied grammar (ibid). The attention for the news media has grown with the idea that the news media do not only report public debates, but also decisively influence these debates (RMO 2003). Several studies examined the 'modes operandi' of the news media (e.g. Altheide and Snow 1979, 1991; Altheide 1997; RMO 2003; Serani 2008; Bennett 2012).

Bennett (2012) for example, distinguishes four 'information biases' that flow from the ways in which the news media operate; the overwhelming tendency to personalize the news with a lack of attention for the more serious analysis of issues and problems, and therefore the bigger (institutional) picture that lies behind the many actors (1), the aspects of events that are reported tend to be the ones most easily dramatized into simple stories and therewith downplay the complex policy information or complex workings of (government) institutions (2), the isolation of stories from each other and from their larger contexts so that the information becomes fragmented and hard to assemble into a bigger picture (3), and the preoccupation with order, along with related questions of whether authorities are capable of establishing or restoring it (4). These information biases can be linked to the attention of the news media for fear (Altheide 1997; Serani 2008). To make the news look more spectacular and stirring, fear-based news programming is a helpful tool. Fear-based news programming has two aims; first to grab the attention of the 'customer' with a teaser. The second aim is to persuade the viewer that the solution for reducing the identified fear will be in the news story (Serani 2008).

The safety of hospitals really well suits the objectives of news organizations, since many news 'customers' identify themselves with 'patients', since everyone is to some extent dependent from the service delivered by hospitals. The attention for unsafe situations in hospitals (and thus fear of customers) is therefore a great opportunity for news organizations to generate higher print- and audience ratings. 'Drama sells', and the media are thus likely to focus on specific cases and particularly incidents to reveal mistreatment and failure (Noordegraaf 2011). The report "To err is human" launched by the American Institute of Medicine in 1999 is a great example of how the media logic works in practice. The news that many patients die in hospitals every year because of preventable errors wasn't that *new* as such, however, from a media perspective the safety story had changed (Millenson 2002). The news media *personalized* the story; the report included references to actual patients who

had suffered from medical mistakes. Further, the statistical finding that "people die" was transformed into a personalized "people like you, the reader, could die". Finally, the mistakes were put into a catchy sound bite form by making a "plane crash" comparison with the magnitude of deaths from breast cancer (Millenson 2002).

2.4. Hypes

Sometimes, news stories turn into hypes (Vasterman 2001; 2005). Once a topic generates a certain 'level' of media attention, it attracts even more attention, and because it attracts more attention, it becomes more newsworthy (Vasterman et. al 2005:111). During a hype, the attention for the topic is expanded by 'news' that for example compares the incident with other incidents, reinterprets incidents from the past, provides (contextual) backgrounds, and pays attention to reactions of the public towards the incident (ibid).

One of the main characteristics of a media hype is that all media 'catch up' the subject. Newspapers report stories, 'experts' give their comments in news programs on television. Much publicity leads to reactions from the public, which are again reflected by experts. At some point, the hype reaches its climax, often with the question; are authorities forced to resign? (Evers 2011, compare with Bennett's authority bias), or the pronunciation of measures to prevent incidents from happening in the future. Finally, the subject disappears from the news content and journalists start looking for 'newer' news.

One of the more recent healthcare 'incidents' which is considered to have been turned into a hype is the outbreak of the H1N1 Influenza in 2009. A new virus developed in Mexico, crossed the ocean and led to the first pandemic in more than forty years. Dutch media started a pandemic 'alarm' and warned for a catastrophic global epidemic. Media compared this epidemic with the Spanish Flu, which is considered the most devastating epidemic recorded in world history and killed somewhere between twenty and forty million people[5]. However, the so called 'Mexican Flu' turned out to be even milder than a common flu (Vasterman and Ruigrok 2013).

Fragmentation is an important element of a hype, since news organizations aim to reduce the complexity of news events by selective imaging. In doing so, news organizations have the tendency to refer to each other in their reporting, which increases a repetitive effect (Bennett 2012). As a result, cross over effects occur between what is labeled 'traditional' and 'new' media; newspapers, television news, news websites and television shows increasingly use and refer to each other's reporting (ibid). Cross over between news sources thus is a factor that explains the expansion of an issue.

'New media' have a few advantages over 'classic news sources'; it allows for more content to be published online, not only incorporating text fragments, but also images, audio fragments and video, and it allows user interactivity (Bekkers et al. 2011). Iyengar and Kinder

[5] http://virus.stanford.edu/uda/

(2010) found in a study conducted in the Unites States that citizens more and more resist a 'newspaper reading habit'; in an information driven society in which leisure time is a scarce good, people are absorbing their information mostly through television items. The study shows that television news powerfully influences which problems viewers regard as the nation's most serious (Iyengar and Kinder 2010).

2.5. Dealing with uncontrollable media attention; the perspective of 'organizing' professionals

Until halfway the twenty-first century, political scholars mainly focused on the role of the news media in politics. As illustrated, the influence on the public opinion and the political agenda setting process has extensively been researched. With changes in the news sector which led to more attention for *infotainment* – a mixture of news and entertainment - and less time for journalists to write their story (the terror of the deadline), the functioning of public organizations became a newsworthy topic for journalists; they hold public organizations to account (McNair 2003). News stories increasingly concentrate on emotions, conflicts and failing authorities (see Bennet's (2012) information biases). An incident in a hospital which led to human victims thus satisfies many of the values of the current media logic.

As organizations cannot *control* the information reported by journalists, they have to *deal* with the news media (Schillemans en Jacobs 2011, Korthagen et al 2011). There have been some academic attempts to instruct public *managers* how they should deal with the news media. Schillemans and Jacobs for example, wrote a chapter 'Public managers and the news media' in the 'Handbook Public Management'[6] (Noordegraaf, Guijen and Meijer, eds. 2011) in which they describe strategies for *managers* of public organizations to cope with media attention. In the fourth edition of his award-winning and best seller 'Understanding and Managing Public Organizations', Hall G. Rainey included an exhibit 'Guidelines for Managing Relations with the News Media' (2010:119), in which the perspective of Public Relations is taken. These attempts illustrate formerly dominant research strands, in which managers are approached as purely distinct from professionals. In responding to media attention, the direct functioning of professionals has until now been beyond the scope of scholars.

However, the increased public attention and fear-based stories created by the news media demands coping mechanisms that go way further than mere public management (Noordegraaf 2011). Professionals *themselves* are forced to organize safety and identify risks while performing their core tasks (ibid).

[6] 'Publieke managers en de nieuws media'; 'Handboek Publiek Management'

2.6 Dealing with change

Since the last decades of the twenty-first century, professional services have been a popular research field. Numerous studies have been executed to describe and explain changes in for example health care, law and education. These changes are associated with broader societal movements in which a market-like orientation of the public sector becomes desirable. For the health care sector, this means that the introduction of an organizational logic in which values such as effectiveness and efficiency interfere with former dominant values such as professional autonomy.

Yet, economic and managerial reforms are no longer the only causes for change. New service realities arise because of the changing social and cultural realities; public images of incidents in hospitals cause that professionals are "named and shamed" in the news media. In the current societal climate there seems little room for the acceptance of mistakes, 'zero risk tolerance' is the norm in different sectors (Power 2007; Carlet et. al 2009; WRR 2008).

One perspective on these social transformations illustrates the professional as a 'victim', in which they will resist organizational standards and values (Noordegraaf 2011). This point of view thus argues a professional logic to be conflicting with other (organizational) logics. Ackroyd et al. (2007) empirically explored this assumption and found that attempts to strengthen organizational logics in sectors where professional dominance has a strong history, seem less successful; when professionals see their sphere under pressure for change, they see no option other than to refuse it.

However, contextual changes do not only lead to resistance, newer perspectives introduced quite different ideas in which professionals evolve and adapt themselves to their new surroundings. In contradiction to the before mentioned conflicts, Noordegraaf (2007:772) states that *"in contemporary societies, professional and managerial roles have become more blurred than the stereotypes suggest."* Just as conflicting logics that led to refusal, more organizing practices have been found in empirical studies (see for examples of these hybrid forms the subheading 'organized professionalism' in the introduction).

Noordegraaf states that especially in health care, where specialized knowledge is required to formulate protocols and guidelines, *"organizing and managing must be seen as professional issues"* (2011:10). Therefore, studying professional services from a broader perspective generates the opportunities to study other, varying responses towards change.

2.7. Organized Professionalism

Noordegraaf (2011) mentions numerous studies that have been published in several leading journals. Remarkable is that all these studies focus on *isolated* aspects of the changes in professional services. Some studies for example focus on *professional groups,* in which an

effort is made to explain the dynamics inside and between professional groups and the rise of new professional groups, whereas others focus on for instance *managerial field* research where the rise of managerial groups is explored (ibid). These research outlooks confirm and maintain clear distinctions between managers and professionals, and between occupations and organizations. The portraying of organizations and professionals as intrinsically conflicting does not add to the understanding of how these actors can work together to face contextual change, for instance in the form of media incidents.

In order to overcome dichotomies, research strands that connect approaches of managers and professionals are favored. Noordegraaf (2011) summarized the different research outlooks in a scheme, and illustrates how more relational approaches can be applied (figure 1).

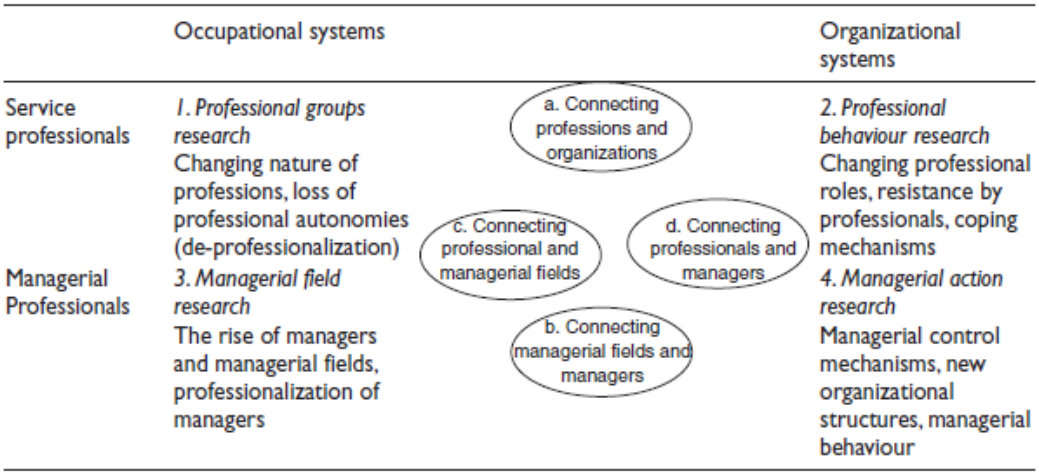

Figure 1: Overcoming dichotomies by connecting research strands (Noordegraaf 2011:1354)

In this study, the aim is to explore the transitions in professional work in which professionals *themselves* start to organize safety while performing their tasks. The focus thus is on the adoption of managerial tasks by health care professionals (category D in the overview of Noordegraaf (2011)). A focus on solely professional behavior leads to an analysis of public professionals within their organizational context, whereas a focus on exclusively managerial action leads to an analysis of managers undertaking their attempts to manage. Some scholars already applied a combination of these two approaches, mainly by focusing on *conflicts* between managers and professionals. Newer approaches however, for example a study by Waring and Currie (2009), highlighted a complete different outcome than conflict; they observed the introduction of new procedures for organizational learning in a Risk Management department in the UK and found that professionals did not resist managerial mechanisms, moreover, they *incorporated* these systems in their functioning (Waring and Currie 2009).

To get an understanding of how professionals develop organizational capacities in order to deal with changing circumstances, not solely *professionals* will be studied, but yet

different actors in the organization to explore how they work together and interact in order to organize patient safety (see chapter 4 for the research design).

2.8. Organizing Patient Safety

Patient safety has been an international issue of major interest for policy makers, care providers and care consumers. In numerous studies an effort is made to identify indicators that improve patient safety. Amongst others, the creation and maintaining of trust throughout the organization, the creation of a culture of openness regarding errors, clinical training, guidelines and actively managing the process of change are considered significant (American Institute of Medicine 2004). Safety management thus contains many different aspects.

Managers and professionals in health care organizations are responsible for the 'governance' of patient safety; the improvement and sustainability of quality and safety in health care (Waring 2007). Although safety management becomes increasingly approached as a strategic goal, one of the main criticisms on health care organizations, for instance ventilated in the news media, is a lack of *systematic* efforts to monitor, improve and sustain patient safety (Leape and Berwick 2005).

Broadly speaking, research efforts regarding patient safety are clustered around three predominant areas (also classified by Battles and Lilford 2003); risk management (1), safety improvement strategies (2), and safety culture (3). Some of the studies that explore the activities undertaken to improve patient safety, consider these three 'areas' as 'stages' or 'phases'. Battles and Lilford (2003) for example, follow Eisenberg's (2001) classification of patient safety efforts as a continuum:

> *"-Identify the risks and hazards that cause or have the potential to cause health care associated injury or harm.*
> *-Design, implement, and evaluate patient safety practices that eliminate known hazards, reduce the risk of injury to patients, and create a positive safety culture.*
> *-Maintain vigilance to ensure that a safe environment continues and patient safety cultures remain in place."* (Battles and Lilford 2003:ii2).

In this study I make a theoretical distinction between the different areas to structure the empirical research. Nevertheless, I do not approach these areas as 'stages' but as *interconnected* areas, which may also partly overlap, and in which no area can flourish independently from the others. For example; one of the measures to identify risks, is the use of medical records and the reporting of incidents. Though, the reporting of incidents requires a safety culture in which professionals feel free to actually report events. A hospital that designs and implements very many safety protocols without paying attention to safety culture is therefore not a hospital with a well-organized safety management system. The same goes for a hospital that solely focuses on safety culture, without grounding it with protocols.

All in all, an exploration of professional practices in all these three areas as a starting point should cover the efforts of professionals to start organizing patient safety *themselves* well (see also chapter 4). The coming subparagraphs separately introduce the three areas including organizing practices that would fit in these zones; paragraph 2.8.4. summarizes these findings in a table.

2.8.1 Risk Management

The first area is concerned with determining the level of *risk* (Vincent, Neale and Woloshynowych 2001). Professionals need to be able to asses and cope with the wider effects of risks (Noordegraaf 2011). In order to prevent adverse effects of professional performance, professionals must be able to determine systematic factors that frame error (Reason 1997), especially when there is media attention and the professional reputation and organizational image is at stake. As said before, professional reputation *as such* no longer guarantees professional legitimacy and right of existence for professional services (Noordegraaf 2011).

More concrete, 'management minded' practices of professionals concerning the identification of and the dealing with (clinical risks) might include the set-up of *risk assessment tools* and *safety checks.* Information required to identify risks are documented practices, such as medical records and the reporting of incidents (in Dutch: VIN-meldingen; Veilig Incidenten Melden). Further, risk management is often linked to retrospective analysis; processes are systematically documented, to reveal organizational weaknesses.

2.8.2. Safety Improvement Strategies

The second range deals more broadly with the implementation of a variety of safety improvement strategies, such as organizational structures, safety guidelines, protocols, clinical training and the implementation of new technologies to improve patient safety.

The implementation of these new strategies and guidelines, might for example be derived from other sectors. In the introduction chapter, it was already stated that health care organizations lack a tradition of system thinking, of which the organization of safety is a crucial aspect. Therefore, Institute of Medicine (IOM) advised *"The experiences of other industries provide valuable insights about how to begin the process of improving the safety of health care by learning how to prevent, detect, recover and learn from accidents"* (IOM 1999:137).

Leape et. al (1998) claimed that health care organizations very much rely on systems that are constructed for 'error free' performance of professionals. In other more hazardous industries, for example the petrochemical industry, a more systematic approach to managing safety is taken. These sectors have realized that human factors play a crucial role in the causation of incidents, this not only includes the professionals on the working floor, but also those in management functions (Flin 2003).

2.8.3. "Safety Culture"

The third area is concerned with fostering *cultural change*. Health care organizations increasingly become aware of the importance of transforming their organizational culture in order to improve the safety of patients. This cultural change often implies a replacement of a 'blame culture' with a more proactive 'safety culture' (Jensen 2007; Neiva and Sorra 2003). The American Institute of Medicine (2001:79) states that *"the biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm."* The promotion of a 'safety culture' has become one of the pillars in the patient safety movement.

Nieva and Sorra (2003) distracted a definition of safety culture from the Advisory Committee on the Safety of Nuclear Institutions (1993), which they considered perfectly applicable for health care organizations:

> *"The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety and by confidence in the efficacy of preventive measures."* (Advisory Committee on the Safety of Nuclear Installations 1993; cited in Nieva and Sorra 2003:18).

The importance of a safety culture is best reflected by its role as requisite for other attempts to work. For example; adverse reporting systems will not overcome *chronic* underreporting problems within an organizational culture where the acknowledgement of errors is not accepted; risk assessment tools will not succeed in an atmosphere bound by an implicit 'code of silence' and a fear of challenging the institutional hierarchy; and even benefits from new technologies designed to improve patient safety will not be realized if they are not accompanied by the right cultural changes (Nieva and Sorra 2003).

The growing interest in the concept of safety culture has been accompanied by the need for *concrete* assessment tools focused on the cultural aspects of patient safety improvement efforts. These safety culture assessment tools are quite new in the patient safety improvement 'arsenal'. The culture measurement tools may be used to develop and evaluate safety improvement interventions in health care organizations. By making "the way we do things around here" visible, professionals are able to introduce concrete mechanisms such as multidisciplinary meetings, co-decision of patients (Vincent and Coulter 2002), and feedback moments, to generate a safety culture (Paragraph 4.3 expands on how 'safety culture' is operationalized into measurable variables in this study).

2.8.4 Schematic overview of patient safety practices

Organizing patient safety		
Area	**Description**	**Concrete mechanisms and indicators**
Risk Management	Determining and coping with the level of *risk*	• Risk assessment tools, such as probabilistic risk assessment • Safety checks • medical records and administrative record review • Retrospective analysis
Safety Improvement Strategies	The implementation of safety improvement strategies	• Incident reporting • Protocols • Guidelines • Technological innovations • Direct Observation • Safety science education • Applying techniques from other sectors
Safety Culture	Transforming organizational culture in order to improve patient safety	• Open communication founded on trust • Shared belief in the importance of safety • Identification of safety concerns • Multidisciplinary meetings / focus groups • Process mapping • Feedback moments • Teamwork training • Conflict resolution

Table 1: Schematic Overview of Patient Safety Practices

2.9. Theoretical Model

The previous paragraphs have shown how news media function and what role they play in nowadays societies (1) and how circumstances for professional health care delivery have drastically changed and what this implies for empirical studies that focus on professional organizations (2). Subject of this paragraph is how these two sections come together.

The next page displays a model which illustrates how the different concepts are related to each other. First, the process takes places at a wider contextual environment (chapter 4). At the outer left, the trigger of the process is illustrated; the independent variable 'media attention'. The media attention is experienced by the (individuals in) the organization. Next, 'things are happening' within the organization. The section 'organizational mechanisms' reflects the 'how come?'-question. At the outer right, possible responses towards media attention are displayed. First, there are several options to start or improve the organization of patient safety. As shown in the previous paragraphs, these efforts are mainly clustered around the areas 'risk management', 'safety improvement strategies' and 'safety culture'. The sub headings reflect how these actions might be organized by different actors, or a combination of these actors. Next to the organizational actions by professionals or managers, these tasks might be outsourced to other actors or organizations. Besides the organization of patient safety, other effects might occur. For example, the media attention might catalyze organizational mechanisms which lead to quite the opposite of taking action, namely an atmosphere of silence. Further, responses might be clustered around dealing with the initiator of the attention (media relations). Naturally, this overview is not extensive. It serves as guidance for the empirical phase. In the empirical reality, 'other effects' not looked at in the figure might occur.

2.10. Expectations

Based on the theoretical framework, some expectations about the outcome of this empirical study are formulated. Earlier studies described how external pressures steered transitions in professional work, but the outcomes have shown strong differences across varying cases. Professionals might be recalcitrant when it comes to change, since they experience change as an attack on professional autonomy. However, there have also been cases in which professionals adopted new strategies or even started organizing themselves. Little is known about the effects of a specific trigger for change; media attention. There are expectations that media attention can function as a catalyst for change, but media attention can also generate an atmosphere of silence in which professionals strictly stick to their 'business as usual'.

In this study, I focus on a specific type of incident that might generate public attention; bacteria outbreaks. I expect that the extent to which the incident is directly linked to the process of care in news items, affects the outcome. For example; in media items about individual neurologists who wrongly diagnose and 'treat' patients, the negative public exposure is directly linked to the process of care; 'the doctor fails'. In the case of bacteria outbreaks however, the 'whodunit' is not that clear. There are many factors that could cause a bacteria outbreak in a hospital, of which for example lacking hand hygiene habits of medical specialists is only one. Therefore, I expect that the *extent to which media organizations directly link the incident to the performance of medical specialists influences the response;* if professionals feel directly accused of poor performance, they probably feel urged to adapt their practices.

On the other hand, I expect that the extent to which medical professionals are 'ruthlessly' blamed and shamed in news affects the response inversely. For example, if professionals are accused of poor performance this might create a sense of urgency to adapt practices, but extensive public shaming might also cause that they retreat into their shells. In other words; I assume that *if media attention is perceived as extremely blaming and painful, this media attention might be an activator for a 'spiral of silence'.*

Further, I expect that the *extent to which the professional is directly affected by media attention, effects the outcome*. This is dependent from how media attention is processed within the organization; are there organizational mechanisms that prevent that media attention directly reaches the professional? For instance, managers might take on protective roles[7] and 'organize' media attention in such a way that it does not directly affects professionals on the working floor. This media buffering by managers could decrease the incentive for professionals to start doing things differently.

To conclude, based on the theoretical review, three concrete expectations have been formulated which have to deal with the direct link to the process of care (1), the experience of media attention (2) and the extent to which professionals are directly affected by media attention (3). The concluding chapter of this thesis will reflect on whether the expectations indeed came to pass.

[7] See for example Weggeman (2007) who introduced the notion of a "heat shield" (hitteschild), by which managers should protect professionals from external disturbance, and Noordegraaf and van der Meulen (2008) who found cases in which management roles were perceived as 'protective' in which outside or 'alien' forces must be recognized, as well as being buffered by managers in order to protect professionals.

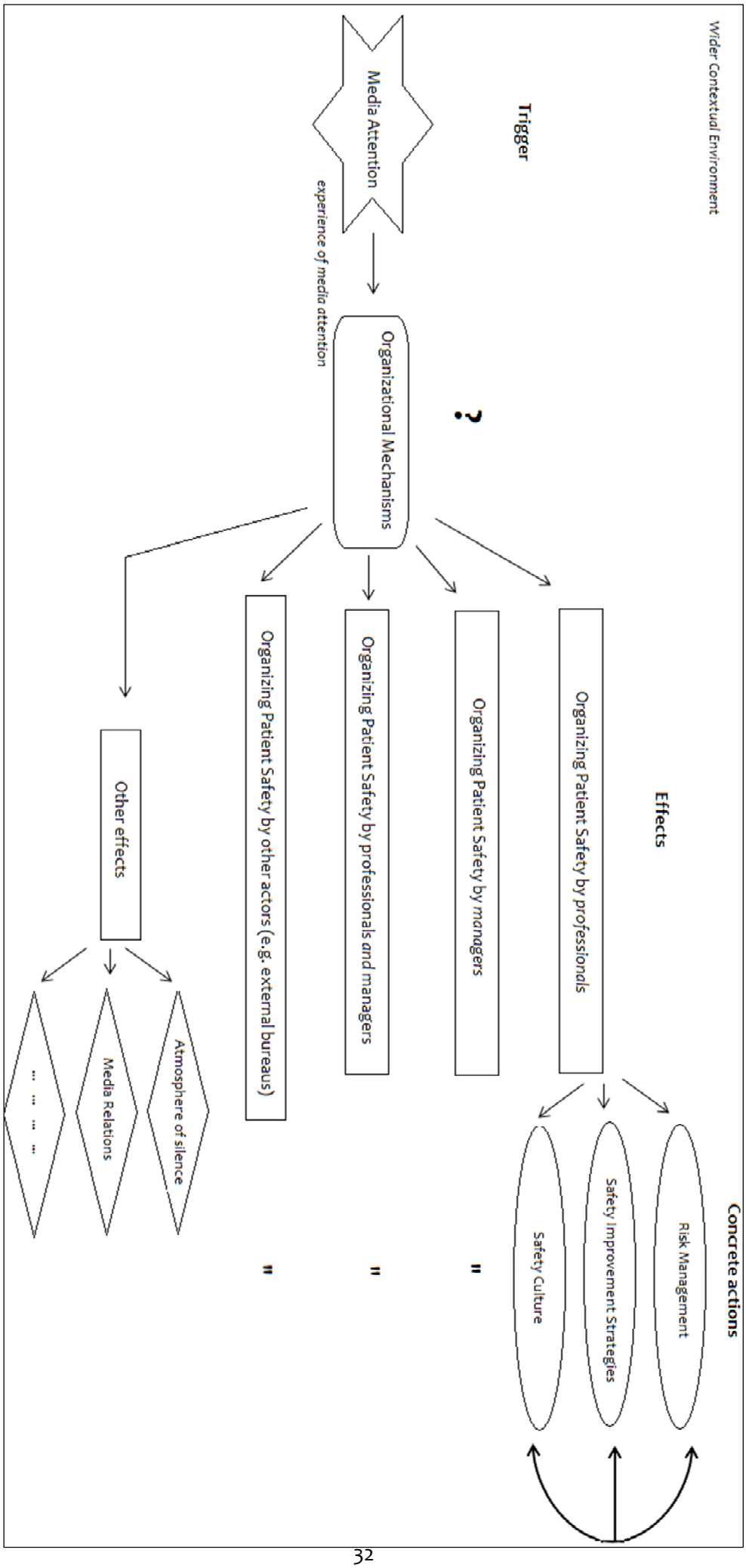

Figure 2: Theoretical Model

3. Contextual Framework:

Bacteria outbreaks in hospitals

Every now and then, high profile stories dominate the content of newspapers and television news and catalyze intense public and political debate. The past few years, disturbances in Youth Care, the riots 'Project X' in the city of Haren and the 'Mexican flu' have all been topics that transformed into what was labeled a 'news hype'. By the beginning of the twenty-first century, medical cases began to attract more and more attention, illustrated by concrete cases; many people are familiar with the recent stories of a neurologist who had been 'treating' patients for years for the wrongly diagnosed diseases or the long-lasting conflicts between pulmonologists in a trusted academic center. The safety in hospitals has become an issue of public concern. The confidence in the services delivered by hospitals that once seemed so self-evident, started to tear down.

This chapter provides a contextual framework in which the specific topic of this study, bacteria outbreaks in hospitals, will be endowed with some background information. However, first some broader trends in health care service delivery will be sketched to illustrate how these bacteria outbreaks are embedded in their contextual environment. Further, special attention will be paid to the media attention for infection diseases and bacteria outbreaks and the documentary of Zembla, which played a key role in the news coverage of this issue in the Netherlands.

3.1. Broader Trends Related to Safety in Health Care

The past three decades, the control of clinical practices has undergone considerable change. Medical specialists have extensively been exposed to management control instruments that have affected the nature of medical professionalism (Numerato and Salvatore 2012). These developments appeared in reaction to several challenges that threatened the medical healthcare sector in Western countries, such as the welfare state and financial crisis, reinforced market requirements (Harrison and Pollitt 1994), more demanding and well-informed clients (Noordegraaf 2007; Light and Levine 1988) and last but not least, publicly exposed medical failures (e.g. Sutcliffe 2011; Weick and Sutcliffe 2003).

Safety challenges persist in many industries, but the issues in health care service delivery are particularly acute. The mandate 'to do no harm' that flourished for a very long time got challenged with mounting evidence over the past few decades; much harm is done in the process of delivering health care (Sutcliffe 2011). Healthcare appeared to be far behind other high risk industries in warranting safety. However, it is only recently that knowledge from other disciplines found its way to the patient safety literature. In part, this diffusion of knowledge from other high risk sectors can be explained by the public spotlight on medical

errors that has followed high-profile events such as the Shipman Inquiry[8] (2002) and the British Royal Infirmary Inquiry[9] (2001) in Great Britain, and the publication of the United States Institute of Medicine's report *To Err is human* (1999). The IOM report received tremendous attention from both the public and the health care system (Blendon et al. 2002). Further, there was extensive media attention for the issue that was closely followed by the American public (ibid). The American health care sector responded almost immediately by introducing a wide range of patient safety efforts (Altman et al. 2005; Leape and Berwick 2005)

Especially The 1999 report "To err is human" by IOM is considered a turning point in the *reporting* of medical incidents (Millenson 2002). The tone transformed from *"dry statistical recitation"* into personalized public shaming of the profession (ibid:60). This trend of 'public shaming' introduced a new discourse in the patient safety movement, and links to a broader social trend in which policy makers, as well the general public demand an insight in the service delivered by hospitals and force professionals to be accountable (Schot 2012).[10] Patient safety became a recurring topic on the Dutch political agenda. Very recently, minister Schippers (Health, Welfare and Sports) had to answer parliamentary questions concerning the "frustrating slow developments in patient safety."[11] Although the knowledge regarding patient safety has increased and many measures have been introduced, the minister argues that patient safety is not yet enough internalized in work processes.

[8] GP Harold Shipman was found guilty to have killed at least 215 of his patients over a period of 24 years. In the Inquiry report it was claimed that the arrangements for death and cremation certification and the coronial system, which are intended to protect the public against the concealment of homicide, had failed to fulfill that purpose.
Link to Shipman Inquiry Report: http://www.official-documents.gov.uk/document/cm58/5854/5854.pdf

[9] British Royal Infirmary Inquiry is one of the most far-reaching and detailed investigations the NHS has ever undertaken, addressing fundamental issues of clinical safety and accountability, professional culture and patient rights.
Link to Britisch Royal Infirmary Inquiry Report:
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005620

[10] The demands of the 'client' have changed; patients take on a more critical position and confront the medical specialist with their own presumed knowledge. Before visiting the doctor, they already 'Googled' their symptoms, and demand treatment for the disease they already diagnosed themselves. Patients do not only become more critical, they also live longer. The aging of society result in multiple and more complex illnesses (e.g. Schot 2012). *More* people need *more* complicated care, but for *less* money in a *more* demanding environment.

[11] http://www.rijksoverheid.nl/documenten-en-publicaties/kamerstukken/2013/01/25/beantwoording-kamervragen-over-trage-vooruitgang-patientveiligheid-in-ziekenhuizen.html

3.2 Media Attention for Infections

Topics that can be linked to infection diseases and infection prevention have dominated the news several times the past few years. In 2009, commotion raised regarding a vaccination campaign by the National Institute for Public Health and the Environment (RIVM) to protect young girls from a virus that causes cervical cancer; debates about the contested safety of this vaccine dominate the news for weeks. Parts of the discussion were pursued through social media.[12] In the same year, a new virus (H1N1), better known as the Mexican Flu, caused the first pandemic in forty years. For almost a year, this 'dangerous' flu was a recurring news item, but in the end this flu turned out to be even milder and caused less deaths than a 'normal' flu. Further, there was the Q-fever from 2007 onwards, which generated mounting media attention when it became clear in 2009 that the consequences of this fever were underestimated; seven people died and more than two thousand people got sick.

In other words, much is going on concerning infection diseases. On a regular basis, infections turn into what is called a media hype, or specifically related to this topic; a 'health scare' (Vasterman 2011). The Mexican Flu and some of the bacteria outbreaks in hospitals dominated the news for months, often related to poor administrative and management performance. Striking is that relatively few people suffer from such infection diseases. In the Netherlands, about 1,5 percent of the bereavements is caused by infection diseases, compared to for example 30 percent deaths caused by cancer (ibid).

Less clear coupled to a specific incident, but still generating much media attention is the increasing use of antibiotics which causes multi-resistant bacteria. In 2011 two Dutch journalists of 'Zembla' won a prestigious media prize (Pfizer Persprijs) for their documentary 'Again antibiotics Alarm'.[13] Zembla is a television program that makes documentaries about actual situations and social developments and herewith aims to inform a wide public and provide an (interpreted) background of these events, as stated on its website[14].

A few years earlier, in 2009, the documentary 'Dirty Hospitals' by Zembla caused a lot of commotion. A journalist armed with a hidden camera, infiltrated a few Dutch hospitals. The main message of this documentary was 'due to a lack of cleansing practices, many patients 'unnecessarily' die in hospitals'. Many other news channels paid attention to the television documentary. 'The Hague' is shocked, and blends into the story. In an answering parliamentary questions, former minister Klink (Health, Welfare and Sports) states that the documentary managed to generate extra attention for hygiene practices in hospitals.[15]

[12] http://stopdeprik.hyves.nl
[13] 'Opnieuw Antibiotica Alarm'
[14] http://zembla.incontxt.nl/
[15] http://www.rijksoverheid.nl/documenten-en-publicaties/kamerstukken/2009/06/05/antwoorden-op-kamervragen-van-van-gerven-over-vieze-ziekenhuizen.html

Although the minister is 'shocked', he argues that the Boards of Governors of hospitals should take the initiative to change culture in order to make health care safer.

Three years later, in 2012, the undercover journalist of Zembla again grabs his camera and applies as a volunteer in a few Dutch hospitals. This time, the focus is on the hygiene practices, or better said, a lack of hygiene practices, by physicians and nurses. Again a wave of media attention appears throughout different news sources. "Lack of hygiene persevering problem" is the heading that appears everywhere in national and local newspapers, as well as on the World Wide Web.

Very recently, in September 2013, Zembla again managed to generate a wave of media attention, this time by diving into the production of meat. After earlier news hypes concerning the use of horse meat labeled as 'beef', Zembla served as a platform for a whistleblower who revealed how feces of animals end up on our plates. Only in newspapers, already 41 news items appeared that reported about this documentary.[16]

3.3. 'Scary little animals'

Probably without exact knowing of what they are, many people will be familiar with the terms 'MRSA', 'Klebsiella' and, more recently 'VRE', because they were widely covered in the news. These are all names for the bacteria that generated commotion inside, and because of public reporting, also outside hospitals. One of the reasons why these bacteria are considered 'dangerous' is their increasing resistance to antibiotics. The discovery of penicillin by Alexander Fleming in 1929 marked the beginning of the antibiotic age (Levy 2002). In the following decades, numerous new classes of antibiotics became accessible for the treatment of a wide range of bacterial infections and resulted in the belief that the battle against infections had been won. Nevertheless, the past few years this optimism has been replaced with serious concerns about the increasing resistance to antibiotics.

Different countries throughout the world apply diverse policies to deal with these bacteria. In the United States, antibiotics are still widely and excessively used. In the Netherlands however, fear for antibiotic resistance makes that policies to deal with bacteria rely on hygiene practices and infection control practices. Hygiene procedures are crucial in the struggle against bacteria, since they spread by direct or indirect person to person contact. Following Rao (1998), excessive antibiotic use (1), overcrowding in hospitals (2) and poor hygiene, are three factors most promoting the spread of antibiotic resistant bacteria.

Developments in health care delivery, as sketched in the previous section, make it plausible that bacteria outbreaks will play a role in hospitals more often in the future. Hospitals increasingly interact with one another, since the specialization of hospitals for

[16] LexisNexis search performed September 11, 2013. Search terms: Zembla AND mest (EN:feces). Limitation. Past month

certain treatments to deal with more complex clinical pictures, makes that patients are being referred to other hospitals more often.

Even though news media often create a rather different image, multi-resistant bacteria are not dangerous *per se*. Most patients carrying these 'animals' with them won't even notice their existence. However, patients who are already weakened by other diseases can suffer from bacteria, and, 'worst case scenario' even die. Crucial, for example considering the framing in news media, therefore becomes whether patients died *from* a bacteria, or *with* a bacteria (for experiences regarding this issue see results section).

3.4. Conclusion

A lot has changed for the health care sector the past few decades. The public exposure and national inquiries that followed on medical failures indicated a new discourse in the patient safety movement. As a news organization, Zembla played a significant role in the accountability of public organizations; they revealed several 'abuses' in different sectors. Health care has been one of the topics that generated attention several times throughout the years. This attention is mainly clustered around a wide-covering topic; infection diseases. These infections are related to hygiene habits of medical specialists, the use of antibiotics (in both health care and agriculture).

Different developments in health care and agriculture indeed provide new risks for safe health care delivery; medical specialists got confronted with more complex cases and are increasingly required to work together to deal with comorbidity. Due to specialized knowledge, patients increasingly have to be transported to different hospitals, which increases the risk that bacteria spread. Moreover, bacteria are to a greater degree resistant for antibiotics. Therefore, media coverage of bacteria outbreaks suits a media logic focusing on fear; a 'health scare' such as an outbreak with patients dying, will generate greater audiences and news organizations therefore cover the deaths caused by these bacteria, even though these bacteria are not dangerous per se.

4. Research Design

This study focuses on exploring the effects of media attention for safety incidents in hospitals on organizing actions by medical professionals. This chapter presents the research strategy that was applied to answer the research questions as presented in paragraph 1.5.

4.1 Comparative Case Study

The approach in this study involves a qualitative, comparative case analysis of the redefined organization of patient safety after media attention for bacteria outbreaks in three Dutch hospitals. Qualitative research is well suited for understanding phenomena within their context, enlightening links between concepts and behaviors, and generating and refining theories (Quinn 2005; Miles and Huberman 1994; Glaser and Strauss 1967). Particularly important is the ability to identify new hypotheses, which case studies can do through a combination of deduction and induction (see also paragraph 4.4).

A 'case' is often still defined as a "phenomenon for which we report and interpret only a single measure on any pertinent variable" (Eckstein 1975, cited in George and Bennett 2005:17). This implies that a case has only one observation of the dependent variable, but many independent variables. Nonetheless, each case in fact has a potentially high number of observations on intervening variables and may include several qualitative measures of numerous dimensions of the independent and dependent variable (King, Keohane, and Verba 1994; George and Bennett 2005). We will therefore follow the definition of George (1979), who defines a 'case' as *"an instance of a class of events of interest to the investigator"*. A case study thus focuses on a well-defined aspect of a historical happening, in which the researcher decides on what events, which facets, and which variables to focus upon (George and Bennett 2005).

Case studies can serve many different goals; developing and evaluating theories, formulating new theories or explaining phenomena by using theories and causal mechanisms (Bennett 2004:21). In this study, I combine within-case analysis and cross-case comparison. Process-tracing is chosen as method to reconstruct the three cases (*within-analysis*).

4.1.2 Causal-process tracing approach (CPT)

This study started with the assumption that a plurality of factors produce the outcome of interest. *"Such a holistic ontological starting point leads to the search for configurations of causal conditions or social mechanisms"* (Blatter and Haverland 2012:25). Process tracing lends itself to in-depth study of a few cases, the analysis focuses on the causal processes by which some events influence others. George and Bennett (2005:176) define process tracing as: *"a procedure for identifying steps in a causal process leading to the outcome of a given dependent variable of a particular case in a particular historical context".*

As the definition states, mostly the outcome 'Y' is already known, for example; Hospital X went bankrupt and the researcher wonders 'Which combination of conditions make this kind of outcome possible?' In this study however, the outcome is 'organizational actions', in which Y is not 'given', but yet a crucial part of the study. Although it is claimed that scholars that apply a CPT-method are not so much interested in the effects of a specific cause (X), but in the many specific complex causes of a specific outcome (Y) (Blatter and Haverland 2012:80), this approach best fits the research goals of this project since: *"causal-process tracing is required if we want to know not only whether something mattered or made a difference but also how exactly it influenced the outcome"* (Blatter and Haverland 2012:85). The question central to this study: How do news media affect organizational actions by medical professionals and what *mechanisms* affect these actions? aims to answer (1) does media attention matter and make a difference, but foremost (2) what mechanisms influence a certain outcome 'Y-organized patient safety'. There is some theoretical focus on what organized patient safety could look like (see paragraph 2.10), although the outcome Y is not as clear as in most process tracing approaches.

Following the assumptions of the CPT-approach based on 'configurational thinking' (e.g. Fiss 2009); (1) almost all social outcomes are the results of a combination of causal factors, (2) there are divergent pathways to similar social outcomes, and (3) the effects of the same causal factor can be different in different contexts and combinations (Blatter and Haverland 2012:80), 'possibilistic generalization' instead of 'universal' generalization is strived for. The aim is to draw conclusions on what sets of (organizational) mechanisms make a specific outcome possible.

4.2. Operationalization

In order to translate the theoretical topics into measurable units, the concepts that altogether give a solid impression of organized patient safety; risk management, safety improvement strategies and safety culture, have been defined and operationalized. First, a further illustration of the concept 'organizational mechanisms' is outlined to demarcate the study and prevent ambiguity, since the concept is widely used, but very many definitions circulate.

4.2.1 Organizational Mechanisms

One of the elementary aims in organization research is to examine how some organizational outcomes occur, or stated more primarily; 'how things work'. The concept 'mechanism' bas become widely used in speaking about organizational change. In doing so, many variations of the concept are being used. For instance, Levinthal and March (1993) write about learning mechanisms, where Chikudate (1999) refers to blocking mechanisms that stop

change (Pajunen 2008). In most cases the definitions of mechanisms remain vague, if even defined at all. Therefore, explicit consideration of what a review of organizational mechanisms explains, is required. Efforts have already been made to actually identify and examine organizational mechanisms. George and Bennett (2005) defend a process tracing approach (see paragraph 4.1.2) as a suitable way for the identification of mechanisms (Pajunen 2008).

This study aims to explore what organizational actions or other effects occur after media attention for incidents. After exploring what actions occur, the question becomes; but what is the underlying mechanism? In this study I follow the widely used definition of Machamer et al. (2000:3) which has strongly influenced successive research (e.g. Pajunen 2008). They state that *"mechanisms are entities and activities organized such that they are productive of regular changes from start or set up to finish or termination conditions".*

Mechanisms that lead to a certain outcome, may thus be *entities* and *activities*. In this study I call an organizational *entity* an agent, of set of agents, functioning under an organizational structure. Entities thus are parts of the organization that because of their structure and consistency affect the organizational response towards media attention. For example, the amount of members working at a Communication Department and the way in which this department is situated in the organogram might influence how other actors (have to) deal with media attention. Further, a Board of Governors that perceives patient safety as a top priority and fulfills a heralding role in this regard, might be a mechanism that affects how and by who patient safety is organized in the organization. Additionally, a team leader that demonstrates the right hygienic exemplary behavior could be a mechanism for a safety culture that favors patient safety. On the other hand, professionals as an entity, might be recalcitrant when it comes to innovations and thus reluctant to implement new strategies.

Activities that can act as mechanism for organizational responses are for example the existence of reporting systems and the frequency of (administrative) deliberation, as well as opportunities to exchange knowledge throughout the organization and the organization and frequency of work meetings.

Organizational Mechanisms	
Dimensions	**Illustration**
Entities	Agent or set of agents functioning under organizational structure - Organizational structuring of departments *e.g. size of departments (amount of employees working there), organogram (Communication Department directly situated under Board of Governors or elsewhere in the organization)* - Leading entities *e.g. leadership roles, example function and behavior of managers, actors that play a pioneering role in improving patient safety* - Recalcitrance of professionals *A group of professionals that is recalcitrant towards change and is reluctant to implement new measures*

Activities	- Reporting systems *medical reporting, incident reporting (e.g. VIN-meldingen; safe incident reporting)* - Exchange of knowledge *Project groups that focus on specific themes (e.g. hand hygiene)* *Use of external knowledge (experts); sessions for managers and/or professionals* - (Administrative) deliberation *Frequency of work meetings. Construction of work meetings (e.g. managers, professionals, communication advisors.*

Table 2: Operationalization of Organizational Mechanisms

4.2.2 Risk Management

This study aims to empirically explore the concept of 'organized professionalism' by specifically focus on safety practices in hospitals. Based on the literature review these safety practices in the three dominant areas; risk management, safety improvement strategies and safety culture are translated to measurable components. The extent to which *professionals* take on these roles, thus empirically reflects the concept 'organized *professionalism*' in this study. The tables provide the measured dimensions including illustrations of concrete practices (see also paragraph 5.4 Data Collection)

Operationalization of Risk Management		
Determining the level of risk		
Dimensions	**Specification**	**Illustration**
Prospective analysis	Possible risks	- Practices that are applied to identify (clinical) risks *On which information are risks identified (e.g. medical records, incident reporting, incidents in other hospitals*
Retrospective analysis	Evaluation reports	- The process by which incidents are evaluated *Construction of evaluation commissions (e.g. which actors represented in commission), usage of external actors/sources.*

Table 3: Operationalization of Risk Management

4.2.3 Safety Improvement Strategies

Operationalization of Safety Improvement Strategies		
Implementation of concrete measures		
Dimensions	**Specification**	**Illustration**
Concrete measures	Concrete measures that were introduced to improve patient safety	- The introduction of new methods *new antibiotics treatments, contact isolation* - The introduction of new regulations *Guidelines, protocols (e.g. hand hygiene, contact isolation, applying antibiotics)* - The incorporation of safety practices in daily work routines *Safety checks, safety rounds, safety work meetings*
Learning from other sectors	Attracting experiences of other high risk industries	- The incorporation of external (specialized) knowledge *Hiring experts from chemical Industries (e.g. how is external knowledge disseminated within the organization. Experts from other (academic) medical centers. (e.g. in what processes do external actors play a role*

Table 4: Operationalization of Safety Improvement Strategies

4.2.4 Safety Culture

The patient safety culture is a component of the wider organizational culture, and includes the shared beliefs, attitudes, values, norms and behavioral characteristics of employees (Davies et al. 2000; Guldenmund 2000). Precise measurement of patient safety

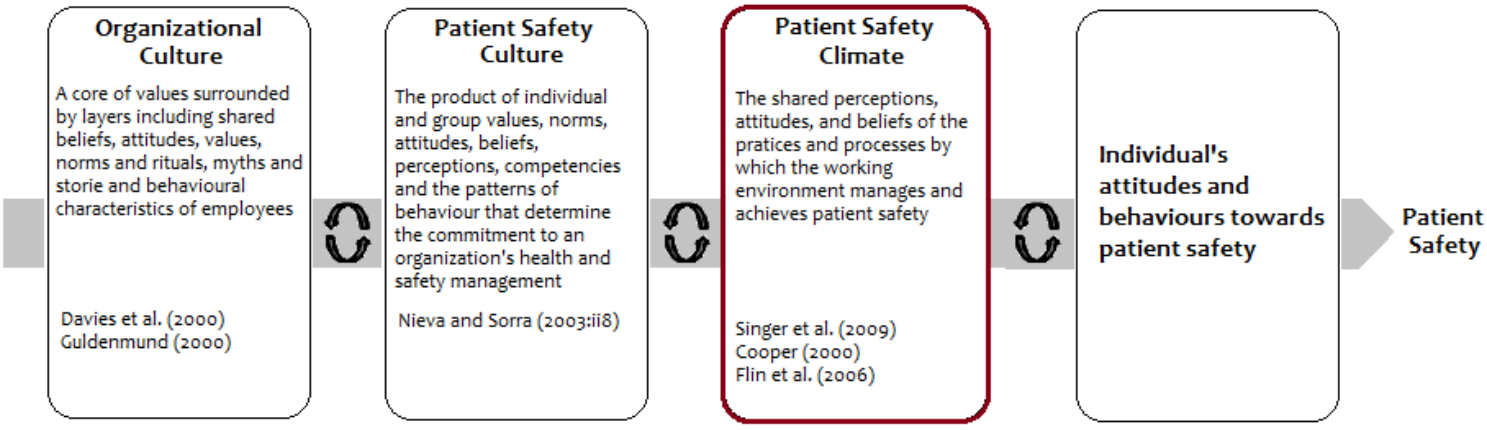

Figure 3: Patient safety culture model (Morello et al. 2013:12)

culture is restricted by the ability to define measurable components of culture (Cooper 2000). One particular focus is the assessment of safety 'climate', a concept that regularly refers to the measurable components of safety culture. 'Safety climate' is defined as 'employees perceptions and attitudes toward apparent features of patient safety culture at a given point in time' (following Flin et al. 2006). The empirical focus is therefore restricted to safety climate, since the attitudes of different actors are measured at a single point in time (see figure 3 and table 4)

Operationalization of Safety Culture		
Measured Dimension: Patient Safety *Climate* Dimensions:	**Specification**	**Illustration**
Perceptions	The shared perceptions of patient safety at a given point in time (e.g. its (relative) importance	*Patient safety is more important than efficiency and competition*
Attitudes	The shared attitudes towards patient safety at a given point in time (e.g. how should be dealt with patient safety)	*Patient safety practices belong to the core tasks of health care delivery*
Beliefs	The shared beliefs about patient safety at a given point in time (e.g. what will patient safety efforts lead to?)	*Attention for patient safety will improve the quality of care*

Table 5: Operationalization of Patient Safety Culture

4.3. Case Selection

A design, most often described with the term 'most similar system design', best suits a causal-process tracing approach (Bennett 2005). Cases are selected on the independent variable 'media attention', whereas other factors such as type of the incident, type of division, and time period of the incident, are kept as similar as possible. A difficulty is that the dependent variable, organized professionalism, is not yet 'filled in'. Although the outcome is not yet specifically known, the theoretical focus of organized patient safety together with the information on the websites of the hospitals is used to get a first grip of their practices with regard to case comparison.

4.2.1 Exposure

Naturally, the pressures by the media vary in intensity and form. By analyzing different intensities of media attention, this research project explores how health care professionals are affected by these pressures and what mechanisms affect the identified responses. Case selection started from the identification of a wide array of possible cases. The amount of media attention, approached as 'exposure' served as a starting point for case selection. Although the concept of 'exposure' is widely used in media studies, it is also highly debated. Media exposure is one foundation of media effects research. In principle, it is a straightforward concept and defined as: *"the extent to which audience members have encountered specific messages or classes messages/media content".* The difficulty arises with the operationalization of the concept; the definition of 'exposure' refers to merely *encountering* media content, whether or not remembered by the 'receiver' (Slater 2004:168).

Unless there still is no solution documented in the literature to overcome the hurdle of measuring effects of messages sent out by news media, changes in communication made things easier. New patterns of communication, defined as 'cross-over effects' (e.g. Bennett 2012; see also paragraph 2.4), illustrate how news items cross from one source to another. For example, a television program airs a documentary on television, which is picked up by newspapers who write several articles about it. News sites act as forum where citizens can react on news stories, which again also become news. At the same time, journalists search these for stories, ideas and information (Bennett 2012). The mass media exposure thus can be multiplied by conversation or discussion. People might initially be exposed to a message by media organizations, and may be exposed again by the same message through social interaction channels.

All in all, an overview of the media exposure of an incident among different media sources gives a quite accurate idea of how much it predominated public debate. Therefore, different media databases have been searched (see also paragraph 4.5). First, newspaper database LexisNexis was searched with key terms 'bacteria outbreak' and 'hospital' to include all hospitals that suffered from such an incident. The search was limited by a time period of five years (2007-2012[17]). This search resulted in 320 hits.[18] Next, all abstracts of the articles were screened for content and controlled for duplicates. A list of 'possible' cases, based on their received media attention and comparability, functioned as a starting point for gaining access.

[17] A time scale of five years was chosen so that it was easier to find individuals willing to cooperate who know the organization well and already worked at the hospital at the time the incident occurred.
[18] Search performed March 21 2013

4.2.1 Gaining Access

Because causal-process tracing depends on gaining a comprehensive overview of the stories, the ability to provide thick descriptions of critical moments, and the possibility of gaining deep insights into the perceptions and motivations of important actors, the *accessibility* of a case is the primary precondition for conducting research (Blatter and Haverland 2012). Because of the sensitivity of the subject, it was chosen to contact possible participants by making use of our research relations with the University Medical Center Utrecht (UMCU) to gain access to the hospitals of study. Therefore, a list with possible cases based on the database searches was sent to the UMCU to see whether hospitals were willing to collaborate. Further, anonymity was ensured to all organizations and individuals to control for socially desirable answers and create an atmosphere in which respondents felt free to express their feelings and thoughts.

In balancing *richness* of the stories and the *amount* of researched cases, richness was favored. Therefore, three cases were selected. *Within* these three cases, uncovering all important perceptions was strived for. Based on preliminary research findings, respondents from the Communication Departments were also included in the design in a later stadium.

4.3 Data Collection; Complementary methods

The core of the data collection consisted of semi-structured interviews. In total, thirteen respondents were interviewed; five in hospital I. and four in both hospitals II. and III. To overcome the before mentioned hurdle of an 'isolated research focus', several respondents throughout the organization were included in the project. Interviews started at the Board of Governors or the division Quality and Safety (based on willingness to participate), and were followed by interviews with managers and finally medical specialists. The holistic approach of the project led to the inclusion of respondents from the division Communication/PR in a later stadium, since the content of the interviews with the other respondents made the researcher decide to do so (see results section for an illustration).

The interviews lasted between 35 en 70 minutes (for a detailed description, see the overview in paragraph 4.6). The interview topics were determined by the theoretical framework and guided the interviews (see appendices I and II). However, the respondents were free to share their interpretations, change the order of questions, and add other topics that they considered relevant.

Next to semi-structured interviews, the data collection was complemented with observations and document analysis. Observations were combined with interview appointments. Some of the respondents offered a 'guided tour' through their division, to generate the possibility to identify the physical structure of the environment and the changes that had taken place in the aftermath of the incident. Next to this, the data collection was

complemented with an analysis of documents. The analysis was based on two sources; (1) posters and documents of campaigns that were handed to the researcher by the organizations, as well as (2) evaluation reports that were written and provided by the hospital itself or by the Health Care Inspectorate (IGZ). One of the participating organizations decided not to share their internal evaluation report; analysis of this case thus relied on interviews and observations.

A methodological triangulation of interviews, observations and document analysis creates an image of the studied phenomenon from multiple perspectives and a layered description (Boeije 2010:176). Data from the semi-structured interviews were mirrored to the observations and documents to test for consistency (Patton 1999).

Research Phases	
Phase I. Preparation / Exploration	Literature review, set up theoretical framework.
Phase II. Empirical Fieldwork	Semi-structured interviews. Theoretical framework as guidance, inductive additions.
Phase III. Consistency / Addition	Document analysis and observation tot test for consistency and prevent from missed-out information

Table 6: Research Phases

4.4. Data Analysis: An Integrated Approach for Developing a Code Structure

The interviews were all recorded and transcribed. Observations were all written down in detailed field notes. A first step in analyzing the data may seem quite obvious, but its importance may easily be underestimated; immersion in the data to comprehend its meaning and its entirety (Pope, Ziebland and Mays 2000). Reading and summarizing the data without yet coding it may help to identify broader themes without losing the connections between notions and their context.

Next, in order to transforming the data into findings, all data was 'coded' by making use of NVivo10 software. According to Silver (2007), coding entails:

> *"… the process by which segments of data are identified as relating to, or being an example of, a more general idea, instance, theme or category. Segments of data from across the whole dataset are placed together in order to be retrieved together at a later stage"* (Silver 2007, cited in Boeije 2010:95)

The role of theory has always been a difficult issue in qualitative research (e.g. Tummers and Karsten 2012). In this project, theory was important for the identification of potential causal linkages and variables that might play a role, as well as for providing a theoretical framework to guide the subsequent empirical research. Data analysis requires

continuously moving back and forward between inductive and deductive tactics. [The trunk of the coding tree was determined by the concepts of the conceptual framework (see figure 4). A deductive approach is a helpful tool for case comparison. These 'preliminary codes' can help the researcher to integrate concepts already well documented in the existing literature and herewith benefit from and build on previous insights in the field. Nonetheless, the researcher should be aware of the pitfall of 'forcing' data into these categories (Glaser 1992; Miles and Huberman 1994). The coding tree was further elaborated by inductive analysis, which implies a process of 'open' coding (Boeije 2010). In this approach, the researcher should be open for unexpected clues and puzzles that indicate the presence of left-out variables, which can finally lead to the development of new hypotheses (ibid).

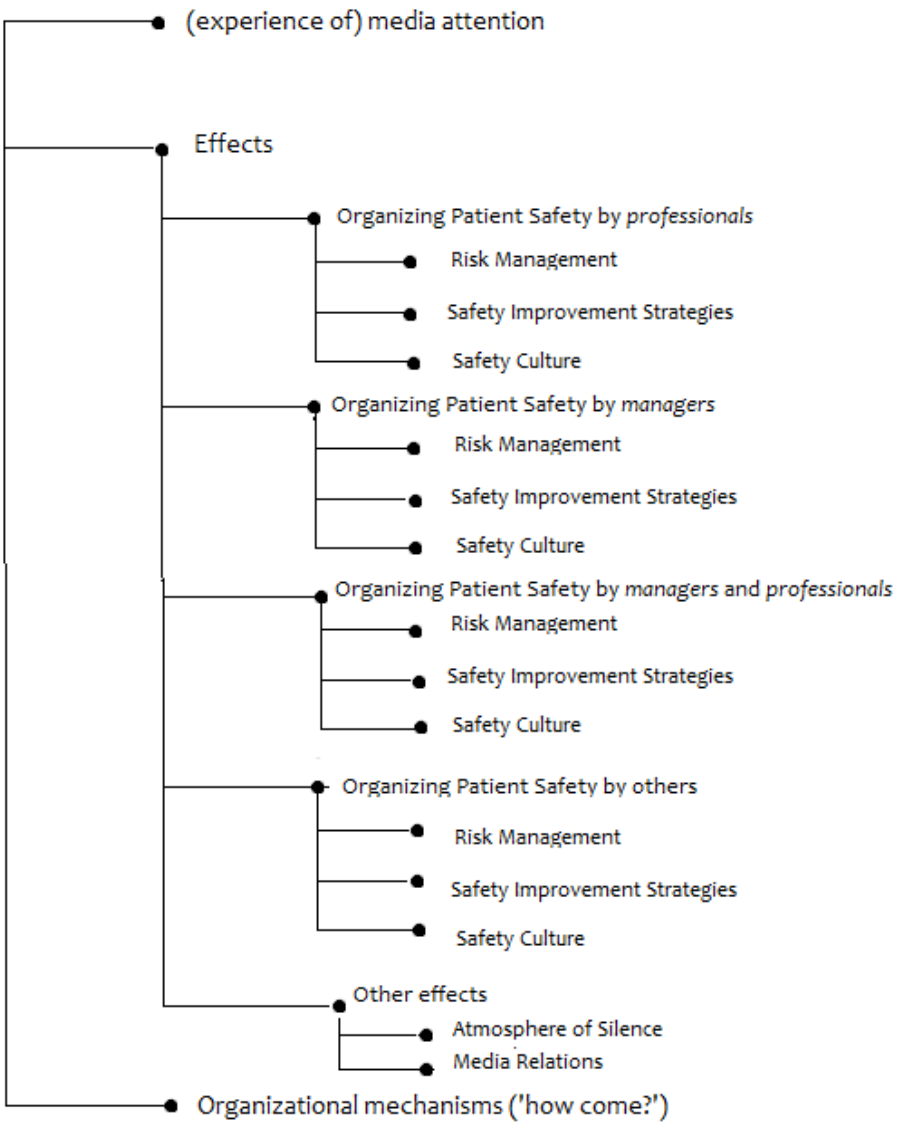

Figure 4: Deductive Trunk of the Code Tree

4.5. "Trustworthiness"

Reliability and validity are terms mostly used in *quantitative* research to underpin and ground the quality of research. Reliability refers to whether the results are replicable, validity refers to whether the means of measurement are accurate and whether they are actually measuring what they are intended to measure. Some of the leading qualitative researchers argued that reliability and validity are terms that belong to the quantitative paradigm and were not applicable to qualitative inquiry (Altheide and Johnson, 1998; Leininger, 1994). Guba and Lincoln (1981) argued that although all research must have "truth value", "applicability", "consistency", and "neutrality" in order to be judged worthwhile, the nature of quantitative knowledge is different from the nature of qualitative knowledge. Therefore, some suggested adopting new criteria for determining reliability and validity, and hence ensuring rigor, in qualitative inquiry (Guba and Lincoln 1985; Leininger 1994; Rubin and Rubin 1995). Guba and Lincoln (1981) proposed that the criteria in qualitative research that ensure "trustworthiness" are credibility, fittingness, auditability, and confirmability.

Despite of the criteria that were developed for trustworthiness, Morse et. al (2002) ventilate their concerns that there has been a tendency in which qualitative researchers focus on the tangible *outcomes* of the research, other than demonstrating how verification strategies were applied *during the development* of the research. In other words, although it may be useful to evaluate rigor, in itself this does not ensure rigor (Morse et. al 2002).

Therefore, in this paragraph I will elicit what strategies have been applied during the research process in striving for trustworthiness. In approaching qualitative research as an iterative rather than a linear process, the researcher constantly moved back and forth between design and implementation to ensure congruence among question formulation, literature, data collection strategies, and analysis. Preliminary results were analyzed and served as input for the design. Following what Flick (2004) labels 'investigator responsiveness', data analysis determined future participant recruitment; the finding that media relations play an important role in determining the outcome, led to the inclusion of these participants in de design in a later stadium. An 'appropriate sample' (Morse 1991) consists of participants who best represent or have knowledge of the research topic, in order to make sure that sufficient data to account for all aspects of the phenomenon have been obtained. However, because of the sensitivity of the topic, gaining access (see paragraph 4.2.1) has been a difficulty in this research project. Respondents have mainly been reached via one contact person in the organization who recruited other respondents based on their function and naturally, willingness to cooperate. This method generated trust, and therefore succeeded in generating equal samples in all three cases.

In order to complement the interview data and test for consistency, data triangulation; *"data drawn from different sources and different times, in different places or from different people"* (Flick 2004:179), has been applied. Besides documents, observations

have been part of the data collection. Visible data are currently receiving considerable attention in qualitative research (Flick 2004). Apart from an emphasis on documents and observation, posters and flyers have been added to the data collection.

Next to data triangulation, various theoretical points of view have been considered (see for example the expectations discussed in paragraph 2.10) . This triangulation of theories means *"approaching data with multiple perspectives and hypotheses in mind. Various theoretical points of view could be placed side by side to assess their utility and power"* (Denzin 1978: 297). For instance; both the hypotheses that media attention catalyzes organization activities (1) *or* catalyzes an spiral of silence (2) are considered.

4.6. Schematic Overview

	News Coverage[1]			Respondents		Complementary Data
	Source	Hits	Label	Function	Length	Source
HOSPITAL I.	Newspaper search LexisNexis - Local Newspapers - National Newspapers	 7 4	I.1.	Member Board of Governors	53 min	Observation: 'guided tour' Intensive Care (respondent I.3)
	NOS Nieuws	0	I.2.	Manager 'Emergency' Division (SEH/IC)	42 min	* Hospital decided not to share its internal evaluation report
	RTL Nieuws	1	I.3	Manager Division Intensive Care	36 min	
	Television Documentary 'Zembla' 2009 Newspaper search LexisNexis 'Zembla' - Local Newspapers - National Newspapers	 157 98	I.4	Pneumonologist – Intensive Care	35 min	
	Video Fragments[2]	4				
			I.5	Senior Communication Advisor/ Public Relations	64 min	
HOSPITAL II.	Source	Hits	Label	Function	Length	Source
	Newspaper search LexisNexis - Local Newspapers - National Newspapers	 17 8	II.6.	Manager Division Quality&Safety	48 min	Observation - 'guided tour' Division Lung (respondent II.7) - Posters
	NOS Nieuws	2	II.7.	Manager Division Lung	54 min	
	RTL Nieuws	1	II.8.	Pneumonologist	30 min	Internal Evaluation Report (not public, only shared with Health Care Inspectorate (IGZ)
	Television Documentary 'Zembla' 2012 Newspaper search LexisNexis 'Zembla' - Local Newspapers - National Newspapers	 186 72	II.9.	Senior Communication Advisor/Public Relations	65 min	
	Video Fragments	0				
HOSPITAL III.	Source	Hits	Label	Function	Length	Source
	Newspaper search LexisNexis - Local Newspapers - National Newspapers	 511 155	III.10.	Manager Division Quality&Safety	52 min	Evaluation Report by the Health Care Inspectorate (IGZ)
	NOS Nieuws	60	III.11.	Manager Division Surgery	67 min	
	RTL Nieuws	4	III.12.	Surgeon	XX min	
	Video Fragments	37	III.13.	Senior Communication Advisor/ Public Relations	XX min	

[1] Search terms; name hospital AND specific bacteria (e.g. CareCentre and Klebsiella)
[2] NOS nieuws, RTL nieuws, YouTube

Table 7: Schematic Overview Data Collection

The coming chapters present the results of the study. Every chapter tells the story of each of the hospitals. These three stories are structured by the topics as represented in the theoretical model (2.12) that were operationalized and translated into topic lists for the interviews (appendix I and II) and a coding tree later on (4.4). The result chapters all start with *description*, in which the attention by the news media and the structural changes by different actors in the organization of patient safety come across. Next, In the concluding paragraphs, there are also first attempts to *explanation,* in which there is specific focus on organizing *professionals.*

The last chapter of this section is arranged for case comparison; what do the cases have in common and where do they differ? Further, small frames that reflect some of the observation experiences were added to the stories.

5. Hospital I. 'We'll show you'

In the summer of 2012, Hospital I. had to close its Intensive Care for a couple of weeks. Patients taken care of at the division had to be transported to other hospitals in the area, and ambulances with new patients had to be redirected. The reason for this thorough measure was the discovery of a very small, but very aggressive 'animal'; a multiple-resistant Klebsiella bacteria. The incident was reported in several local, and national newspapers. The local broadcasting company also paid attention to the incident on television.
A few years earlier, Hospital I. was already rapped over the knuckles by the Zembla documentary concerning cleaning practices in hospitals. At the time, the hospital promised improvement.

5.1 Media attention

'*Accept it, deal with it*'

Although whilst about a year ago, the incident at the Intensive Care still remains fresh in people's minds. Both the team manager and the medical specialist working at this department emphasize the high impact the incident has had:

> *"People have been cleaning every single corner with a toothbrush in here, and uh.. everything has been disinfected with alcohol, everything that has been laying here in the cupboards has been thrown away.. all the materials. Well, people stood here with tears in their eyes because of everything what was thrown away. That has had an enormous impact."* (Respondent I.3; team leader)

> *"It was uhm.. it has been very heavy, and emotional too. I have to be honest that it has had a great impact here, not only on the nurses but also on us as medical specialists. Yes, it has been a heavy task. We had to redirect all patients to other hospitals in the area. We had to stop hospitalization of new patients, which we had to announce at the ambulance services.. All in all, it has had a great impact on all of us.."* (Respondent I.4; medical specialist)

Striking is that these respondents, both situated at the working floor, elaborate on the intensity of the incident *itself*, and not so much on the media attention for it, whereas for respondents in a management function media coverage seems to be quite important. It shows that at higher levels of the organization, much attention is being paid to controlling media content (read further 'Influencing media content'). The efforts of the department Communication & PR, make that those on the working floor do not feel really affected by media reporting, because they don't *have* to:

> *"That these stories make it to the news media.., well if the content remains neutral, than it doesn't affect me, but if it is negative attention, of course it really affects you! But luckily this media attention remained quite neutral to me."* (Respondent I.4; medical specialist)

The media attention by Zembla two years earlier, worked out quite differently. In contrast to an internal incident, such as a bacteria outbreak, where the organization can decide for itself when and how to inform the public, Zembla was considered as an 'incident' itself. The organization was confronted with footages made by an undercover journalist and thus felt forced to *react.* For the team leader IC and medical specialist however, Zembla doesn't seem to play any role; the pneumonolgist in case hadn't even seen the documentary (compare management practices concerning Zembla). Nevertheless, for those at the management level, this kind of media attention has had a great impact. The experiences of this kind of media attention are twofold; first there was anger and disbelief, but later on, it was also seen as a helpful tool, which was made very concrete by the Board of Governors (see subsection 'Safety Culture').

The general idea regarding media attention is that it doesn't make any sense to be 'against it'. Media attention is considered a fact, something that is out there; 'accept it and deal with it' is the message. Respondent I.1. states:

> *"That* (Zembla) *was really difficult! Naturally it easy to say, 'we abominate the way of working', and 'it is rude to excess a hospital incognito! That is your first reaction of course; you're just irritated! That they did this to you, but we.. we didn't do it. We took the time to let the anger pass, and after that we applied the strategy to accept it the way it was."* (Respondent I.1; member Board of Governors)

This strategy of openness and acceptance is built upon earlier experiences as well as strong convictions of the Communication department (read further Media Relations).

For one of my interviews I have an appointment at the division which had to close its doors about a year ago; the Intensive Care.
A small, almost hidden elevator brings me to the first floor of the hospital. After asking one of the employees how to get to the IC, a long hallway leads me to one of the hospital wings. At the end of the hallway, I face a huge closed sliding door. Next to it, I face a button which says 'press to enter IC'. Before entering, I use some of the disinfection gel hanging prominently next to it, just to be sure.

5.2. Changes in the organization of patient safety

Never again

In the aftermath of the outbreak, the department had to get back on track and process everything that had happened. All respondents unanimously knew one thing for sure; 'this may never happen again'. Therefore, some structural changes were introduced. In this section, a description of these structural changes by different actors in the organization of patient safety are structured by the three topics as illustrated in the theoretical framework. The concluding paragraph will pay special attention to the organizing activities of *professionals*.

5.2.1. Risk Management

Hospital I. already had a firm founding in Risk Management, in which both prospective and retrospective methods are being applied. A member of the Board of Governors claims that Risk Management is about mapping the risks that the goals the organization has set, will not be reached. Those risks that are not made visible by Risk Management, are the ones hardest to manage. And yet, Zembla is referred to as an example to illustrate the complexity of Risk Management:

> *"When the journalist of Zembla called us and said 'we want an appointment with the Board of Governors', we all sat together and thought of whatever it could be that they called us for. We listed ten different things that all could be the case, but this.. this definitely wasn't one of those things! That illustrates how difficult Risk Management is."* (Respondent I.1; member Board of Governors)

Prospective practices concerning Risk Management, such as mapping possible risks by looking at medical records, are mainly executed by those with managing functions. *Retrospective* analysis however, is based on a team process in which all layers of the organization are represented. Emphasis is put on a very strong connection between Risk Management and Safety Culture, in which the professionals on the working floor fulfill a crucial role, as illustrated by the Board of Governors:

> *"A division that reports little safety incidents, is not a good division; a division that reports little safety incidents doesn't keep an eye on patient safety."* (Respondent I.1; member Board of Governors)

As stated, the professionals on the working floor provide the information necessary for accurate Risk Management. The organization of Risk Management practices itself did not structurally change after the incident; efforts have been put in the other linked areas.

5.2.2. Safety Improvement Strategies

"Six (or seven, or eight, or nine..) Golden Rules"

Structural changes have been implemented at the Intensive Care, mostly very practical ones. Professionals themselves initiated an adaptation of safety protocols. Further, contact isolation was introduced, including an accompanying protocol. However, the complexity of bacteria outbreaks makes that new strategies are mostly invented during a team process. Different actors possess different kinds of knowledge;

> *"The adaptation of the safety protocols was initiated at the Intensive Care, and a new method to drain away body liquids presumably a level higher.. that is where the Infection Prevention gets involved, specialized knowledge is required there. But in most cases it is teamwork. The micro-biologists clarifies how the bacteria behaves, whether is spreads by*

air or hand contact, all this information is important. What happens subsequently is that people start to think along; 'ah if that is the case, this might be a solution'. So actually, it is a real team process." (Respondent I.1; member Board of Governors)

This team process is structurally organized in the form of a 'crisis team'. When a crisis occurs, a team is assembled based on the character of the crisis, to control the crisis, but also to evaluate (cf. Risk Management), and to determine what policies are necessary to improve service delivery in the future. 'Equality' is used as a term to describe the sphere in a crisis team (Respondent I.1; member Board of Governors, Respondent I.4; medical specialist)

Besides structural changes at the Intensive Care, some strategies were aimed at the organization as a whole. Managers were already familiar with so called 'safety rounds' in which they visit a division and analyze safety practices by direct observation. A new focus in these rounds however, became an analysis of the 'Six Golden Rules'. Together with the team leaders six basic hygiene rules were formulated. Since these rules were not all-embracing, professionals on the working floor were stimulated to develop adding rules that fit their specific department.

Further, the Management Team took the initiative to invite a 'safety expert' from the chemical industry. Sessions were organized to learn more about high risk organizations (these sessions also generated input for the formulation of the Golden Rules). The manager acute care emphasized that the support of a Board of Governors is crucial, their enthusiasm for a measure is a requisite:

"The Board of Governors played an immense enthusiastic role, they were convinced that we should do this, right from the start; 'Although it costs a great deal of money, invest in it, because it will pay back.'" (Respondent I.2; care manager)

5.2.3. Safety Culture

"Kitchen Rules"

The central role for safety culture as reflected in the academic literature, is perfectly reflected in this case. Different respondents underline the importance of an established safety culture;

"You have to make sure that the culture in the organization is finest, and that everybody is aware of the measures that have to be implemented." (Respondent I.1; member Board of Governors)

"We had a discussion like 'we can implement a system with safety pillars, but underneath these aspects about content, there is an attitude aspect. Underneath the safety system, there is an aspect like 'why am I doing this? What is my contribution to this? How do I keep this theme alive at my division?'" (Respondent I.2; care manager)

By making a comparison with the hospital's kitchen, professionalism is labeled as a barrier for a flourishing safety culture (Respondent I.1.; member Board of Governors, see also 'Organizational mechanisms'). Traditionally, the kitchen has a very strong safety culture; employees get instructions by their manager, if they do not live up to the rules, they get warned, followed by a sanction, and finally they get fired. Professionals however, 'start thinking themselves' and decide for themselves what is important and what is not.

Two-track policy

To deal with different kinds of professionals, in which medical specialist are approached as different from nursing employees, a two-track policy was introduced. The managers (Respondent I.2) focused on instructing the team leaders (Respondent I.3) , who lead up to the daily care delivery at the divisions. This instruction of the team leaders focused on fulfilling an example role and the formulation of the Golden Rules. The Board of Governors specifically focused on the medical specialists;

> "*Respondent I.1 organized a few sessions, the so called 'lunch sessions', in which he ate lunch with the medical specialist. Every one of them was obliged to attend one of these sessions. In the lunch sessions, Respondent I.1 indicated what he expected from the medical specialists and emphasized that there was no room for manoeuvre, that they had to live up to the safety program; 'whenever you are at the nursing division, whenever you are at the policlinic, these are the rules we will confirm to, and I want you to carefully monitor each other'"* (Respondent I.2; care manager)

However, this group of professionals not reacted positive to this approach immediately;

> "*If I tell you that during a lunch session, suddenly a group of cardiologists entered, wearing a ring at each finger.. you can imagine that initially, professionals made fun of these sessions* (Respondent I.2; care manager)

Further, the documentary of Zembla, which was based on the situation in Hospital II. was applied as concrete measure to improve the awareness and herewith the addressing culture:

> "*That clearly was an idea of the Board of Governors. In that sense, Respondent I.1 is extremely passionate in expanding the 'safety theme'. So at one moment, he brought about twenty cd's and said; 'guess what guys, we're gonna show these in the work meetings, obligatory, to improve the addressing behavior'"* (Respondent I.2; care manager)

Despite some criticism of medical specialists, and the fact that some of them haven't actually *seen* the documentary as meant by the Board of Governors (see also paragraph I.1. of

the results section), the interviewed medical specialist describes a change in the safety climate. The respondent notices that quality and safety are top priorities for the Board of Governors. Because of repeated attention for the subject, *"It has also become a top priority for us"* (Respondent I.4; medical specialist). The medical specialist uses the words 'easy accessible' to describe how different employees interact on the working floor;

> *"This climate of 'accessibility', already existed before the incident occurred. However, the way of working, the way of working with patients, the way of working with each other, in addressing each other's faults, that is something that changes after the temporary closure of the Intensive Care. Everyone realized that 'this is our Intensive Care, we're doing this for our Intensive care, and it also is our daily bread.'"* (Respondent I.4; medical specialist)

This image sketched by the medical specialist is confirmed by the team leader. She describes the safety culture at the Intensive care as *"very strong embedded";*

> *"Actually, you only have to sit like this (directs to finger) in front of each other, 'oh yes, ah I see', and off it (ring) goes* (Respondent I.3; team leader)

To keep the theme 'alive', posters are used as measure to remind all members of the organization of the Golden Rules and the importance of a climate in which people can mention each other's faults;

> *"I said 'we have to create something specifically aimed at the addressing culture and the Golden Rules'. Well, the result was a poster; half gold, half silver, and it didn't say 'speech is silver, silence is gold', but the other way around of course! 'Speech is gold, silence is silver'. And a sub sentence added: 'we address each other's behavior concerning the Golden Rules'."* (Respondent I.2; care manager)

5.3. Other effects

As stated in the theoretical model, other effects on media attention than the organization of patient safety, such as a 'atmosphere of silence' are hypothesized in the academic literature. Based on inductive analysis ('open coding'), this paragraph presents the other effects on media attention that appeared in this case.

Influencing media content

A topic that appears several times throughout the story, is the crucial role of the Communication/PR department. The effects of these actions were already reflected in the attitude of the medical specialist, who doesn't really bother as long as the content of the news items is neutral. The other respondents (I.1., I.2 and I.3) all specifically mentioned an individual employee working at this department. For example;

"See, we do have, and that really makes a difference.. How is a Communication Department situated? What kind of people work there? We have someone working at Communication who really is an old hand in dealing with media issues." (Respondent I.2; care manager)

The influential role of the Communication/PR department is structurally reflected in the organization of the crisis team. When an incident is considered a crisis, a team is assembled to control the crisis. The Communication department is part of this team from day one on. The applied communication strategy is described as follows:

"So we tax what the impact of an incident on the local community will be, and the chance that news organizations will report about it. Based on that, we either wait or act pro-active and launch a press communiqué." (Respondent I.1; member Board of Governors)

These earlier revelations about 'an old hand' who exactly knows how to handle the press, led to the incorporation of this part of the organization into the study in order to answering questions like: What does influencing media content look like, and how does it affect professionals on the working floor? In the interview with the senior communication advisor that followed (Respondent I.5.), the story already told by the other actors got confirmed; 'transparency' is the magical word. However, another aspect seems from a communication perspective just as important: *timing:*

"Transparency is a principle we hold dear, it really is important to be transparent, but it also is important to pick the right moment. Because uhm.. at some point..things might leak out at some point. I always have a press communiqué and information for on the hospital's website ready to release, even if we decided not to release it yet. At the time news organizations call for information, I can act immediately and publish the information. It is a conscious strategy sometimes not to bring out information, to prevent from catalyzing unnecessary worries, because news organizations are right on top of it." (Respondent I.5; communication advisor)

The activities of the communication department are diverse; from marketing activities to preparing internal newsletters, and from creating posters to press releases. However, the main activity appears to be to maintain positive relationships with media organizations in order to get control over the content of news reporting.

"You know, one of my biggest challenges is to turn negative information into positive information. It is real fun working on that. It is even more fun, I you see that it works out the way you planned it'." (Respondent I.5; communication advisor)

That it indeed it is possible to *change* media content as an organization, is illustrated by the member of the Board of Governors who exactly experienced such a transformation during a bacteria outbreak a few years earlier;

"Actually, that was funny, because at first sight, media attention was rather negative like 'ew, dirty hospital! Bacteria sprout there!' However, subsequently, it turned out really positive when we published information about the bacteria and everything we did to solve the problem and prevent it from happening again, at that time it also showed that many more hospitals were struggling with the same problem and kept silent about it. The news content transformed into 'fantastic that they are being so honest' and 'others never revealed anything'" (Respondent I.1; member Board of Governors)

This story perfectly strokes with how media attention for the Klebsiella bacteria at the Intensive Care was experienced by those on the working floor. The medical specialist framed the media attention as 'neutral'. The team leader states that the incident *itself* has had more impact than the attention for it. Hereto, actors on the working floor specifically refer to the role of the communication advisor (Respondent I.5) as an explanation. If the media also report *positive* news, such as what the organization does to control and prevent crises, there is also positive attention (Respondent I.3).

5.4. How come? Organizational mechanisms

As stated earlier, it is a difficult task to reveal how things come about. However, this subparagraph provides first attempts to explanation, based on the empirical findings of organizational mechanisms.

'Indirect' sense of urgency

In the theoretical model presented in chapter two, 'Media Relations' was considered an *effect* of media attention. However, the empirical findings show that this influencing of media organizations might also act as a mechanism for other responses. More concrete, the *neutralizing* of media items by the communication department, affect professionals on the working floor. As stated earlier (by the care manager); it matters *where* in the organization the Communication Department is situated. In Hospital I., this department is structured directly under the Board of Governors. This organizational structure reflects the importance attached to this unit, but also the density of interaction between the Board of Governors and the Communication Department.

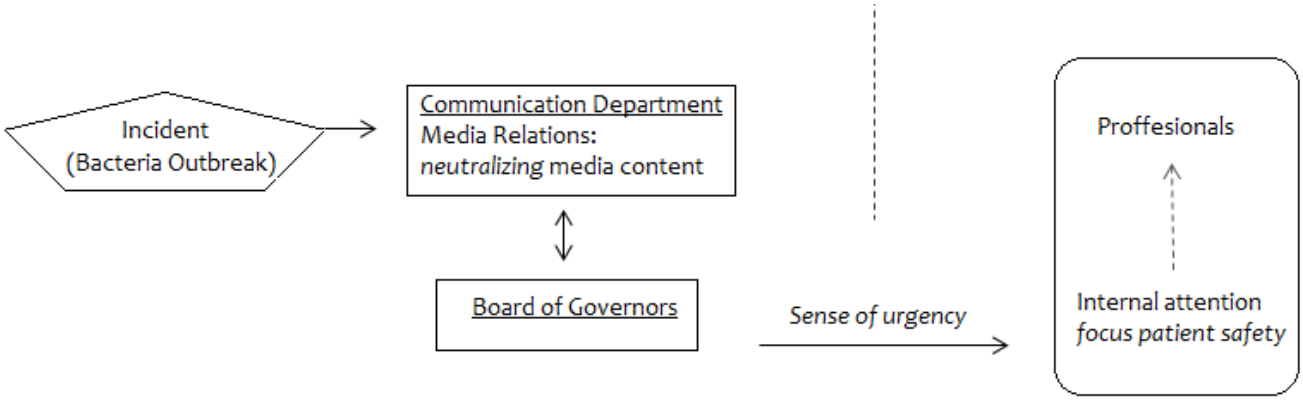

Figure 5: Visualization of communication process

Although direct media attention is 'filtered' for those on the working floor, a sense of urgency is *indirectly* 'forwarded' to the professionals. In figure X, this process is visualized. After an incident occurs, the Communication department directly interferes. Efforts are made to neutralize the content of media items, or even turn them into positive marketing items. Therefore, an *direct* trigger for professionals is wiped away. Nevertheless, the Board of Governors is directly involved with Communication activities and *is* aware of the media trigger. This media attention is therefore translated into a sense of urgency to adapt practices at the management level, and *indirectly* forwarded to professionals on the working floor.
In this case, managers thus function as a protection shield for professionals, direct media attention is kept away from professionals. A sense of urgency to adapt practices is forwarded by managers.

"Follow the leader"

Further, professionalism is considered a 'barrier' for a flourishing safety culture. As defined in the theoretical framework, a safety culture requires *"shared perceptions of the importance of safety and by confidence in the efficacy of preventive measures."* (Advisory Committee on the Safety of Nuclear Installations 1993; cited in Nieva and Sorra 2003:18). An attitude in which professionals are selective in what measures they implement (based on whether they consider these measures important), will block an effective safety culture. A mechanism that aims to influence professional attitude, is leadership style. Respondents I.1, I.2 and I.3 all mentioned leadership style as a critical element in determining the organizational actions;

"It think that, as a leader, you clearly have to play a role there. If you do not take the lead and demonstrate the right behavior, who will? (Respondent I.3; team leader)

The leadership style disseminated by the team leader of the Intensive Care, is a 'personal' style, in which conversation is a crucial element. Three elements are mentioned that make up such a personal style; be clear in what you want (1), by paying *positive* attention to the subject (2) and demonstrate the right behavior yourself (3) (Respondent I.3; team leader) A factor which influences such an approach is the size of the department; a small Intensive Care with a few employees (there are eight medical specialist working at the department) makes it more easy to interact and manage at a personal level and herewith shape an 'open' atmosphere.

5.5. Conclusion: Organizing professionals?

After the temporary closure of the Intensive Care, things have changed. Professionals initiated an adaptation of safety protocols, and also contact isolation was introduced as a standard procedure at the department. Although these new strategies have been implemented, besides the introduction of contact isolation, there is not much empirical evidence that the ways of working of professionals *an sich* have intensely changed. The biggest transition has taken place at the level of safety climate; the *awareness* of patient safety has enormously risen and professionals aim to fulfill their tasks as safe as possible. However, 'fulfill their tasks as safe as possible' implies that they kept to their core business of treating patients and did not incorporate organizing activities into their occupation.

For professionals on the working floor, media attention for the incident did not act as a direct trigger to adapt practices. At higher levels of the organization, much attention is structurally being paid to managing media attention. Therefore, higher managers serve as a protection shield for professionals; they keep away external pressures from the working floor. However, this media attention is intensively experienced at the higher levels of the organization. This media attention for incidents therefore generates a sense of urgency in which patient safety has become an organizational top priority. Next, this sense of urgency is disseminated by managers to professionals.

All in all, signals to adapt practices reach professionals indirect through the Board of Governors and managers. Professionals feel the need to adapt their practices to new safety standards, but did except from the application of contact isolation not evidently transform their ways of working.

Summary: Changes in the organization of patient safety		
	Concrete action	Illustration
Organizing by *professionals*	- Adaptation safety protocols - Introduction contact isolation including protocol - Introduction SDD (new antibiotics treatment) including protocol	New strategies were introduced to make practices more safe. Contact isolation and SDD as whole new methods.
Organizing by *managers*	- Introduction Golden Rules; incorporating analysis of Golden Rules in 'safety rounds' - Hiring high risk expert	An analysis of the Golden Rules structurally incorporated in the safety rounds by care managers. An expert from the chemical industry was recruited to gain expertise
Organizing by *professionals*	Team process in crisis team	Solutions are made up in a team

and managers		process, based on 'equality'
Organizing by *others*	- Infection Prevention: Introduction new method to drain away body liquids	The department Infection Prevention (situated directly under the Board of Governors) adapted the removal of body liquids (specialized knowledge)

Table 8: Schematic Summary Results Hospital I.

6. Hospital II. 'Who is.. the mole?'

In the spring of 2012, Hospital II. found a bacteria population that seemed quite different from 'normal' populations. Micro-biologists looked at the nature of the bacteria, and since the amount of infections kept growing and growing, the 'VRE-problem' was considered an outbreak. Soon, the department Quality, Safety & Accountability got involved. At the end of the summer, when the organization was still trying hard to get grip on the outbreak, Zembla knocked on the hospital's doors. The hospital became subject of a documentary where lacking hygiene habits of medical professionals were presented to the general public.

6.1 Media attention

'Accept it, deal with it'

The outbreak and the documentary of Zembla 'merged', so to say. While the bacteria outbreak was still going on and various news organizations reported about the incident, Zembla added to the story by broadcasting the documentary. Especially this documentary and the cross-over to other news organizations caused a lot. First, there was anger, and also fear for the reputation of the hospital. Nevertheless, with hindsight the media attention is labeled as a great learning tool for the improvement of safety practices.

> *"That really caused a lot to be honest! Uhm I think that we.. uhm, we used it, the documentary, to heighten the sense of urgency. You can be angry of course, and we were angry, ore more like 'how is it even possible that someone undercover..' and 'ridiculous!' You can start looking for judicial possibilities, and there have of course been people who proposed to do so. But quite soon we changed our attitude and said 'that all won't help!' We can better say 'Okay, that undercover journalist revealed practices that are no good, and we know they are no good, which means that we should do something about it."* (Respondent II.6; manager Quality, Safety and Accountability (QSA))

> *"Those two merged so to say. So the VRE outbreak on its own, already was a moment at which everyone got aware of the necessity of the rules I think, but it got emphasized all the more by the broadcasting of the Zembla documentary. So the documentary of Zembla is I think.. in a certain way.., yes we turned it into something positive, in order to make everyone aware of the fact that it is important to live up to the safety protocols."* (Respondent II.8; medical specialist)

Although this media attention was thus experienced as an instrument to increase the sense of urgency, there was also fear for reputation damage, caused by a 'distorted picture' in both the Zembla documentary and in newspaper items.

> *"There are two things you want to do; on the one hand you indeed think some things are not right yet and require improvement.., but on the other hand, you don't want it to cause*

that..that people who come to this hospital think it is an inferior hospital, because that really isn't the case! That conclusion might be drawn way too soon sometimes. If there was something weak in that documentary, it is that they really focus on the things that do not go that well, and if for example about ninety percent of the doctors and nurses do comply to the guidelines, that image isn't shown. However, it does suit these kind of documentaries to blow things up. (Respondent II.6; manager QSA)

"You see, not every bacteria, not every multi-resistant bacteria is a problem. That is something that is overlooked way too often. If you take a look at the news reporting, it says 'ten people died from MRSA', you know, in hospital blabla. But the question is; did people die from MRSA, or did they die with MRSA? In most cases die answer certainly is that they died with MRSA, but nuance is not interesting for news organizations of course." (Respondent II.8; medical specialist)

Even though the content of news items was characterized 'distorted', after the first anger was over, media attention was not only seen as a helpful tool to improve practices, it was also considered positive for *society;* media attention also functions as legitimate instrument to generate transparency. Hospitals are public organizations paid with public money, therefore their practices should be transparent.

"If you ask me, we are burning public money in here, so everyone may take a look at how we are doing so. An instrument for accountability are news organizations. They may come and take a look. And if you don't allow them, they will find another way, you see, then there is Zembla. You can better try to deal with it as transparent as possible, other than refusing it." (Respondent II.7. care manager)

In short, media attention cannot be neglected, it is therefore better to accept it and deal with it, rather than refusing or neglecting it, is the adagium in this hospital.

6.2. Changes in the organization of patient safety

Addressing the addressing culture

After the discovery of an enormous bacteria population, 'everything necessary' was done to control the crisis. In a later stadium, more attention was being paid to more structural transformations in health care delivery. Again, first a description of the structural changes by different actors in the organization of patient safety are described by the three topics as illustrated in the theoretical framework. The concluding paragraph will specifically focus on the organizing activities of *professionals*.

6.2.1. Risk Management

New established division

The new division Quality, Safety and Accountability (further: QSA) was established at the end of the year 2011, just a few months before the VRE-bacteria outbreak. Mostly all employees working at this department already worked at the hospital, but more spread throughout the organization. One of the fundamental aims of this department is to map risks based on a 'risk model'. The division utilizes indicators to measure the quality of care and map possible risks.

Next to prospective analysis, retrospective analysis is an important aspect of Risk Management. This is amongst other things illustrated by the extensive internal evaluation report based on this specific bacteria outbreak. The evaluation was executed by an evaluation commission which consisted of two external experts (a professor Infection Diseases and a physician-microbiologist from academic medical centers), and four organization members (a division manager (respondent II.7), a member of the QSA-department, a medical specialist and a hospital-pharmacist.

'Learning from others' was not only reflected by external experts who guided the evaluation process, but also in the utilization of evaluation reports based on the crisis in Hospital III. Based on the information in this external rapport, new risks were identified.

In short, there is specific attention for Risk Management, but there are no structural changes perceptible in this area. Other than member of an evaluation commission, there is no clear (organizing) role for medical professionals.

6.2.2. Safety Improvement Strategies

Protocols and sanctioning

Several strategies were implemented in the organization to take patient safety to a higher level, for example by sharpening safety protocols. However, to make them work in practice, many efforts have been put in sanctioning possibilities. The QSA-department aimed at generating possibilities to actually sanction professionals who do not live up to the guidelines, something that was jurisdictionally not possible up till then. *Compliance* is therefore a main theme.

Changes in the care process initiated by professionals on the working floor themselves, stick to a very practical level. Medical specialists manly indicate what they need to live up to the guidelines. Examples of these practical solutions are for example disinfectants at every hospital bed and prepared sterile sets at the policlinic.

Although there is little effort from medical specialist in the initiation of new safety strategies, there is a role dictated for them in executing these new policies. A project group 'hygiene, just do it!' was established after the broadcasting of the Zembla documentary (reed also 'safety culture') and initiated some concrete safety measures. Two of these measures

specifically rely on the efforts of medical professionals; the hygiene checks labeled 'time-outs' which have to be carried out before every patient visit and the co-called 'quick scans' in which professionals have to audit hygiene practices.

6.2.3. Safety Culture

All in the game

The transitions in safety improvement strategies were quite limited and practical in their nature. Urged by the media attention, presumably by Zembla, time and money have been invested to improve the safety culture. Even though the incident and earlier public attention already led to the acknowledgement that things had to change, the organizational climate did not provide the atmosphere required for *actual* change:

> *"Yes, anyhow it triggered us. We thought that we had set up several things, because we used the VRE outbreak itself to emphasize all the basic hygiene rules once more, but apparently..there we needed more to really get something done. And Zembla did speed up that process."* (Respondent II.6, manager QSA)

A main conclusion based on the Zembla documentary was that organization members find it really hard to address undesirable behavior of others. One of the concrete measures to improve the safety culture was the establishment of the temporary project group 'hygiene just do it!' which was initiated by the Board of Governors (Internal Evaluation Report 2012). The project group, consisting of employees of Infection Prevention, Marketing and Communication, the medical staff and care management and chaired by the physician-microbiologist initiated some concrete measures (examples previous paragraph) to improve the process of care. However, most emphasis was put on a change of professional *behavior.*

Concrete measures regarding patient safety culture were extensive and diverse. The instruments most mentioned by different respondents were the 'posters' and the game 'who is..the mole?' This game was based on the eponymous Dutch television program in which a team of players aims to fulfill different assignments, but one of them sabotages the game. In order to improve an 'addressing culture', this hospital set up their own 'who is the mole?'; different actors throughout the organization functioned as 'mole', they intentionally ignored the hygiene rules, for example by wearing long sleeves or rings and watches. At the moment a colleague addressed this undesirable behavior, the 'mole' handed a card to the employee. The employee who had collected most cards at the end of the game, received a reward.

> *"What you do achieve with this game, is that not only the behavior of the 'moles' got addressed, but also that of employees that just do not live up to the regulations, so that is a strong boost for the addressing culture. We're definitely going to repeat this game. Another hospital took over this game, and we had a gift voucher of 25 euros or something,*

the other hospital rewarded an ipad mini, ..the amount of cards gathered! (smiles) That was far more than at our game! So, I'm not sure whether we should also start working with ipads or… so you see!" (Respondent II.6; manager QSA)

Next to this game, posters were spread throughout the building to increase the awareness and herewith improve the 'addressing culture'. A medical specialist poked fun at these posters, but more strikingly, discussed the topic in a general sense; 'it is a good thing', and not so much as if these measures are aimed at the medical staff:

"*I think they are awesome! (sarcastic) Especially one, I won't name the medical specialist, but there is a poster with a medical specialist with a real angry face on it 'just talk to me!' But when I see his face.. I do think.. 'well..' No, that's a bit stupid, but I do think that it is a good thing in itself.* (Respondent II.8; medical specialist)

Despite some critiques, these instruments are not fundamentally challenged. However, some discussion arises concerning the financial investment in patient safety culture. Besides the reward for the 'winner' of the game, 'who is the mole?' is not an expensive measure. In contrast, an audit with a member of the Board of government is considered successful, but does also raise some questions:

"I think we paid attention to this in a great manner. But on the other hand, you can ask some questions regarding the financial aspect; how much did this attention actually cost us? If we ask one of the members of the Board of Governors to monitor the entrance of the restaurant for an hour, and discuss the way how people are dressed, that is a real expensive audit! Amazing how it works! But it is.. it is public money that is being spend. Apparently we need it." (Respondent II.7; care manager)

Unless all the efforts to generate a prosperous safety climate, apparently there is still a lot to gain. Awareness of patient safety lacunas is immensely important. However, again a bridge has to be built between safety culture and actual practices. Sound safety practices do not only require an atmosphere in which professionals *are willing to* incorporate new strategies, they also have to be trained to *actually* embed new ways of working into their daily practice:

"*Personally I think we should take it way further, we should get from 'having protocols' to 'living up to protocols', to auditing and training protocols. You can perfectly write down how to nurse a patient isolated, but a reanimation also isn't something we learn from paper. We train it. You have to train professionals in order to get it internalized, that's how it works."* (Respondent II.7; care manager)

6.3. Other effects

As stated earlier, other effects on media attention than the organization of patient safety, such as a 'atmosphere of silence' or strong media relations are hypothesized in the academic literature. Based on inductive analysis, this paragraph presents the other effects on media attention that appeared in this case.

Media Relations

The experience of media attention is threefold; media attention is experienced as annoying (1), presumably regarding the *content* of messages. But ironically enough on the other hand it is also considered a legitimate instrument for accountability (2), and it was also helpful to generate a sense of urgency (3). To take away the 'annoying' aspects of media attention, efforts have been made to influence the content of the news items by being transparent:

> *"You're in the newspaper! Well uhm, to what extent are we capable to influence that? In other words, can you provide news organizations with information in such a way that they tell the true story and not make a tendentious story out of it. Uhm, I do think you can influence that. It starts with transparency. At the moment you shut the door, they are being harsh on you. So, yes I do think you can influence that."* (Respondent II.7; care manager)

Exact for that reason, the Communication department was included in the crisis team real soon. Immediately a transparent approach was chosen, in which all patients were informed about the incident. However, there was no *pro-active* communication to news organizations, but at some point media organizations picked up the item to create their own story:

> *"Actually, we immediately communicated real transparent. We informed the patients and because at some point it was picked up by the media, it became an issue. An then we had, somewhere in May I guess, it became a real news hype. For a whole day long, the telephones in this department were jumping off the hook like we had something severe going on in here."* (Respondent II.9; communication advisor)

About half a year before the incident occurred, the organization had decided upon a new communication strategy. There had been some reorganizations and new employees had been attracted (among who Respondent II.9). From that moment on, more time have been invested in building relations with (local) news organizations. A new, more transparent, strategy initially also caused some anxiety:

> *"The Board of Governors was getting cold feet, but gradually they noticed that it has the desired effect"* (Respondent II.9; communication advisor)

6.4. How come? Organizational mechanisms

As stated earlier, it is a difficult task to reveal how a certain outcome originates. Nevertheless, this subparagraph provides first attempts to explain how certain outcomes came about.

Professionalism as barrier

Throughout the story, 'professionalism' several times pops up to illustrate the difficulty of creating a new organizational climate, in which all organization members unanimously recognize the importance of patient safety. Traditionally, medical specialists have gained autonomy in their service delivery, which have led to taken for granted ways of working. This attitude forms a barrier to take on new safety practices:

> *"The higher educated the professional, the more difficult the addressing behavior. You know, the medical professional has read an article somewhere on which he or she decides not to comply to safety rules.. Those articles are easy to find. Ten per day. So, look for an article that underlines your opinion. Easy as that."* (Respondent II.7; care manager)

The professional logic is reflected in the ways in which medical specialists decide upon how to apply the regulations; for each individual case it is considered whether or not to strictly follow safety protocols.

> *"In general, the nurses were aware of the fact that you shouldn't that more soon than, I think.. several medical specialists. And that has to do with the fact that as a doctor, it matters whether you go from patient visit to patient visit at the nursing division, or whether you see patients at the policlinic. If you shake hands with a patient at the policlinic and wash your hand with water and soap, that will be sufficient in nine out of ten cases, whether you wear a watch or not."*(Respondent II.9; medical specialist)

6.5. Conclusion: Organizing professionals?

The media pressure, mostly executed by the documentary of Zembla, generated an organization broad awareness of the importance of patient safety. Most of the concrete measures introduced after the incident, were initiated by the recently developed Quality & Safety department. Most of these actions were specifically aimed at developing a sound patient safety climate, such as the audits by the Board of Governors, the posters and the game 'who is the mole?'.

The project group 'hygiene just do it' consisted of different organization members, amongst whom medical specialists. This group produced a few concrete measures to improve the safety of practices. There is a clear role for professionals in the execution of these new measures. However, in general medical specialists do not seem to play an distinctive role in the organization of patient safety; their efforts stick to relatively 'practical' adjustments such as an expansion of disinfection possibilities. Their efforts thus are demarcated by the guidelines set up by managerial levels.

Summary: Changes in the organization of patient safety		
	Concrete action	Illustration
Organizing by *professionals*	-Expansion of disinfection possibilities	Actions by professionals were very practical in their nature; they responded to what they *need* to live up to protocols
Organizing by *managers*	-Sharpening safety protocols - Auditing by Board of Governors - Posters - Games	Efforts by managers twofold; sharpening protocols, but most emphasis on culture by audits, posters and games
Organizing by *professionals and managers*	-Project group 'Hygiene just do it!' : Introduction 'safety checks' and 'quick scans'	Team process in which safety improvement measures were made up. Explicit role for professionals in the *execution* of new policies
Organizing by *others*	-	

Table 9: Schematic Summary Results Hospital II.

7. Hospital III. 'Falsely accused of sweeping issues under the carpet'

In the spring of 2011, the Netherlands was being startled by an item broadcasted at prime-time's public service television news; a bacteria outbreak in a Dutch hospital had caused ten deaths. In no time, other television shows, newspapers and news sites copied the exact content of the message. The day after, the hospital informed the Health Care Inspectorate, which immediately put the hospital under supervision. In total, more than a hundred patients were tested positive with this Klebsiella bacteria, of whom three (compare news content) were identified to have died from this bacteria.

7.1. Media attention

'Ten patients died'

Except from the enormous *amount* of media attention, the *content* of the news story is striking in this case. The story ventilated by the news media mainly concentrated around a specific aspect of the incident; patients that had died from the bacteria. A few months before the news media got involved, micro-biologists had found a bacteria population that was different from what was known up till then. While still verifying how to deal with this bacteria, somehow public service television (In Dutch: NOS) found out that 'something was going on' in the hospital. At the time the media confronted the organization with their news item, the Board of Governors was not yet aware of the situation at the working floor, and thus there also hadn't been any press communication towards media organizations. The situation got out of hand when the content of the reporting shifted to patients that would have passed away because they were infected with this Klebsiella bacteria.

> *"And then an untenable situation arises. (…) At first, it was quite manageable, but at some point it turned into an uncontrollable situation because there was mainly attention for patients that died from the bacteria. So, from the moment death and destruction are linked to the bacteria.. that is.. that is steering emotions."* (Respondent III.11; care manager)

The pressures by news media, presumably executed by the public service television news (NOS) and one of the bigger newspapers (Algemeen Dagblad) has had an immense impact at individuals working at different levels of the organization. Specifically the *content* of the message which was unanimously considered 'wrenched', caused disappointment, and even pain;

> *"I experienced it as going way too far. That is also the feeling that predominated throughout the organization. Actually, that makes the feeling of powerlessness and grief even bigger. Because.. you got confronted by so many things (…) at a certain point things*

got discussed in the news media that do not contain any truth, but it is reported that way though."(Respondent III.10; manager Q&S)

"The general public is interested in: who died from that bacteria? Where should I be afraid of? (..) If you see the whole process, I have had conversations; what does it mean to you, the media, that it is in the newspapers? Well, crying, because someone at the tennis club said: shouldn't you start washing your hands?! That is how people treat each other, pure bullying behavior, bullying at the tennis courts."(Respondent III.11; care manager)

"*It felt like an attack. Highly personalized, without any background (…) There are so many people without a considerable deal of knowledge who think they can write whatever they want, without knowing anything about it really."* (Respondent III.12; medical specialist)

Lagging behind

The ways in which some news organizations acted, was labeled an 'assault' (e.g. Respondent III.12; Respondent III.13). The organization was being accused of a lack of transparency, but never intended to wipe issues under the carpet (Respondent III.11, Respondent III.13). However, the situation that had occurred in which news organizations created their own story, based on information played through by other 'unknown' actors, and without pro-active communication of the hospital made that the organization lost control over the *content* of the story. In a later phase, there have been major attempts to turn the story, but without success.

"*We were seized by all the media attention at that time. It was known within the organization that something was going on, but that signal hadn't reached the Board of Governors yet. At the time the information made in to the Board of Governors, we scaled up immediately and contacted news organizations pro-actively. However, it was said in the news media that we ought to sweep issues under the carpet, but of course we never intended to do so! All the time, our medical specialists though that the situation was under control. At the time we found out it wasn't.. that is when you start up the communication chain and try to turn the communication strategy from re-active into pro-active.. try to get back the control over what is communicated to the public."* (Respondent III.13; communication manager)

"*And even after the inquiry it has proven almost impossible to get the communication right. The Board of Governors made several efforts to get things right if you ask me, but every time the information appeared differently in the news. It feels like; 'no, that isn't the story we wanted to tell!' (..) Every time the message 'Hospital III. is sweeping issues under the carpet' popped up again. We have no clue whatsoever of what we should have been sweeping under the carpet!* (Respondent III.11; care manager)

"Initially, we had to defense ourselves. We were being accused of x, y or z, and we were lacking behind all the time" (Respondent III.12; medical specialist)

The Communication Department responded late, it was not prepared for such a crisis. Additionally, in this hospital a role in which media content is influenced and controlled by the organization, was not even *assigned* to the Communication Department;

"I think that they.. I think that they missed out some things at the beginning. But that is.. naturally, as a hospital you never got confronted with these kind of issues. Later, they hired all kind of people who were considered to possess specialized knowledge, that is when things started to turn right. However, the start was less promising. It was an attack, but it is not their task to.. it is their task to deliberate with journalists and invite people, but that is something way more friendly. This is.. suddenly, it felt like we were the center of the world!" (Respondent III.12; medical specialist)

7.2. Changes in the organization of patient safety

Patient Safety as Focus

I am a bit early for my appointment with an employee of the Quality & Safety department. I have been asked to wait a few minutes at the huge round table that is situated in the middle of this huge room where several people are working behind their desks. While nipping my tea, my attention is drawn by several newspaper cuttings that are spread over the table. All have something to do with incidents in newspapers.
Later, when I ask the interviewee why that table is strewn with these news messages, see tells me that the Communication department collects all these news items every day to follow how news media operate and what topics they cover.

The enormous media attention that was experienced as 'painful' throughout the organization, urged the hospital to make huge steps forward in the organization of patient safety. Again, first a description of the structural changes by different actors in the organization of patient safety are structured by the three topics as illustrated in the theoretical framework. The concluding paragraph will explicitly focus on the organizing activities of *professionals*.

7.2.1. Risk Management

New established division

Before the bacteria outbreak, there was no systematic attention for mapping risks in the organization. Pressured by the Health Care Inspectorate, the department Quality and Safety was established. There is an explicit role for this bureau in mapping risks. Nonetheless, the organizations strives for more involvement of medical professionals in mapping risks:

"Since last year, Risk Management is very concrete reflected in the year plans. We expect from all the divisions that they make a prospective risk analysis of one or two processes. We, as a Quality & Safety division, are preparing techniques and education in order to enable the divisions do Risk Management themselves." (Respondent III.10; manager Q&S)

The initial phase has just been passed, but the organization is still reorganizing and focusing on the 'division of labor'.

7.2.2. Safety Improvement Strategies

Professionals in the lead

Despite all the efforts of the new division Quality and Safety, there are also some concerns about the current attention for patient safety and the effects on the process of care. Striking is that these feelings are ventilated at the *management* level, safety practices are not so much considered as 'core business';

> *"I experienced it as if we had to live up to all kinds of obligations and regulations. 'You have to do this, we are going to arrange that'. And I thought, well, we still have to do our job right, which is taking care of patients!"* (Respondent III.10; manager Q&S)

The perspective of the medical staff contrast sharply however. There have not only been practical changes to be able to live up to safety protocols, such as disinfectants at every bed, but medical specialists have also adopted new ways of working. Safety practices have been incorporated into their core business. Before the incident, there was a little structured, more arbitrary way of working;

> *"A result was passed on, … or not, and it was noted down on paper,… or not, and then someone saw that result,… or not."* (Respondent III.12; medical specialist)

Since the public shaming after the bacteria outbreak, the medical specialists felt urged to adapt their practices. Safety protocols have been checked, contact isolation was introduced and there was more awareness regarding the prescription of antibiotics. Checklists and inter-collegiate-audits have been introduced (Respondent III.11; care manager). Moreover, some strategies have been adopted, in which professionals organized their own safety practices. Structurally, on a weekly basis, together with the Infection Prevention and a micro-biologist, so called 'infection rounds' are held to monitor bacteria populations and their possible effects. Next to this, safety issues have been incorporated within daily meetings:

> *"At our division, there is a daily overview of all the patients with multi-resistant organisms, they are discussed every day during work meetings, both in the morning and in the afternoon. Like 'is there something going on, should we do something about this? So that makes that the awareness, at least at our division, drastically changed."* (Respondent III.12; medical specialist)

7.2.3. Safety Culture

Setting Priorities

Before the Klebsiella outbreak turned everything upside down about two years ago, the hospital 'was doing great'. The hospital stood out in the region, and was strongly competing with others;

> *"We had a managing director who had real high ambitions, who fully defended the competition model. That was the time when there was a focus on the competition in the region. And.., people appreciated that. Because we were working hard, new projects were set up, new developments were introduced."* (Respondent III.12; medical specialist)

With hindsight, it is stated that the attention for competition and efficiency was at the expense of patient safety. However, a transition in the organizational climate led to a whole new priority; *"Now it is safety above anything!"* (Respondent III.11)

There have not been applied concrete measures to establish a safety culture, other than just shifting priorities and paying attention to them. The extensive and negative media attention was enough to generate awareness and turn patient safety into a top priority;

> *"You see, focus, gives an effect. When you focus on one or two specific themes in the organization, than those things will improve. At first, there was attention for competition and financial recovery so to say. Afterwards, quality and safety got a focus. That is where you see things changing, and improving."* (Respondent III.11; care manager)

> *"Quality and safety are topics that are covered on the agenda of all meetings; meetings of cleaning personnel, meetings of the Board of Governors, it is on the agenda of every work meeting. Another thing is that we experienced the whole incident. I do not need to explain the necessity, I only have to refer to what has happened to us. So the 'shock effect' the hospitals experienced that were visited by Zembla.. we had that shock effect, but even ten times bigger!"* (Respondent III.13; communication manager)

> *"Every meeting starts with that subject. So, if you keep on repeating it.. I must say, that went real quick. You have to have walked around here back then, so to speak, to experience what the impact of such a situation is.. everybody was willing to do everything that was necessary (…) How we realized that?, well the media effects have been huge"* (Respondent III.12; medical specialist)

7.3. Other effects

Fear as trigger

The extreme media attention thus led to drastic changes in the organization. The media attention led to a new safety climate, in which organization members were willing to do 'everything necessary'. This sense of urgency however, was partly increased by fear. Fear is hypothesized as causing a 'spiral of silence' (see theoretical model). Although fear in this organization did not lead to apathy but concrete actions, some concerns rise regarding the *motivation* to adopt practices;

> *"Everyone is afraid that there is a journalists standing behind every door, every time you ask yourself the question 'who would that be', So that does play a role. If you walked out of the door, a camera crew was standing over there, as if horrible things had happened here."* (Respondent III.12; medical specialist)

> *"But the fact that news organizations are blackening the reputation of your hospital, (..) it does affect medical specialists, it makes them scared, it makes that they want to put everything on paper. It leads to an atmosphere which on the one hand is really good since it gives quality and safety a boost, but on the other hand is also creates a culture of fear. Fear can also be a stimulus to start doing things which you should do, but fear always is a bad advisor. That is when you start doing things for the wrong reasons. Because, are you adapting you work to prevent from being blamed in the news media, or to really improve your working process?"* (Respondent III.10; manager Q&S)

7.4. How come? Organizational mechanisms

As stated in the operationalization of the concepts, it is a difficult task to reveal how a certain outcome originates. Nevertheless, this subparagraph provides first attempts to explain ´how come?´

New ways of working catalyze awareness, or awareness catalyzes new ways of working?

In the theoretical framework, the importance of safety culture was illustrated by its role as *requisite* for other safety strategies to work in practice (Nieva and Soraa 2003). It is stated that safety tools will not work in an atmosphere that lacks the awareness of patient safety issues. In other words; new instruments designed to improve patient safety will not be implemented if they are not accompanied by the correct cultural changes (Nieva and Sorra 2003). However the story of Hospital III. displays quite the opposite image; the introduction of new strategies (the incorporation of 'bacteria status' as structural topic in daily work meetings), led to a change in the culture (*"So that* (new practices) *makes that the awareness, at least at our division, drastically changed").* In other words, concrete *actions*, make visible that a change in the safety culture is needed. The introduction of new physical measures

regarding patient safety (in which medical specialists played a leading role) created awareness of the importance of patient safety.

Positive news

As stated earlier, right from the start, the organization was 'lagging behind' regarding their communication activities. The Communication Department is structurally located directly under the Board of Governors, but there was no immediate action. Partly, this late responding can be assigned to the fact that the Board of Governors was informed in a very late stadium (right after the news media had picked up the information). But still, the underlying mechanism apparently is not the organizational structure of this entity, but the *activities* appertained to the division. An important role was assigned to the Communication Department, but controlling media content was not seen as a (necessary) task.

7.5. Conclusion: Organizing professionals?

As the overview demonstrates, most of the significant changes in this case were initiated and adopted by professionals themselves. Although these efforts have partly been motivated by fear, they did lead to structural changes in the ways of working. The professional attitude towards patient safety transformed, it is now seen as an indispensable part of the 'core business'. Physically, this is demonstrated by the introduction of safety checks, safety rounds and moreover, the inclusion of the topic into daily work meetings.

At the management level however, the pressures executed by the news media and followed by the Health Care Inspectorate, made that management employees felt pressured to adapt their practices. They felt pressured to launch new rules and guidelines. Long-term plans regarding patient safety, such as the establishment of a Quality and Safety department were handed down from on high. Therefore, the attitude towards patient safety at the management level is quite different, since new practices were seen as an 'extra burden' and not so much as a part of the core business 'treating patients'.

What happened in the news media, took the organizations as a surprise. Therefore, there was no solid preparation to handle media attention and thus professionals were not protected from these external pressures, they were directly affected by what came about. Further, before the incident occurred, controlling the content of news media items was not even seen as a task of the Communication Department. They had 'softer' tasks such as informing news organizations about new born babies and a new building.

Summary: Changes in the organization of patient safety		
	Concrete action	Illustration
Organizing by *professionals*	- Safety protocols (antibiotics, contact isolation) -Checklists - Inter-collegiate audits - Work meetings	An adaptation of protocols and the creation of new protocols assembling antibiotics prescription and contact isolation. Checking safety conditions before every patient visit. Professionals checking each other's safety behavior . Presence of bacteria structurally adopted in daily work meetings
Organizing by *managers*	- Establishment Quality & Safety department	Staff division that focuses on the development of a Risk Management System
Organizing by *professionals and managers*	No organized actions in which professionals and managers explicitly worked together	
Organizing by *others*	- Evaluation of the process	The Health Care Inspectorate played a significant role in evaluating the process and establishing a Quality & Safety department

Table 10: Schematic Summary Results Hospital III.

8. Comparative Case Analysis

The previous chapters all outlined the story of one of the hospitals. This section is arranged for case comparison and aims to bring the three stories together. Differences in the media trigger and organizational responses are described, with a focus on organizational actions by medical professionals. Next, first attempts are made to explain how these differences came about.

8.1 Media attention

Hospital I. already had a firm background in dealing with media issues. Especially one individual had strong ideas about a transparent strategy, in which timing is a crucial aspect. The organization is prepared for varying incidents and has built steady relations with different media organizations. At the time of the incident, immediately a press communiqué was sent out to inform the public. The organization kept control over what was ventilated by news media; in a mostly neutral way media reported about the closing of the Intensive Care. Professionals were not directly affected by what was written or broadcasted. A sense of urgency was disseminated by the Board of Governors.

Also aspiring transparency, Hospital II. decided to inform their patients at the moment the outbreak was considered a crisis. However, in contrast to Hospital I. media organizations were not pro-actively contacted. The information leaked out to media organizations, and so Hospital II. appeared in several newspapers and in regional television news. From that moment on, the communication department also highly interacted with news organizations. While the outbreak was still not under control, Zembla broadcasted a documentary which again generated commotion. The hospital decided to co-operate, even though the content of the documentary was highly contested.

The most extensive and negative media attention was given to Hospital III. The organization was not prepared for such aggressive media attention in which journalists hunted for scoops. New organizations broadcasted items even before the Board of Governors was informed. After that, it demonstrated almost impossible to get control over media content. The attention concentrated around deaths, and professionals were highly affected by this media attention.

There are clear differences in the stadium in which media organizations got involved, timing seems crucial. A pro-active approach seems to higher the changes to keep control over the content of reporting and even 'neutralize' the content. A late response however, might have disastrous consequences which cannot be turned around and make that professionals on the working floor feel assaulted.

8.2. Organizational Response

Although in Hospital I. media attention was 'organized away' by the Board of Governors in collaboration with the Communication Department, medical professionals were confronted with the effects of media attention on the management level. The Board of Governors turned patient safety into a top priority, and this sense of urgency was disseminated to the working floor. Although team leaders and medical specialist ought to 'make their practices safer' and reconsider protocols and guidelines, professionals did only introduce contact isolation as a whole new measure in the process of care. Most efforts to improve patient safety were initiated at higher levels of the organization, following a two-track policy, which does not mean that professionals do not *comply* to new standards. Their input in adapting ways of working is limited however.

Hospital II. responded to the media attention by prioritizing safety culture and rule compliance. Up till then, there were no jurisdictional possibilities to actually sanction professionals who demonstrate undesirable behavior. Inspired by a sphere in which professionals are perceived as 'recalcitrant' organization members, managerial efforts aimed at sanctioning inferior performance. From a management level, many measures have been implemented to improve the addressing behavior of professionals, such as posters and 'games'. Further, a project group, also including medical professionals, initiated safety checks by professionals. This project group consisted of different organization members; e.g. staffing personnel, managers, medical specialists and nurses.

The Quality and Safety department that was established in Hospital III, pressured by media attention and the Health Care Inspectorate, considered patient safety practices, besides its benefits, as an extra burden that does not directly belong to the core business. Medical professionals however, felt urged to adapt their ways of working and incorporated safety practices into their core business. Fear for public shaming did not lead to apathy, but concrete actions. Weekly 'infection rounds' became standard procedure. Further, the presence of bacteria became an standard agenda item at daily work meetings. Values as effectiveness and efficiency, presented by the Board of Governors, predominated throughout the organization before the incident occurred. Afterwards, patient safety became a first priority.

8.3. Organizational Actions by Professionals

Hospital III. demonstrated most organizing actions by professionals. They did not only adopt new regulations initiated by the Board of Governors and managers, but they also organized their own safety practices, as reflected by the safety checks and work meetings. Fear for public shaming clearly was a stimulus for professionals to introduce new measures. In Hospital I., patient safety clearly is the flagship of the Board of Governors, which explains all the efforts made by this entity to make steps forward in the organization of patient safety.

However, as long as many ideas and instruments are initiated from above, and professionals are already stimulated to adapt their practices by their managers, they do not feel the need to take on these roles themselves.

The concluding tables that provide an overview of organizing practices in each hospital, show that the activities by *managers* in Hospital I. and Hospital II. exceed those of Hospital III. In the first two cases, managers 'organize a lot' and initiatives of medical professionals remain quite ´practical´ in their nature; professionals point out what they need (disinfection possibilities) to live up to rules set by managers (hand hygiene protocols). It might therefore be argued that intensive actions by managerial actors lower the motivation and decrease the space for professionals to take on organizing actions.

A recalcitrant attitude of professionals towards initiatives from the Board of Governors and the Quality and Safety Department to increase the *awareness* of patient safety and improve the *addressing culture,* are reflected in both cases I. and II. Professionals made ´fun´ of these attempts, by taking shots at posters or wearing rings and watches on purpose. In Hospital III. however, none of these concrete instruments was applied by managers and the necessity to adapt practices was not denied by professionals. The media attention (external pressure) had been so intense that the awareness already reached a very high level.

8.4. Underlying Mechanisms

This paragraph aims to explain the similarities and differences in the entities and activities (mechanisms) that caused the outcomes found in the three cases. 'Entities' are seen as 'agent or set of agents functioning under the organizational structure' (for definitions and operationalization see chapter 4). 'Professionals' and 'managers' can both act as entities that influence the outcome, sometimes hindering each other's activities. In both Hospitals I. and II., professionalism was considered a barrier for the organization of patient safety, with special regard to the safety *climate.* The internalized professional autonomy leads to the *selective* adoption of new instruments; professionals decide for themselves what is important, and what not. In this sense, professionalism hinders the regulation and organization of patient safety. This perspective all the more explains the efforts of other actors, for example managers who take the lead and look for sanctioning possibilities, since they assume that professionals are not *willing* to structurally improve ways of working.

Entities at a management level thus also affect the outcome. Especially in Hospital I. where the Board of Governors proclaims 'patient safety' as a top priority, a sense of urgency is disseminated to professionals on the working floor. This entity thus mainly affects the safety climate. The same goes for team leaders who are motivating and demonstrate the desired behavior. 'Pioneers' thus can have a very strong influence in getting others 'on board'. On the other hand, organized attention for patient safety in the form of a Quality and Safety Department, might also take away a trigger for professionals to start organizing

themselves. The activities undertaken by the Q&S department in Hospital II. are almost 'overwhelming'; campaigns, project groups, posters, games and more. In Hospital III, this department is still getting on track and is preparing measures, and has the clear aim to assign a major role to professionals in the process. It has shown that professionals in Case III. took more initiative in the organization of patient safety than their colleagues in the other two cases.

Besides differences in the nature of activities; there are also converging ideas about how safety practices relate to each other. In both Hospitals I. and II., a just safety culture in which employees address each other's behavior is seen as a requisite to make other safety strategies work. This approach also reflects theoretical underpinnings (see for example Nieva and Sorra 2003). In Hospital III. however, this process seems to work the other way around. The introduction of new safety measures consequently improved the awareness. In other words, the physical presence of instruments and measures such as safety checks and safety rounds, makes professionals aware of the importance of the patient safety theme.

Further, there seems to be a crucial role for Communication Departments in the outcome of the process, not only concerning how the department is situated in the organization, but the more regarding its activities. A Communication Department that has the assignment to 'play' with media content and is prepared for 'aggressive' media reporting, is more likely to keep the content of news items *neutral.* Pro-active performance and timing both influence the content of news reporting, and herewith determine the response of professionals. Experience of communication employees seem crucial in determining the accurate timed and correct response.

8.5. Conclusion

The empirical results demonstrate clear differences in how media attention is processed within the organization. For the outcome, it proves important *how* the media attention reaches the professional; if professionals are directly affected by media attention this seems to urge them more to adopt organizing activities than if they are protected by their managers and a sense of urgency if more indirectly forwarded to them. In other words, organizational pressures are more 'soft' than direct media attention.

The ruling image of professionals in the organization seems to matter in how their organizing capacities are estimated by other actors; if the idea of recalcitrant professionals dominates, managers are more likely to play a leading role in the establishment of safety systems. This initiating role of administrators may cause that professionals feel less urged to start organizing themselves. There thus seems a self-fulfilling prophecy in here; if managers believe that professionals are recalcitrant and thus refuse change, they will start setting-up safety systems which indeed causes that professionals feel less motivated to initiate new policies. Since in these scenarios professionals do not create measures, they also feel less connected with them. Safety practices therefore become more of a compliance issue; line or

staff managers construct new (hand)hygiene protocols and monitor if professionals live up to them or whether they have to be sanctioned. However, it has also demonstrated that when there is a lack of systematic efforts to organize patient safety, for example when a Quality and Safety division is still rendering and managers did not yet set up measures to control professionals, professionals can take on a leading role and initiate new ways of working themselves. Initiatives reach further than demands for what is needed to live up to rules, professionals can also arrange work arrangements in which patient safety efforts are incorporated, for example in the form of safety rounds and work meetings.

9. Conclusion and Discussion

9.1. Introduction

The past few decades, public health care delivery has undergone drastic change. A former dominant professional logic in which professional autonomy served as a basis for professional behavior got contested by developments that appeared in reaction to several challenges that threatened the Western health care sector, such as the welfare state crisis and the financial crisis, reinforced market requirements and more demanding and critical clients. Because of these increasingly dynamic environments, organizations are continually confronted with the necessity to adapt their practices. Hospitals more and more embrace an organizational logic, where values as effectiveness and efficiency flourish. These values were at odds with the former dominant logic of autonomous professional service delivery, since traditionally professionals were considered a groups of workers who control themselves.

News organizations function as a stepping stone towards accountability, something that is increasingly demanded by policymakers and 'clients'. News coverage of medical errors ever more dominates the news; professional conflicts, wrongly diagnosed patients, bacteria outbreaks and so on, but it is not clear how this reporting affects professionals on the working floor. It is argued that the news media act as a 'watchdog' and cause that professionals feel the need to adapt their practices. It is also hypothesized however, that media scrutiny can create a culture of fear and herewith apathy. Various studies have focused on the reconfiguration of professionalism from different angles, but a clear gap in the understanding of media effects thus remains. In order to explore this domain, this study focused on the effects of media attention for bacteria outbreaks in hospitals on organizing actions by medical professionals. In order to finally answer the central research question, first the theoretical and empirical questions will be answered step-by-step.

9.2. Theoretical questions

In order to demarcate the research topic and explore what knowledge is yet available in this field, three subsequent theoretical questions were formulated. In this paragraph, these questions will be answered.

1. <u>What are incidents and what is media attention?</u>

To be able to say something about the *effects* of media attention for incidents, there should first be a clear understanding of *what* these incidents are, and what media attention looks like. 'Newsworthiness' is a theoretical concept which explains whether something is considered an incident (worthy to report about), or not. Developments in the news sector such as shrinking budgets and growing competition, influenced the ways in which news organizations operate. Traditionally, the journalistic 'mission' was to factually report the news, balanced and with integrity. However, due to these pressures, news has become a

'money making industry' in which the journalistic focus shifted from 'getting the facts right' to acquiring customers. Regarding incidents, news organizations can report the event and disseminate (official) information to the public, but they can also play a significant role in the social construction of a problem or incident. Therefore, *framing* has become one of the main topics in media studies.

The safety of hospitals really well suits the objectives of news organizations, since many news 'customers' identify themselves with 'patients', since everyone is to some extent dependent from the service delivered by hospitals. The attention for unsafe situations in hospitals (and thus fear of customers) is therefore a great opportunity for news organizations to generate higher print- and audience ratings. 'Drama sells', and the media are thus likely to focus on specific cases and particularly incidents to reveal mistreatment and failure. Extensive media attention can turn into a news hype, in which media organizations structurally report about an item, interpret the situation and repeat each other; an item can consequently dominate the news for weeks.

To conclude; the functioning of the news media is of significant value for health care organizations since they play a significant role in the framing of societal problems and attracting public and political attention to them. The activities of the news media are crucial for public organizations, since both positive and negative publicity affect the *legitimacy* of the organization, and hereby its right for existence. Failures in hospitals are often considered 'newsworthy' since they can be linked to fear of clients and herewith increase audience ratings.

2. <u>What is reconfiguration of (public) professionalism and what is organized professionalism?</u>

The past few decades, a lot has changed in the work domain of public professionals. Economic and managerial reforms affected the autonomy of professionals. These reforms however, were not the only causes for change; new service realities arise because of changing social realities in which professionals are being 'named and shamed' in the news media. Empirical studies demonstrated how contextual changes led to resistance. However, this research paradigm in which managers and professionals are approached as opponents and focuses on resistance towards change, got contested by newer perspectives followed by empirical studies that show how professionals evolve and adapt themselves to their new surroundings.

The concept of 'organized professionalism' refers to professionals that develop organizational capacities in order to deal with changing circumstances. While focusing on media attention for bacteria outbreaks, in this research organized professionalism is reflected by professionals who start to organize patient safety *themselves* while performing their tasks. Especially in health care, where specialized knowledge is required to formulate protocols and guidelines, organizing and managing must be seen as professional issues (see Noordegraaf 2011). Activities in three predominant areas in the patient safety field; risk management (1), safety improvement strategies (2) and safety culture (3), provide a holistic overview of the activities of professionals to organize patient safety.

3. How can media attention for safety incidents in hospitals affect organized professionalism?

The final theoretical question addressed how media attention for safety incidents and organizing actions by professionals are related. The theoretical model (as displayed in paragraph 2.9) provides an overview of possible effects of media attention. First, because of a public exposure of incidents in hospitals, medical professionals might feel urged to indeed adapt their practices, and start organize patient safety. Further, professionals might also start organizing patient safety in collaboration with their managers. The other two 'organizing effects' are activities to improve patient safety executed by managers or other (external) actors.

Besides the organizing effects, media attention might have other outcomes. As already stated in the introduction, public shaming might lead to a culture of fear which generates apathy. An atmosphere of silence will thus precisely have the opposite effect. Further, organizational responses might be clustered around dealing with the initiator of the attention. Media relations might influence how news content affects medical professionals.

An overview of the literature demonstrates that there is a clear gap in the understanding of how news media affect medical professionals. Different hypothesis exist, not yet funded with clear empirical evidence. This study aimed to fill this gap by empirically exploring the effects of media attention. The coming paragraph provide answers to the empirical questions.

9.3. Empirical results

In order to explore how news media affects medical professionals, three hospitals where multi-resistant bacteria sprouted up recently and herewith received substantial media attention, were researched. This paragraph will answer the three empirical questions that were central to this study.

1. Which incidents and media attention have taken place in various cases?

As stated earlier, all three cases were confronted with a bacteria outbreak, which in all three hospitals caused that departments had to be closed for a while. Patients had to be redirected to other hospitals and to control the bacteria, all areas had to be cleaned thoroughly. The media attention for these incidents differed in their nature and extensiveness.

Hospital I. had been confronted with the documentary makers of Zembla in the past; a few years before this bacteria outbreak appeared, the hospital had been subject of a documentary about cleaning practices in hospitals. At the time, the incident caused a lot of commotion. This experience however, made that the content of media reporting about this bacteria outbreak remained relatively neutral (reed also sub-question 3.). The incident was

covered in a few national newspapers, but most attention was concentrated at the local level. There has also been an item at the local television news.

In the other two cases, the public was exposed to far more news items reporting about the bacteria outbreak (for exposure rates see overview paragraph 4.6.). In case II, the central element was the documentary of Zembla, in which lacking hand hygiene habits of medical professionals are shown and discussed. This documentary turned into a news item itself and crossed-over to other news sources. In this case, news coverage thus concentrated mostly on the (hand) hygiene behavior of medical professionals.

The most excessive media attention has been paid to the incident in Hospital III.(511 items in local newspapers, 155 items in national newspapers and 64 items at (public) television news). The news coverage in this case mainly concentrated around two topics; a lack of transparency of the organization, stated as 'sweeping issues under the carpet' (1), and deaths caused by this bacteria outbreak (2). Sub-question two concentrated on how this media attention was experienced, and how it affected organizing actions by medical professionals.

2. How are medical professionals affected by media attention and does it affect organizational actions?

Medical professionals were highly affected by the media attention for the bacteria outbreak in their hospitals. It indeed did have an effect on their organizational actions; although there are some clear differences in the nature and extensiveness of these actions, all three cases showed empirical evidence for structural changes in the organization of professional work. The slightest organizing actions by medical specialists were found in case II.; in this case changes initiated and adopted by medical professionals remained rather practical in their nature; professionals mostly indicated what they needed to be able to live up to safety programs set up by managers and the Quality and Safety division. These actors did initiate various strategies, mainly to improve the safety culture. Medical specialists initially made fun of some of the strategies initiated by other actors; they felt less affected by media attention than (staff)managers.

Hospital III. on the other hand, demonstrated most organizing actions by professionals. Professionals were highly affected by media attention and even felt assaulted. They did not only adopt new regulations initiated by the Board of Governors and managers, but they also organized their own safety practices, as reflected by the safety checks and work meetings. Some of these actions however, were stirred by fear. This experience of fear did not lead to an atmosphere of silence, but made that patient safety became a structural item on the agenda of all meetings.

In Hospital I., patient safety clearly is the flagship of the Board of Governors, which explains all the efforts made by this entity to make steps forward in the organization of patient safety. A sense of urgency was disseminated to the working floor, professionals indirectly became aware of the urgency to improve patient safety. They did introduce contact

isolation and a new antibiotics treatment (SDD), but most of the organizing actions were performed by administrators who took the lead.

Although there are differences in the actual practices in the researched cases, it must be stated that in all three hospitals huge steps are made in the safety climate, the *awareness* of patient safety issues has risen enormously. This awareness seems best translated into actual practices in Hospital III.

3. What mechanisms affect responses towards media attention?

A successive question becomes; how do these different responses towards media attention come about? It has shown that in cases were medical professionals were viewed as 'recalcitrant' and thus a barrier for innovation, other managerial actors took on a leading role in the organization of patient safety. The idea of 'refusing' medical specialists lead to the establishment of safety guidelines by managers with a focus on sanctioning possibilities.

Although the structural attention for patient safety by a Board of Governors and a Quality and Safety division indeed can cause a transformation in the climate in which organization members become aware of the necessity to adapt their practices, 'overwhelming' activities by other actors in the organization may lower the motivation of professionals to take on organizing roles.

Other mechanisms that had a significant effect on the organizing actions by professionals were the organizational structure of Communication Department (1) and its activities even more (2). A Communication Department that puts great efforts in neutralizing media content and is prepared for 'aggressive' media reporting, is more likely to keep the content of news items *neutral.* A neutralized media item makes that professionals feel less affected by the media and herewith fades the incentive to adapt practices. In cases where influencing media content plays a substantial role, professionals are *indirectly* affected by news media via a sense of urgency spread by their managers.

9.4. Answering the research question

The answers to the empirical sub-questions as provided in the previous sections, altogether lead up to an answer to the central research question:

How do news media affect organizational actions by medical professionals and what mechanisms affect these actions?

Media attention does have an effect on organizing actions by professionals. Direct media attention is a stimulus for adapting work processes. Explicit media attention can cause fear, but this does not directly cause apathy, but even motivate professionals to take on new roles. Examples of new organizing actions by professionals are safety checks, safety rounds and the inclusion of bacteria as a structural topic on the agenda of work meetings. If organizations have strong mechanisms to control media content, a sense of urgency to

improve patient safety is not directly transferred to professionals by media organizations, but more indirectly by managers. A strong role for administrators in carrying out patient safety as a top priority may help to improve the safety climate, but overwhelming activities initiated by staffing members may also reduce the stimulus for professionals to transform their ways of working.

9.4.1. Looking back: research expectations

At the end of chapter two, some expectations about the research outcome were formulated. In this paragraph, I will reflect on these expectations.

The first expectation was that *extent to which media organizations directly link the incident to the performance of medical specialists influences the response;* if professionals feel directly accused of poor performance, they probably feel urged to adapt their practices. However, there is not enough information to make clear statements about the direct linkage between the incident sketched as poor performance of professionals and their organizing activities, since in all three cases professionals felt directly accused of poor performance ('dirty doctors', 'ten people died'). Although professionals endorsed that bacteria outbreaks can be caused by many factors, in the picture painted by news organizations 'it's their fault'.

The second expectation was that *if media attention is perceived as extremely blaming and painful, this media attention might be an activator for a 'spiral of silence'.* There is empirical evidence to invalidate this expectation. In the case where media attention was perceived most blaming and painful there was fear, but this fear did not lead, as expected, to a spiral of silence. Although there might be concerns about this fear, it did lead to actual changes in the organization of patient safety. Professionals felt urged to adapt their practices and adopted safety checks and safety rounds and included the topic in their structural work meetings.

The final expectation was that the *extent to which the professional is directly affected by media attention, effects the outcome.* Striking is that the case in which professionals were most directly affected by media activities, demonstrated most significant transformations in the organization of patient safety by professionals. In the case where the controlling of media content seemed most successful, and professionals were protected from these external pressures by managers, professionals took less initiative to organize patient safety. This finding thus fulfills the expectation.

9.5. Implications

The final question asked in the introduction was: What are theoretical and practical implications? The outcomes of this study present some new findings that add to the knowledge of the contemporary organization of professional health care delivery. This paragraph focuses on what these insights imply for both health care practice and academic

research and theories that focus on the reconfiguration of professionalism and the adaptation of organizing activities by professionals, and what new questions they raise.

In health care studies, an individual approach towards changes in professional work prevails. This paradigm is for example illustrated by individual competency frameworks, of which the CanMEDS Roles Framework is a trusted example. As stated in the title 'CanMEDS Physician Competency Framework', this paradigm focuses on the knowledge, skills and abilities physicians need for better patient outcomes. The framework focuses on *individual* capacities. Although communicator, collaborator and manager are labeled as roles that medical specialists should possess, there is no attention for the contextual and relational embeddedness of practices. Grant (1999) for example argues that 'competence' as a construct is a fundamentally weak approach, since *"the sum of what professionals do is far greater than any of the parts that can be described in competence terms"* (p.273). Another significant comment on these individual competency models focuses on *interaction.* Lingard (2009) argues that these frameworks focus on individuals while *"competent individuals can – and do with some regularity – combine to create an incompetent team"* (p.626).

I therefore argue that there are limitations to these theoretical approaches. They do not explain how different organizational actors collaborate and interact to produce better outcomes. The findings of this study demonstrated that there is more need for theoretical approaches in which 'organizational systems' are the central element of analysis; patient safety efforts have shown to be a complex process which relies on system competencies, rather than individual competencies. Organizational entities seem to play a significant role in the determination of organizational responses, individual members cannot create a sound safety system. More research on the the complex reality of interactions and collaborations between different organizational layers in therefore needed. An focus on individual capacities of professionals does not lead to a clarification whether and how organizations and professionals can work together to adjust to new pressures. In order to get a better understanding of the complex reality in which professionals and managers work together to face new pressures such as media attention, more research projects set up from a system approach are desirable and could improve the understanding of patient safety efforts.

In complex systems, for example hospitals that deliver health care, many factors influence the rate of 'errors' (Nolan 2000). Cook and Woods (1994) divided these factors in two groups; the causes of errors are usually associated with some combination of the care team, one of its members (compare individual competency models), the task performed and the patient. The authors called these factors the 'sharp end' of the health care system. However, the seemingly less obvious factors; institutional context, organizational structure, management and work environment, the so called 'blunt end' of the system, must also be addressed (ibid). A broader organizational focus than the widely used individual competency frameworks is needed.

Further, the results of this study oppose to earlier images of 'recalcitrant' professionals who fight against change (see for example Marquis and Lounsbury 2007;

Lounsbury 2007; Reay and Hinings 2009; 2005; Kirkpatrick et al. 2005). The research findings join up to studies that found more hybrid forms rather than only clashes. Media attention has proven to be an important factor in bringing about these subtle reactions. Theoretically, this study is a contribution to media effect studies; it was argued that media attention for incidents could indeed provide the required resources for change, but the contradictory view in which media attention causes fear and apathy was also ventilated. The findings demonstrate that media attention indeed can catalyze change, but the hypothesized fear however does not necessarily lead to a spiral of silence, fear can trigger the introduction of new work practices.

More than twenty years ago, Ackroyd, Hughes and Soothill (1989) reported that in the context of professional service delivery, professional groups resist the implementation of bureaucratic control strategies. Consequently, a 'custodial' mode of management triumphed. The concept 'custodial management' referred to the primary concern of managers to *"preserve and perpetuate customary [professionally determined] kinds and standards of service provision"*(p. 603). The authors suggest that a custodial mode of line management has traditionally prevailed within organizations such as hospitals and universities. It is argued that in order to realm the collegial relations required, supervisors defend professional autonomy and demonstrate a reluctance to supply performance data to senior management (Power, 1997). However, the introduction of an organizational logic from the 1990s onwards, threatened this 'collegial' kind of managing (Kitchener, Kirkpatrick and Whipp 2000). The development of performance management and herewith the attempts to introduce hybrid 'practitioner managers' who monitor and control professionals interfered with former 'protective' managerial modes (Ferlie et al. 1996).

However, the results of this study show that still some specific forms of 'protective' management persist; an important research finding is that hospitals aim to organize media attention in such a way that professionals are protected from external disturbances. Media attention as *direct* trigger to incorporate more organizational practices is thus restrained from professionals. This approach also directly links to for example the work of Weggeman (2007) who encouraged protective roles by managers by functioning as a 'heat shield' and prevent from intervening with the autonomy of professional's service delivery.

Though, the results of this study show that the case where such a protection of professionals was absent, safety climate drastically changed without concrete measures of managers, and work processes mostly changed in order to improve patient safety. Normatively, organizations can have a debate regarding the sustainability of this approach. Nevertheless, the complexity of this issue seems to be grasped in a 'balancing challenge'; it has been demonstrated that the protection of professionals from external disturbances such as media attention can lower the motivation to adapt practices, whereas 'unfiltered' media attention can create fear, which is not a desirable climate, whether it encourages new practices or not. The key to balancing this issue might be at (1) Communication Departments that by applying a transparent strategy filter out extreme assaulting media attention and (2)

managers who have to seek for motivating forces that indeed make professionals feel the take on new roles, other than refusing organizational logics.

In two of the cases, professionalism was considered a barrier for improving safety practices. As a reaction to this, managerial actors claim the design of new safety strategies. However, these actions might tap into the professional autonomy and turn into self-fulfilling prophecy; if professionals play a clear role in the creation of new safety protocols, based on their specialized knowledge, they are probably more willing to adapt to these regulations. If however, based on the idea that professionals will not initiate new ways of working themselves, managers take on these organizing roles, professionals might feel threatened in their autonomy and are more likely to indeed refuse these protocols. The idea of 'recalcitrant professionals' did not empirically flourish in this study; if there is room for professionals to take on new roles, they are willing to do so.

Quality and Safety departments seem to sprout up in many hospitals. However, there seem to be clear differences in the actual tasks of these departments; they are for example *supportive* in in their nature by providing professionals with resources and education to identify risks *themselves*, *or* they do take over the efforts for safety practices of other actors; 'we do have a department that takes care of patient safety'. The research findings unravel a certain tension between top-down approaches and the 'self-organizing' capacities of professionals. Safety practices are often 'outsourced' to staff departments. Quality and Safety divisions make the attention for patient safety 'tangible' for the public. The presence of such departments underlines patient safety as a top priority; 'We pay attention to patient safety'. Structured attention for patient safety indeed led to new initiatives to improve patient safety in practice. However, hospitals might start a discussion about the exact role of these departments, since this structure might also wipe out motivators for professionals to start organizing things *themselves*.

In the academic literature regarding patient safety, safety *culture* has been illustrated as a requisite for other measures to work (see for example Nieva and Sorra 2003). Conversely, the research findings demonstrated that actions in the other two areas can also act as triggers for improvements in the safety culture. Balltes and Lilford (2003) classified patient safety efforts as a continuum in which efforts to improve the safety culture follow on the design and implementation of safety strategies, which again follow in the identification of risks. These theoretical classifications seem more complicated and 'blurred' in practice; the *awareness* which is part of a just safety culture may be improved by the implementation of new strategies, since the physical presence of safety measures can act as a reminder for the importance of patient safety. Therefore, patient safety should not only be classified as a *requisite* to make concrete measures work, concrete measures may also *lead* to a more flourishing safety culture.

Next, a qualitative focus is predominant among studies that have focused on the reconfiguration of professionalism. Although this approach fits the subtle and discursive nature of the explored reality, the knowledge of transitions in professional work could be

further complemented with more quantitatively driven research. A linkage between 'hard' data that focus on organizational performance (e.g. medical discharge registers or mortality rates) and more 'soft' data such as survey data or interview data regarding professional autonomy would represent a new stimulating opportunity for future research. A mixed-methods approach in which in-depth approaches to trace the mechanisms for establishing organizational actions by professionals are combined with 'harder' outcome rates to find correlations between organizing actions by medical professionals and performance outcomes will add to the knowledge of the *effects* of reconfigurations in health care professionalism.

As a final point, this project aimed to explore the effects of a specific external pressure; media attention, on the reconfiguration of professionalism. The acquired knowledge added to the understanding of how this attention is translated *within* organizations and affect responses. It might be interesting to further explore how other *external* actors, such as the Health Care Inspectorate (HCI), are influenced by media attention and merge into patient safety movements. In some of the researched cases, the HCI got involved at some point of the story. An analysis of how these organizations are influenced by media attention and how it affects their involvement would add to a broader and thus more complete understanding of incidents and the various actions by different actors that follow.

9.6. Closing remarks

This study wondered if 'the news media are cleaning up dirty hospitals'. With hindsight it can be stated that 'dirty hospitals' indeed is terminology that fits the repertoire of news organizations. The image is sketched that a bacteria outbreak certainly implies a dirty hospital. Although this reality constructed by the news media is highly debatable, it is something health care organizations have to deal with. And to the extent that hospitals indeed *are* dirty, news media play a role in cleaning them up; it has shown that media attention can be a stimulus for adopting new (organizing) practices that prevent 'filthyness' and more generally improve patient safety.

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I. Topic list Interview Professionals and Managers

Inleiding

- Introductie mijzelf en onderzoek
- Doel: puur wetenschappelijk leerdoel (master thesis)
- Geluidsopname en anonimiteit
- Anoniem.
- Opzet interview
- Algemene informatie over de persoon zelf (leeftijd, functie, ervaring # jaren)

1. Media incident

Context

- Hoe heeft u destijds de media aandacht beleefd?
- In hoeverre kunt u zich identificeren met de berichtgeving in de media?
- Hoe beïnvloedt dit uw werk?

Opinie

- Wat vindt u van de media aandacht voor X
- Waarom vindt u dit?

2. Organisatie respons

Fase I: Open benadering

- Kunt u beschrijven wat er binnen uw ziekenhuis/afdeling gebeurd is na het media incident?
- Hoe bent u persoonlijk met het media-incident omgegaan?
- Zijn er dingen veranderd na de media-aandacht (wat)?
  - Hoe komt dat?
- Welke initiatieven zijn ondernomen?
  - Hoe komt dat?
- Bij wie lag het initiatief tot verandering/actie?
  - Hoe komt dat?

Fase II: Link theoretisch model

- **Risk Management**
  - Hoe wordt er met risico's betreffende patiëntveiligheid omgegaan?
  - Zijn er concrete middelen om risico's te identificeren? Waarom wel/niet?
  - Wat is uw rol in het identificeren van risico's
- **Safety Strategies**
  - Kunt u omschrijven welke concrete middelen er voorhanden zijn om de patiëntveiligheid te verbeteren (denk aan richtlijnen, protocollen, trainingen)
  - Hoe zijn deze tot stand gekomen en wat was uw rol hierin?
- **Safety Culture**
  - Wordt er gesproken over patiënt veiligheid? Op welke wijze? Hoe komt dat?

- Hoe zou u omschrijven welke houding er binnen uw afdeling heerst ten aanzien van patiëntveiligheid?
- Welke waarde hecht u zelf aan patiëntveiligheid?

- **Andere effecten?**
  - Wat zijn andere effecten van media-aandacht

- **Nog andere onderwerpen relevant?**

Afsluiting

- Samenvatting van het gesprek (verificatie)
- Extra vragen van de kant van de respondent
- Uiteindelijke rapport opsturen?

II. Topic list Interview Communication Advisors

Inleiding

- Introductie mijzelf en onderzoek
- Doel: puur wetenschappelijk leerdoel (master thesis)
- Geluidsopname en anonimiteit
- Anoniem.
- Opzet interview
- Algemene informatie over de persoon zelf (leeftijd, functie, ervaring # jaren)

1. Media incident

- Waren er relaties met nieuws organisaties *voor* het incident, zo ja, kunt u deze beschrijven?
- Kunt u beschrijven wanneer en op welke wijze u destijds bij het incident betrokken bent geraakt?
- Hoe was het contact met andere delen van de organisatie (RvB, managers, professionals)
- Hoe zou u de communicatiestrategie van Ziekenhuis X omschrijven? Hoe is er destijds gehandeld, waarom?
- Hoe heeft u destijds de media aandacht beleefd?
- In hoeverre kunt u zich identificeren met de berichtgeving in de media? Hoe komt dat?
- Hoe beïnvloedt dit uw werk?
- Wat vindt u van de media aandacht voor X
- Waarom vindt u dit?

2. Organisatie respons

- Is de communicatiestrategie na de bacterie uitbraak veranderd? Waarom wel/niet?
- Is uw beeld van nieuwsorganisaties/journalisten veranderd na het incident? Waarom?
- Hoe zou u de ideale communicatiestrategie omschrijven? (wat zijn kernwaarden, waarom?)

- **Nog andere onderwerpen relevant?**

Afsluiting

- Samenvatting van het gesprek (verificatie)
- Extra vragen van de kant van de respondent
- Uiteindelijke rapport opsturen?

III. Interview Quotes in their Orgininal Language

(In order of appearance)

Hospital I.

Paragraph 5.1

"*mensen hebben hier echt met tandenborsteltjes elk richeltje en elk gaatje schoongemaakt, en uh.. alles met alcohol gedesinfecteerd, alles wat hier in de kast lag is weggegooid.. Al het materiaal. Nou, hier hebben mensen met tranen in hun ogen gestaan om wat hier weggegooid werd. Dat heeft echt héél veel impact gehad*" (Respondent I.3; team leader)

"*Dat is uh..dat is zeer ingrijpend, en het was ook emotioneel. Ik moet eerlijk zeggen dat het wel een grote impact gehad heeft, niet alleen op verpleegkundigen maar ook op ons als artsen. Ja, dat was ook een zware taak. Wij moesten alle patiënten gewoon vervoeren naar andere ziekenhuizen. Uh, en wij moesten ook de opname stoppen, en dat moesten we allemaal aankondigen bij de ambulancedienst, ja dat heeft wel een grote impact op ons gehad.*" (Respondent I.4; medical specialist)

Paragraph 5.2.1

Toen Zembla belde; we willen een afspraak met de Raad van Bestuur, toen zijn we met zijn allen bij elkaar gaan zitten; wat zou er aan de hand kunnen zijn? En toen hebben we tien dingen bedacht die er allemaal aan de hand zouden kunnen zijn, maar dit uh.. dit zat er niet tussen! (lacht). Dat geeft dus wel aan hoe lastig risicomanagement is." (Respondent I.1; member Board of Governors)

"*Een afdeling die weinig incidenten meldt, is geen goede afdeling, dat is een afdeling die geen oog heeft voor veiligheid.*" (Respondent I.1; member Board of Governors)

Paragraph 5.2.2.

"*Dat protocol aanpassen op de IC is daar vandaan gekomen, en het niet weggieten van lichaamsvloeistoffen dat zal waarschijnlijk een niveautje hoger bedacht zijn, daar komt de infectiepreventie bij, daar is ook gewoon wat meer specifieke kennis voor nodig, over zo'n bacterie. Maar vaak is het ook gewoon in samenspel hè. Dus de microbioloog geeft uitleg; hoe gedraagt die bacterie zich, waar ziet hij z'n kansen, verspreidt hij zich via de lucht of via handen, allemaal dat soort informatie is belangrijk. En dan zie je iedereen meedenken, van 'oh, als dat zo is, dan zou dit wel eens een goede oplossing kunnen zijn.' Dus het is eigenlijk een teamproces.*" (Respondent I.1; member Board of Governors)

"De Raad van Bestuur heeft daar echt een geweldige enthousiaste rol in gehad, die was vanaf het begin ervan overtuigd dat we dit moesten doen, ook al kost het een paar centen, investeer er maar in, want het komt eruit." (Respondent I.2; care manager)

Paragraph 5.2.3

"Je moet wel ziekenhuis breed zorgen dat je cultuur optimaal is, en dat iedereen ervan doordrongen is wat de maatregelen zijn die je moet nemen." (Respondent I.1; member Board of Governors)

"Wel hadden we zoiets van 'ja, we kunnen wel een systeem met een aantal inhoudelijke pilaren inrichten', maar onder dat systeem ligt een houdingsaspect. Onder het systeem ligt gewoon het aspect van; 'waarom doe ik dit? Wat is mijn bijdrage daarin? En hoe houd ik dat levend op mijn afdeling?'" (Respondent I.2; care manager)

"Respondent I.1. heeft een aantal verplichte sessies georganiseerd, de zogenaamde lunchsessies, waarbij hij samen met de artsen een broodje at, en iedere arts was verplicht zo'n sessie bij te wonen. En in die lunchsessie heeft hij aangegeven wat hij van hen verwachtte, aangegeven dat er geen speelruimte was en dat ze zich aan het programma moesten confirmeren; 'wanneer je binnen de afdeling bent, wanneer je op de polikliniek actief bent, zijn dit de regels waar we ons nu aan gaan houden. En ik wil graag dat jullie mekaar daarop scherp houden.'" (Respondent I.2; care manager)

"Als ik je vertel dat bij die lunchsessie de groep cardiologen plotseling binnenkomt met aan iedere vinger een ring… dan kun je je voorstellen dat daar wel een beetje de draak mee wordt gestoken in eerste instantie." (Respondent I.2; care manager)

"Dat was nota bene écht een initiatief van de Raad van Bestuur zelf! Wat dat betreft is Respondent I.1., uitermate gedreven om dat thema veiligheid verder uit te bouwen. Dus hij persoonlijk kwam op een gegeven moment met een stuk of twintig cd's een keer terug. En hij zei; 'weet je jongens, wij gaan deze verplicht in de werkoverleggen tonen, om ons aanspreekgedrag naar elkaar toe te verbeteren" (Respondent I.2; care manager)

"Het klimaat van laagdrempeligheid, die was al aanwezig ook daarvoor, maar de manier van werken, de manier van werken met de patiënten, de manier van werken met elkaar, gewoon elkaar aanspreken bij fouten, dat is wel veranderd na de afsluiting van de IC. Iedereen heeft zich gerealiseerd; 'dit is 'onze' IC en wij doen het gewoon voor onze IC, en dat is eigenlijk ook ons broodje!'" (Respondent I.4; medical specialist)

"Je hoeft eigenlijk alleen maar zo te zitten hè (wijst naar vinger), tegenover elkaar, 'oh ja… oh ja',… en dan gaat ie (ring) al af." (Respondent I.3; team leader)

"Ik zei, 'we moeten specifiek op die aanspreekcultuur en de gouden regels iets maken'. Nou het werd een poster; de helft goud, de helft zilver, en dan niet spreken is zilver, zwijgen is goud, maar net andersom hè! Spreken is goud, zwijgen is zilver. En daaronder

een subzinnetje; 'wij spreken elkaar aan op de gouden regels'." (Respondent I.2; care manager)

Paragraph 5.3

"Kijk we hebben ook, en dat scheelt ook wel hoor.. Hoe is een afdeling PR gehuisvest? Wat voor een ervaren mensen zitten daar in? We hebben iemand die op PR zitten die echt een ervaren rot is in het omgaan met de pers." (Respondent I.2; care manager)

"Dus we taxeren een beetje wat de impact is op de lokale samenleving, de kans dat het door de media wordt opgepakt, en op basis daarvan kijken we of we wachten of dat we zelf pro-actief naar buiten treden." (Respondent I.1; member Board of Governors)

"Wij hebben dus transparantie heel hoog in het vaandel staan, het is echt heel belangrijk om transparant te zijn, maar het is heel belangrijk om ook het moment goed te kiezen. En uh.. op een gegeven moment kunnen dingen uit gaan lekken. Ik heb ook altijd als ik heb besloten niet extern te gaan al wel een persbericht klaar liggen en heb ik ook alles gereed staan om het op de website te zetten, of wat dan ook. En op het moment dat de pers belt dan kan ik direct handelen en dan stuur ik het eruit (…) dit is zo een bewuste handelwijze om soms nog niet naar buiten te treden ook om mensen niet ongerust te maken, want de media zitten er boven op" (Respondent I.5; communication advisor)

"Kijk één van mijn grootste sportactiviteiten is om negatieve informatie om te buigen naar positief en het is echt heel leuk hoor, als je daar mee bezig bent. Als je ziet dat het lukt, is het nog leuker." (Respondent I.5; communication advisor)

"Dat was op zich wel heel grappig omdat in eerste instantie de media aandacht negatief gekleurd was. Van 'bah wat vies dat ziekenhuis, daar groeien zomaar bacteriën!' En in tweede instantie, is dat eigenlijk heel positief uitgepakt omdat bleek dat wij toen iets gepubliceerd hebben, we zijn daar zelf toen ook mee naar buiten gegaan, met de aard van de bacterie en hoe we het hebben aangepakt, uh en toen bleek opeens dat het in het land in veel meer ziekenhuizen een probleem was en dat die allemaal erover gezwegen hadden, dus uh in eerste instantie negatief, en het werd al heel snel positief van 'wat goed, dat ze daar zo eerlijk over zijn!' En 'he, anderen hebben nooit iets gezegd.'" (Respondent I.1; member Board of Governors)

Paragraph 5.4

"Ik denk dat de leider daar wel echt een rol in moet spelen. Als die niet het voortouw neemt, niet eerst het goede voorbeeld geeft, wie dan wel?" (Respondent I.3; team leader)

Hospital II.

Paragraph 6.1

Dat heeft wel wat teweeg gebracht eerlijk gezegd! Uhm, en ik denk dat we daar.. uh.. heel goed, we hebben het gebruikt, die uitzending, om de sense of urgency nog verder te verhogen. Je kunt natuurlijk heel erg boos zijn, en dat waren we ook, of boos, zo van; 'hoe kan dat nou dat iemand undercover zo maar in ons ziekenhuis..' en 'belachelijk!' En je kunt gaan kijken of het juridisch wel mag en dat soort dingen. Nou daar zijn vast een paar mensen die dat even zo geopperd hebben, maar we hebben ook heel snel het roer om gegooid en gezegd; 'daar hebben we allemaal niks aan.' We kunnen beter zeggen van; 'Oké, deze undercover journalist heeft dingen gezien die niet horen, waarvan we zelf ook zeggen dat het niet goed is, en dat betekent dat we daar verder iets mee moeten." (Respondent II.6; manager Quality, Safety and Accountability (QSA))

"*Dus die twee vielen net samen. Dus die VRE uitbraak op zich, was denk ik al een moment waarop iedereen zich bewust werd van het belang van de regels, en dat werd nog eens een keer benadrukt door de Zembla uitzending. Dus die Zembla uitzending is denk ik ook..is op een bepaalde manier, ja..hebben we omgedraaid tot een gunstig iets, dat iedereen zich terdege bewust werd van het feit dat het belangrijk is dat je je houdt aan die richtlijnen."* (Respondent II.8; medical specialist)

"*Je wilt twee dingen doen; aan de ene kant vind je ook dat de dingen ook echt nog niet goed gebeuren en dat er iets moet verbeteren.., en aan de andere kant wil je niet dat het veroorzaakt dat, dat de mensen in de buurt die naar dit ziekenhuis komen opeens denken dat het een slecht ziekenhuis is. Want dat is ook niet het geval! En die conclusie kan soms wel erg snel getrokken worden. Als er iets niet goed was aan de uitzending, is het dat er natuurlijk erg wordt ingezoomd op de dingen die niet goed gaan, en stel dat negentig procent van de doktoren en verpleegkundigen zich wel aan de richtlijnen houdt, ja dat wordt dan niet weergegeven. Maargoed, dat hoort ook bij het type uitzending om dat dan ook uit te vergroten."* (Respondent II.6; manager QSA)

"*Kijk, niet elke bacterie, niet iedere resistente bacterie is een probleem. En dat wordt vaak wel eens over het hoofd gezien. Als je het nieuws hebt, dan staat er in het nieuws; tien patiënten overleden door MRSA, weet je wel, in ziekenhuis huppeldepup. Maar dan is de vraag; zijn ze overleden dóór MRSA, of zijn ze overleden mét MRSA? En in de meeste gevallen zal het overleden mét de MRSA zijn, niet overleden dóór de MRSA. Maargoed, nuance is natuurlijk in het journaal, veel minder interessant."* (Respondent II.8; medical specialist)

"*Ik vind ook wij verstoken hier gemeenschapsgeld, dus iedereen mag hier komen kijken hoe we dat verbranden. En een instrument is de media. Zij mogen komen kijken. En als je dat niet toestaat dan doen ze dat toch hè, want dan hebben we Zembla. Je kunt beter*

proberen er zo open mogelijk mee om te gaan, als dat af gaan schermen." (Respondent II.7. care manager)

Paragraph 6.2.3

"Ja, heeft het ons toch wel getriggerd, wij hadden het idee dat we al best wel wat dingen hadden ingezet, want ook die VRE uitbraak hebben we natuurlijk gebruikt om nog eens een keer die regels van de basis hygiëne in het huis te verspreiden, maar blijkbaar was er gewoon nog meer nodig om echt iets op gang te krijgen. En daar heeft Zembla wel in versneld." (Respondent II.6, manager QSA)

"Wat je daarmee bereikt, is dat ook de mensen worden aangesproken, die helemaal niet de mol zijn, maar die gewoon zich gewoon niet aan de regels houden, dus het aanspreek gedrag wordt daar enorm mee bevordert. We gaan dit ook weer herhalen. Een ander ziekenhuis heeft dit ook weer overgenomen, en wij hadden gewoon geloof ik een tegoedbon van €25 , een ander ziekenhuis heeft een ipad mini uitgeloofd, nou het aantal bonnetjes.. (lacht) Ja, dat was wel heel veel meer dan bij ons! Dus ik weet niet zeker of wij nou ook met een ipad mini moeten gaan werken of, ja.. zo zie je maar." (Respondent II.6; manager QSA)

"Die vind ik geweldig! (sarcastisch) Vooral eentje; ik zal geen namen noemen, maar eentje van een specialist die echt met een donderweergezicht; 'spreek mij gerust aan!' Dan zie ik die zo kijken en dan denk ik.. 'nou..!' Nee, dat is flauw, maar, ik denk op zich dat het goed is." (Respondent II.8; medical specialist)

"Ik vind wel dat we daar op een hele goede manier aandacht aan besteed hebben. Maar aan de andere kant kun je je dan weer afvragen; hoeveel heeft die aandacht eigenlijk gekost? Want als wij een van de leden van de Raad van Bestuur vragen een uur voor de ingang van het restaurant te gaan staan om mensen aan te spreken op hoe zij gekleed zijn, dat is een dure audit. Hij werkt fantastisch. Maar het is wel.. het is wel gemeenschapsgeld wat we op dat moment verbruiken. En wat we blijkbaar dus ook nodig hebben met mekaar." (Respondent II.7; care manager)

"Ik denk zelf dat we daar toch nog wel veel verder in zullen moeten gaan en veel meer ook moeten niet naar het 'hebben van protocollen', maar het 'naleven van protocollen', het auditen en het trainen van die protocollen. Dus je kunt heel mooi opschrijven hoe je iemand omgekeerd geïsoleerd moet verplegen, maar een reanimatie, dat doen we ook niet van papier. Dat oefenen we. Bij professionals is het toch zo, dat je dat zeg maar 'in moet trainen.'" (Respondent II.7; care manager)

Paragraph 6.3

We staan in de krant , nou uh.. in hoeverre zijn we in staat om dat te beïnvloeden? Dus kun je die media zo informatie geven dat ze het juiste opschrijven en dat ze er geen

tendentieus verhaal van maken. Uh… daar heb je wel degelijk regie op, die begint bij transparantie . Op het moment dat jij de deur dicht doet gaan zij denken 'de pen is hard'. Dus ik denk dat je daar invloed op hebt ja." (Respondent II.7; care manager)

"*En toen hebben we eigenlijk meteen daar heel open over gecommuniceerd. We gingen patiënten daarover informeren en het werd een issue doordat het op een gegeven moment door de media werd opgepikt, en toen hadden we, het was ergens vorig jaar mei geloof ik, toen werd het opeens een hype, echt een dag lang werd ik plat gebeld door alle media alsof wij iets heel ergs hadden."* (Respondent II.9; communication advisor)

"*De Raad van Bestuur had daar ook wel enige koudwatervrees bij, maar gaandeweg hebben ze ook wel gezien dat het effect heeft"* (Respondent II.9; communication advisor)

Paragraph 6.4.

"*Hoe hoger opgeleid die professional, hoe ingewikkelder het aanspreken.. Want ja, dé medisch specialist heeft ergens wel een onderzoek gelezen waarop hij baseert dat hij zich niet aan die richtlijn hoeft te houden. Hè, en dat onderzoek is er ook te vinden. Wel tien per dag. Nou, uh, zoek een onderzoek wat jouw mening onderstreept. Simpel als wat."* (Respondent II.7; care manager)

"*De verpleging, die was in het algemeen al sneller ervan bewust dat je dat niet moet doen, dan denk ik… meerdere artsen. En dat heeft ook te maken met het feit dat je natuurlijk, het maakt heel veel uit of je als arts van patiënt tot patiënt in het ziekenhuis visite loopt, of dat je patiënten op de poli ziet. De patiënt die je op de poli een hand geeft en daarna met water en zeep je handen wast, dat zal eigenlijk negen van de tien keer volstrekt voldoende zijn, of je nou wel of niet een horloge om hebt.."* (Respondent II.9; medical specialist)

Hospital III.

Paragraph 7.1.

"*En dan ontstaat er een onhoudbare situatie. (…) Eerst was het nog redelijk beheersbaar, maar op een gegeven moment is het onbeheersbaar geworden omdat er met name gesproken werd over mensen die aan de bacterie zouden zijn overleden. Dus op het moment dat er dood en verderf aan een bacterie wordt gekoppeld, dat is..dat is emotiewaardig" (Respondent III.11; care manager)*

"*Zelf heb ik het wel ervaren dat het veel te ver ging. En dat is ook het beeld dat er in de organisatie is geweest. En dat maakt eigenlijk je machteloosheid en je verdriet nog groter. Want er komt zo veel over je heen (…) op een gegeven moment er dan worden dingen bijgehaald die absoluut geen enkele waarheid bevatten, maar die wel als waarheid in de krant staan."* (Respondent III.10; manager Q&S)

"Het grote publiek, die wil weten; wie is er doodgegaan aan die bacterie? En waar moet ik bang voor zijn? (…) Je moet het hele proces zien, ik heb gesprekken gevoerd; wat doet het je nou, die media, dat het in de krant stond? Ja gewoon janken, omdat ze op de tennisclub aangesproken zijn van; goh, zou jij je handen niet eens gaan wassen?! Zo gaan mensen onderling er dan mee om he, dat is puur pestgedrag, puur pest gedrag op de tennisbaan." (Respondent III.11; care manager)

"Het was als een soort aanval in de rug. Heel veel op de man gespeeld, zonder verdieping. (…) Heel veel mensen zonder kennis van zaken die van alles meenden te mogen schrijven en van alles meenden te mogen zeggen over zaken waar ze eigenlijk niets vanaf wisten." (Respondent III.12; medical specialist)

"Wij werden op dat moment heel erg overvallen. Het was wel bekend in de organisatie dat er iets aan de hand was, maar dat signaal had nog niet de Raad van Bestuur bereikt. En op het moment dat het de Raad van Bestuur had bereikt, zijn wij natuurlijk gigantisch opgeschaald en hebben we ook pro-actief met de media contact gezocht. En toen is er in de media geschreven dat wij het in de doofpot hebben willen stoppen, maar dat is natuurlijk nooit het geval geweest! Het is altijd de gedachte geweest van de medisch specialisten dat het onder controle was. En op het moment dat wij er achter kwamen dat het dus niet meer onder controle was, ja dan start je je hele communicatie-chain op en heb je pro-actief contact met je media. Dan wordt er ook opgeschaald en probeer je van heel erg reactief naar pro-actief.. zelf weer een beetje de regie terug te krijgen in de communicatie" (Respondent III.13; communication manager)

"En zelfs ook na het onderzoek, zag je dat de communicatie niet recht te krijgen was. Er zijn vanuit de RvB in mijn overtuiging echt 7pogingen gedaan om echt de informatie goed naar buiten te brengen, maar dan toch altijd net weer anders in het nieuws. Dat je het idee hebt, nee dit is niet hetgene dat we willen zeggen (…) Steeds kwam terug Hospital III veegt vanalles onder de mat. We hebben geen flauw idee wat we onder de mat zouden hebben moeten vegen!"(Respondent III.11; care manager)

"Iedereen moest in het begin in de verdediging. We werden beschuldigd van x,y, of z, en liepen daar steeds achteraan" Respondent III.12; medical specialist)

"Ik denk dat ze.. ik denk..ze hebben in het begin her en der wel iets gemist denk ik. Maar dat is..als ziekenhuisorganisatie heb je daar natuurlijk nooit mee te maken met dat soort dingen? Daarna hebben ze allerlei mensen ingehuurd die dan geacht worden verstand van zaken te hebben, toen zijn heel veel dingen ook ten goede gekeerd, maar de start is weinig veel belovend geweest, het is een overval, daar ben je helemaal niet voor om.. je bent ervoor om iets te overleggen met een krant, of iemand uit te nodigen, maar dat is een veel gemoedelijker baan dan dit, dit is..in een keer het centrum van de wereld leek het wel." (Respondent III.12; medical specialist)

Paragraph 7.2.1.

"Risicomanagement staat sinds vorig jaar ook heel concreet in de jaarplannen. Van iedere afdeling wordt ook verwacht dat ze van een of twee processen een prospectieve risico inventarisatie doet. En waar we nu als afdeling Kwaliteit en Veiligheid mee bezig zijn is veel meer voorbereiden dat we daar methodes en technieken en scholing voor gaan geven zodat iedereen het op de afdelingen ook gewoon zelf kan. (…)Daar zijn nog heel veel stappen voor te maken." (Respondent III.10; manager Q&S)

Paragraph 7.2.2.

"Wat ik daar vooral uit heb ervaren, is dat het opdrachten en verplichtingen regende. Je moet dit doen, we gaan daarover, we gaan dit regelen, we gaan als afdeling dit, als medewerkers zus zo, dat ik dacht van; ja hallo! We moeten ook nog gewoon ons werk doen. Daar zijn we hier namelijk voor; om voor patiënten te zorgen!" (Respondent III.10; manager Q&S)

Er werd een uitslag doorgebeld, ..of niet, en die kwam ergens op papier, ..of niet, en dan zag iemand hem of wel,.. of niet." (Respondent III.12; medical specialist)

"Wij hebben bij ons op de afdeling dagelijks een overzicht van patiënten met bijzondere resistente micro-organismen, die worden elke dag besproken op de overdracht, 's ochtends en 's middags. Van is daar nog iets mee, moeten we daar iets mee? Dus dat leidt ertoe dat het besef, in ieder geval bij ons op de afdeling enorm veranderde." (Respondent III.12; medical specialist)

Paragraph 7.2.3.

"We hadden een nogal ambitieuze directeur, die het concurrentiemodel vol etaleerde. Die ging ook vol in de regiostrijd om het zo maar te zeggen, en dat werd door heel veel mensen in dit ziekenhuis zelf enorm gewaardeerd, want er werd hard gewerkt, en er werden allemaal mooie dingen gedaan, we hebben veel ontwikkelingen gestart" (Respondent III.12; medical specialist)

"Kijk, focus, geeft effect. Op het moment dat je je focust op een of twee punten binnen de organisatie, dan verbeteren die punten. Dat waren eerder misschien concurrentie en zegmaar financieel herstel, aandacht had. (…) Daarna hebben daarna kwaliteit en veiligheid een focus gekregen, Ja, dan zie je een grote verandering, en grote verbeteringen daarin" (Respondent III.11; care manager)

"Kwaliteit en veiligheid staan bij elk overleg op de agenda; ook in de werkoverleggen van de schoonmakers, ook in de werkoverleggen van de RvB, in elk overleg staat het op de agenda, Dat is een. En twee is, wij hebben dit hele incident doorgemaakt. De noodzaak uitleggen hoef ik niet meer, ik hoef alleen nog maar te refereren aan wat we doorgemaakt

hebben. Dus dat schokeffect, in die ziekenhuizen waar Zembla is geweest.. dat hebben wij nog tien keer groter gehad!" (Respondent III.13; communication manager)

Elk overleg begint nog steeds met dat onderwerp. Dus als je het maar steeds terug laat komen.. Ik moet zeggen; dat is vrij snel gegaan. De impact was zo groot! Je moet hier bij wijze van spreken rondgelopen hebben om het te ervaren, wat de impact van een dergelijk situatie was..iedereen was echt volledig bereid alles te doen (…) Hoe hebben we dat gedaan, ja de media invloed is toch wel heel diep geweest (Respondent III.12; medical specialist)

Paragraph 7.4.

"Iedereen is bang dat achter elke hoek een journalist staat… en achter elke deur die open gaat het idee van wie zou dat nou toch weer zijn? Dus dat speelt mee. Als je hier de voordeur uitliep, stonden hier cameraploegen, alsof er echt de meest vreselijke dingen gebeurd zijn" (Respondent III.12; medical specialist)

Maar het feit dat je als organisatie zo in het nieuws komt en zo zwart gemaakt wordt, (…) dat doet iets met specialisten, dat maakt ze bang, dat maakt dat ze dingen vast willen leggen, alles moet op papier. Het geeft een bepaalde beweging die enerzijds heel erg goed is, want het heeft de kwaliteit en veiligheid heel veel voortgang gegeven, maar aan de andere kant krijg je ook een beetje een angstcultuur (…) Vanuit angst kun je ook dingen gaan doen die je zou moeten doen, maar angst is nooit een juiste raadgever. Dan doe je het eigenlijk met een verkeerde reden. Want doe je het nou om te voorkomen dat je nog meer negatieve media aandacht krijgt of doe je het nou om écht je proces te gaan verbeteren?" (Respondent III.10; manager Q&S)