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Making Sense of Tragedy: The 'Reputational' Antecedents of a Hospital Disaster

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This paper is circulated for discussion purposes only and its contents should be considered preliminary.

Abstract

This article explores the workings of Reputational Dialogues (RD) (as a form of organizational discourse); within the setting of a UK NHS hospital that has encountered disaster. The disaster in question took place at the Bristol Royal Infirmary (BRI), circa 1984-1995; and is thought to have incurred the deaths of 34 'special heart babies'. The article explores patterns of RD *utilization* associated with the tragedy. Transcripts from the hearings of an inquiry into the disaster are used to access these patterns– if within specific limits and constraints that are discussed in the article. The article seeks to comment on the workings of RDs within the BRI disaster setting and considers, tentatively, how these dialogues may have helped to institutionalize dominant and (counter-cultural beliefs) about the BRI and its reputation as a provider of cardiovascular care to young children. Overall, the article contributes to organization theory by beginning the process of observing the institutionalization of RD and its by-products, as organizational phenomena.

Descriptors: Reputation effects, the medical profession, organizational crisis, institutionalization, discourse analysis.

Making Sense of Tragedy: The 'Reputational' Antecedents of a Hospital Disaster

Introduction

Over the past two decades or more, the United Kingdom's National Health Service (UK NHS) has transitioned through several distinctive, if fad-driven, 'eras' of New Public Management (NPM) reform (see: Ferlie et al. 1996). The nature of these reforms are extremely well documented, as are the organizational discourses, doctrines and controversies they have created (see most recently: Davis and Thomas 2004; Iedema et al. 2004; Mueller et al. 2004).

During the same time frame, the NHS has weathered a series of momentous disasters, of which the BRI tragedy, the Alder-Hey and BRI tissue retention scandal; and the Shipman murder case have created the most public disquiet. Despite the wide spread coverage these disasters have received journalistically, and the numerous reports, inquests, court cases, and judicial inquiries they have generated, such disasters remain palpably under-analysed as organizational phenomena.

This article contributes to a growing body of research within organization theory that seeks to question the efficacy and safety of the NPM project; and understand the causes of organizational disasters and failures within NPM and UK governmental settings (see for example: Smith 2003; Clarence 2002; and Brown and Jones 2000). Following this introduction, the remainder of the article seeks to 'reanalyse' the BRI disaster, building on previous normative studies of the case and its consequences (Weick and Sutcliffe 2003**;** Aylin et al. 2001). However, this reanalysis is performed with some important theoretical considerations in mind that are not at first obviously connected with the tragedy, and the study of health disasters, per se.

Here, an attempt is made to observe the workings of the Reputation Effect (RE), as a social and organizational institution (or mechanism of compliance and conformity – see ostensibly Barley and Tolbert 1997); and the outplay of its multiple incarnations (n= 4) within the context of the Bristol Royal Infirmary (BRI) disaster. The BRI tragedy took many years to unfold (c.1984-1995) and, upon its disclosure, represented something of a *cause celebre* for the British medical establishment. It is now thought to have claimed the lives of 34 infants and neo-natal 'special heart babies', referred to the hospital for complex open heart surgery (see: Aylin et al. 2001). The relevance of the BRI tragedy to the study of REs, may, at first, appear to be somewhat tangential. However, it is clear from reading the report of inquiry into the disaster (see: CM5207 2001– referred to

hereafter as the 'Kennedy Report') that reputation played a major part in the construction of this tragic narrative, and its disastrous consequences.

Tentatively, the argument is put forward in this article is that REs exerted important influences over the sensemaking and decision-taking of actors in the tragedy (Weick 1993; Weick and Sutcliffe 2003). A decision to act or withhold action, was, it is contended, often attenuated with beliefs about reputation, and in particular, dominant perceptions (and persistent images) of the BRI's reputation as a specialist centre for cardiovascular surgery and medicine. Within the story, one can note, shifts in this dominant institution (Barley and Tolbert 1997). To begin with, the BRI is seen as a laggard within the specialism; but one with the potential to "shine as a star" (see: transcript for Day 13 of the BRI Inquiry – annexe to the 'Kennedy Report' 2001). As time wears on, and new medical and surgical personnel are recruited to the BRI, one sees a questioning of this logic, and worst still, concerns arising within the new professional corps that practices not only lag behind, but are potentially dangerous and putting the lives of young children at higher risk than was the norm (Aylin et al. 2001).

The 'renalyses' of the case expedited within this article, therefore focuses on what can be learnt from the BRI story about the nature of RE institutionalization; and changes to the RE, as an institution, over the course of the tragedy. The article focuses on identifying patterns of RE *utilization* within witness transcripts from the public inquiry into the disaster (the 'Kennedy Report' 2001). It is argued from this, that as an organizational institution, the RE arises in myriad incarnations, but that these diverse patterns of utilization are underpinned by 'production processes' that share similar processual features (Barley and Tolbert 1997; Phillips et al. 2004). An attempt is made, further on in the article, to map these processes based on insights from the BRI case, and specifically, witness transcripts from the public inquiry that followed its disclosure (c. 1998-2001).

Following a discussion of the data, and what it reveals, the article explores some wider themes the case raises for understanding REs, their composition, institutionalization and role in augmenting actions (and inactions). The study is situated within organizational institutional theory (as one might expect) but draws ostensibly upon the work of institutional theorists seeking to understand the part enacted by discourse and language in the shaping of institutions that foreground action (Phillips et al. 2004; Barley and Tolbert 1997). It is argued that REs arise from, and are the outcomes and by-products of, complex webs of discursive exchange between organizational actors (Barley and Tolbert 1997). It is my contention, furthermore, that where REs are concerned, talk plays a vital part in

their social construction and institutionalization (Phillips et al. 2004). This is because REs are crafted principally upon the exchange of 'subjective' stories, impressions, opinions, myths and gossip about extant parties (Bromley 1993). Over time, and with dissemination, these subjectivities acquire objective values, enter into objective discussion, and become taken for granted as inherently truthful, or stories which are seen to be close to the truth (Barley and Tolbert 1997). It is at the moment of being taken for granted that reputational stories and images become institutionalized and generate effects. These effects work alongside other perceptual factors to encourage actors down particular paths of action and causation, with sometimes dangerous results.

In arguing the above, the article seeks to contribute primarily to understandings of the role discourse and discursive practices play in the institutionalization (or naturalization) of hegemonically taken-for-granted beliefs and interpretations (Phillips et al. 2004). In a concluding note, the article also offers some reflections on implications for disaster theory.

The article is divided into four further sections. The next section explores the theoretical background to the study and its relevance to organization theory. Section two considers, in more depth, how and why the BRI case is pertinent to the study of REs. This is then followed by a description of the methodology, and a results section synthesizing the main findings of the fieldwork. The article concludes by distilling observations of relevance to organization theory, institution theory and knowledge of disasters.

The Reputation Effect: An Institution in Need of 'Processual Analysis'

For many years now, social and institutional theorists have been enthralled by the elixir of the RE, and its mythical fate-determining power within markets (Raub and Weesie 1990; Montgomery 1998). In studying this elixir, social and institutional economists have focused their attentions primarily upon the exogenous social and economic conditions that encourage organizations to develop formidable and exalted reputations ("for excellence"); and in so doing, create for themselves unassailable market dominance (see also: Wilson 1985). This body of work has the search for success formulas at its core, and is strongly associated with the institutional literature on mimetic isomorphism (Strang and Macy 2001).

The social component to this form of RE analysis focuses largely upon interpersonal networking, and the role this plays in the augmentation of REs – particularly ones that are favourable to organizations. REs are normatively seen by social and

institutional economists as an epiphenomena of embeddedness - or a social phenomena that arises from the sharing of information between actors (Granovetter 1985; Raub and Weesie 1990; Bromley 1993). Within the embeddedness approach, actors are seen to utilize knowledge of reputation, to for example, determine transactional risks, and assess whether a fellow actor in a market is trustworthy (Granovetter 1985).

Over a twenty year period, a great deal of effort has been invested by both social and institutional economists such as Wilson (1985); Raub and Weesie (1990); and Montgomery (1998); in mathematically modelling and predicting the impact REs have on the behaviour of organizations, and organizational actors in networks and markets. In Raub and Weese's (1990) simulation, they show how, by altering the degree of embeddedness - or the extent to which actors are socially bound to one another - patterns of RE utilization change. Thus, for instance, in a low trust, low bond situation, the significance of REs are magnified exponentially (in the manner of the Prisoner's Dilemma – see also: Montgomery 1998).

Whilst enriching our understanding of the links between REs and calculative, normative-rational understandings of human decision-making, and risk and trust; actors in these abstract simulations remain somewhat anonymous and voiceless. We can observe the outplay of social interactions with them, but in a fairly stilted and didactic way, that does not normally explore the construction (and / or structuration) of actions beyond the level of 'actor A provides actor B with reputational information, actor B then considers how to act…' (Barley and Tolbert 1997). To the qualitative researcher, these models are thus highly dissatisfying – we are left with a significant interpretive vacuum, particularly in terms of *how* REs are created as institutions and diffused within and between organizations and networks of interpersonal actors.

Clearly, the REs depicted in these mathematical simulations cannot emerge without talk, dialogue, story, metaphor and imagery – actors must, after all, 'exchange' what they know of another's reputation using words and by assembling verbal pictures; and using analogies (Morgan 1986). The RE, is thus, arguably an institution framed by talk and conversational dialogues, saturated with emotions, subjectivities, images, stories and metaphor (Morgan 1986; see also, indirectly, Bromley 1993). It might, on these grounds be plausible to view the RE as a discursively fashioned institution (Phillips et al. 2004).

Discourse and Institutionalization

Increasingly, institutionalization - or the processes that encourage practices and beliefs to become taken for granted and 'naturalized' within organizational settings (Barley and Tolbert 1997) - is being seen as a discursive cycle; in which action, talk and text are inextricably interwoven (Phillips et al. 2004). This represents something of a departure from normative theories of institutionalization which have tended to focus on the links between institutions (as mechanisms of conformity and compliance) structuration (how behaviours are ordered and how they conform to prevailing institutions); enactment (via scripts or interpretative schemas that codify action); and action itself (see, ostensibly, Barley and Tolbert 1997; also Zucker 1991). This work revisits questions that have long since pervaded the economic and institutional literatures concerning the relationship between structure and agency; and how people come to 'internalize' institutions; enact, and reframe them (Barley and Tolbert 1997).

In a recent paper, Phillips et al. (2004) have returned to Barley and Tolbert's work in an effort to bring discourse into the theoretical foreground of the institutionalization debate. Discourse, they argue, has always been present in theories of institutionalization - which see institutionalization fundamentally as an iterative, ongoing process - it has just not been given enough prominence. Thus for example, Barley and Tolbert (1997: 96-97) refer at one point to institutions as a form of grammar, but develop this analogy no further. More indicatively perhaps, Barley and Tolbert bring institutions, structuration, and action together around the notion of scripts – which even if not committed to the page, represent a form of 'text'.

Drawing on discourse analysis – or the systematic study of texts and the meanings and ontology's they produce – Phillips et al. (2004) construct a more nuisanced view of the dynamics of institutionalization in which, actions produce texts, that produce institutions, that then produce further actions and further texts. They start from the assumption (as Barley and Tolbert also begin) that researchers are most likely to observe the reframing of existing institutions, rather than the birth of new ones; as most institutions are deeply historically entrenched and new institutions are a rarity. (This is certainly true of the RE, which represents both an ancient social and market institution; and a long standing embedded psychological trait – see: Bromley 1993). It is only within extraordinary frame-breaking moments of crisis and struggle that institutions are overturned through radical, dialectical change (Barley and Tolbert 1997). Even then, it is questionable that attempts to vanquish institutions actually work. More often than not,

institutional change happens as an emergent process, through time (Barley and Tolbert 1997).

Phillips et al. (2004: 640, quoting Taylor and Van Every 2000: 289) argue that discourse and specifically texts that "leave traces" play a significant role in emergent processes of institutional change; helping to frame and reframe institutions; and in doing so, set the stage for variations in existing forms of action. The model that Phillips et al. (2004) produce to further this claim, seems to begin with the *antecedent institutions* that support and underscore prevailing hegemonies and behaviours. These antecedent institutions alter and begin to change dynamically, because they are threatened; actions arise as a protective measure; texts are generated to help preserve the institution by changing it; and the outcome is an institutional shift. These ideas are well rehearsed elsewhere within institution theory: see for instance, Oakes et al. (1998). What Phillips et al. (2004) provide us with, nonetheless, is a way into to seeing institutionalization and institutional change as dynamic processes, which owe much of their dynamism to discourse; and discursive interactions.

This observation is highly salient to the research at hand. REs are, I believe, created and sustained, by discursive interaction, and principally, actors' engagement in, and with, Reputational Dialogues (RDs). These dialogues (which are rarely researched) seem to me to play a pivotal part in the creation of the REs as organization institutions (see: Bromley 1993) but that before an RE can be created *other* reputationally-related discourse framed institutions need to exist. The literature on REs, suggests, for example, that story plays an important role in communicating subjective reputational knowledges between actors (Bromley 1993). This same may also be true for rhetoric. Could these vehicles represent institutions, and institutionalizing forces in their own right?

Importantly, one might also foresee incidences when Reputational Storylines (RSs) and Reputational Rhetoric (RRs) enter into the moment of decision-making; and are utilized, along with other stimuli, to justify and legitimate a particular path of action. It is also arguable, that it is in this moment of 'use' that RSs and RRs produce REs. An attempt has been made in *Figure 1*, to capture the discursive, story telling, rhetorical, interpretative mechanisms that may underscore processes of RE formation.

The above represents a deliberately contentious sketch of some assumptions that are explored within the remainder of the article. Here, what I propose to do is to explore the BRI case to surface observations of RD, RSs, RRs, and REs (ostensibly using a grounded approach – Glaser and Strauss 1967) that I hope will encourage further debate. This, essentially, represents a grounded exploratory endeavour to see whether the notion

of 'story-telling and rhetoric as ciphers' for REs is efficacious; and if so, how it plays out within complex a real world organizational setting such as the BRI disaster, where (1) reputation represented a pressing strategic and competitive issue; and (2), because of this salience, actors engaged in forms of talk and writing where reputation was often the 'object' (Parker 1992); and (3) where reputation was either central to, or background component of, dominant organization discourses (i.e. those created by managers and leading medical professionals).

[INSERT FIGURE 1 HERE].

The Relevance of the BRI Case

At first, the BRI tragedy may appear tangential to the interpretative study of REs, and their foundations in discourse. In this section of the article, I explore why the case is actually an apposite case for such an endeavour.

RDs play an important role in the shaping of organizational, market, and actor relations within healthcare. Changes in reputation and status (whether good or bad) can dramatically alter the ability of a hospital, medical contractor, or individual practitioner to attract referrals, contracts with 'health purchasers', commercial sponsorship, research funding and charitable patronage. While there have been studies within organization theory of the effects these discourses and dialogues have upon relations between contractors in health markets (see ostensibly: Flynn et al. 1996; Ferlie et al. 1996); there has been little or no research thus far to document the workings of these RDs *within* complex health organizations, such as a modern NHS Trust, or, as in this case, the BRI and its parent NHS Trust – the United Bristol Healthcare Trust (or "UBHT").

Much has been made of the ways in which the principal actors in the BRI disaster, heart surgeons Mr. James Wisheart and Mr. Janardan Dhasmana, and their medical and managerial colleagues, became 'entrapped' or 'encased' by false sensemaking; denial of the situation; and a failure to recognise that clinical practices were placing lives at risk (see**: '**the Kennedy report 2001'; Weick and Sutcliffe 2003). The disaster literature *per se* would see the causes of this perceptual faltering as predominantly cultural (Weick and Sutcliffe 2003; also, indirectly, Brown and Jones 2000). While this is not in dispute, organizational cultures are composed of many things – including shared beliefs and forms of sensemaking that may have been shaped by engagements with and exposures to,

numerous organizational discourses and dialogues, including RD; and the impressions and images they create (Bromley 1993).

Furthermore, it is arguable that the themes of reputation, and *reputation building* were central to the tragedy. During the public inquiry that followed the BRI disaster, witnesses attested to how important securing a reputation for excellence in adult and paediatric cardiovascular surgery had become for the medical and surgical professionals involved in the tragedy; and how this search for excellence became a critical organizational and strategic issue for the BRI's parent NHS Trust – the United Bristol Healthcare Trust (UBHT). Transcript data also points to major fissures within this community, which partly arose from disagreements about the reputation, status and ergo, the *safety* of the BRI versus other UK and international hospitals, particularly those thought to in the vanguard of cardiovascular surgery and cardiovascular medicine.

Whilst the UK NHS may have 'moved on' since the BRI disaster, the case nevertheless has much to say about the ways in which actors *interact* with powerful organizational discourses and dialogues, such as RD; but also those associated with transformational change, performance enhancement, excellence, and at a broader level, the NPM. The lessons provided by the BRI disaster are highly relevant, moreover, to the contemporary NHS scene, within which it has become of paramount importance for hospitals, NHS Trusts and, in particular, the new, controversial, generation of 'Foundation Hospitals' to show that they are working towards achieving excellence in clinical care, clinical research, and organizational effectiveness and efficiency (Mueller et al. 2004).

NHS Trusts (and hospitals allied to them) are thus increasingly engaging in (1) 'targeted changes' that they hope will magnify their reputation, and 'brand image'; and (2) the kinds of jockeying for position that institutional economists sometimes refer to as 'reputational gaming'(see: Wilson 1985; and Raub and Weesie 1990; for simulations of reputational gaming in abstracted markets). There is, at present, very little research to record either the ways in which this 'ratcheting-up' of the 'reputational game' is being played out within NHS Hospitals Trusts; or the effects it is having upon organizational discourses, dialogues, sensemaking, and action.

Fieldwork and Methodology

Fieldwork

The fieldwork for this study is drawn from a broad analysis of texts from a public inquiry into the BRI disaster, held in Bristol and London, circa 1998-2001. The findings of this inquiry were published in the UK in 2001 (see: the 'Kennedy Report' 2001). The article synthesizes part of the fieldwork from this project - which has involved the content analysis of 69 transcripts, that recount testimony from approximately 74 witnesses, who gave evidence to the inquiry during a programme of public hearings held in Bristol, between March and December, 1999.

The aim of the research began as one of surfacing actors' cognizance and sensemaking of the disaster (Gephart 1993; Weick 1993; Brown and Jones 2000; Brown 2004), but, over time, this objective altered to one of understanding the role discourses, and in particular, Reputational Dialogues (RDs) played in influencing and altering the disaster's trajectory. Theoretical observations of what Phillips et al. (2004) describe as 'discursive institutionalization' have been honed from a process of reviewing these dialogues, as they are reproduced, and made sense of, within the transcripts.

Methodology

Organizational Discourse Analysis (ODA) has, of late, entered into a period of sustained resurgence - see, for example, recent commentaries by Boje et al. (2004); Grant and Hardy (2004); and Chia (2000). Studies situated within this genre of organizational research tend to rely on methods such as conversational analysis (Psathas 1995; Pomerantz and Fehr 1997; Iedema et al. 2004); narrative deconstruction (Brown 2004); and less often, 'content analysis' (Boje et al. 2004) to explore language, its construction, 'patternation', and meanings it attributes within organizational settings. ODA studies focus on the way texts (and the actors producing them) express, reify, legitimize, condone, reject, or "rule in" and "rule out" particular forms of thinking and action (Grant and Hardy 2004**;** Phillips et al. 2004 quoting Hall 2001:72). ODA thus primarily involves the study of the ways in which discourses (and the texts and dialogues associated with them) influence sensemaking and action (*see, for example*: Iedema et al. 2004). Often ODA is teamed with Critical Discourse Analysis (CDA) to produce studies of actor sensemaking, which reveal the hidden workings of institutions of power and control; and

with this hegemony, and inequality within organizations (Zanoni and Janssens 2004; Fairclough 1995).

This study of RD is foregrounded within the ODA tradition. While the study has involved a broad analysis of textual materials generated by the inquiry, including commissioned reports, the final report of the inquiry itself, evidence and where appropriate, witness statements, it has focused primarily on the 'content analysis' of witness transcripts (n=69, from a possible sample of 74). Content analysis has been criticized, in the past, for tending to produce overly-descriptive and rigid results (Silverman 1993). While this may be true of its uses in past research contexts, it served a useful purpose in this study: enabling the researcher to trace discursive threads within complex, lengthy and idiosyncratic transcripts that did not naturally avail themselves to conversational or narrative deconstruction (Brown 2004). Content analysis was, in many ways, one of few qualitative research methods which could be applied to trace these threads competently, within such a large and differentiated data sample.

The textual analysis of the transcripts followed a 'grounded approach' (Glaser and Strauss 1967; Strauss and Corbin 1990); beginning with a broad survey of the 'text' with the transcript for each day's hearing (n=74). Computerised notes were produced for each transcript, together with a series of short 'theoretical memos' (Brown 2004; see also: Glaser and Strauss 1967; Strauss and Corbin 1990). A series of data tables were then compiled. 'Reputational comments' appeared as one of the core thematic headings within the table. Other headings included 'audit' 'disclosure' 'management' and 'sensemaking of the situation'. This helped to identify 69 days and around 74 'witness accounts' where reputation emerged as a significant theme. The final sample was then analysed for content a second time. This simple process of content analysis helped to identify patterns of RD utilization that might otherwise have remained hidden.

It is acknowledged that there are some important limitations to both the data, and the uses to which it may be put. The witness testimony (from which the data has been compiled) provide us with contradictory, emotion-laden, and autobiographical 'snapshots' of life within the BRI and the tragedy which unfolded there. Witnesses to the inquiry gave evidence under intimidating conditions, and were required to reconstitute pictures of their sensemaking after a long period of time has elapsed, when memories of the disaster had eroded and, in some instances, become confused or complicated by what they have seen and heard since from other actors, and in the media. The transcripts do not therefore represent 'normalised conversance' but 'speech under scrutiny' (Fairclough 1995; Silverman 1993). These transcripts were, furthermore, 'constructed' within a formal

institutional setting and a courtroom steeped in the etiquette and majesty of the British legal system. In this instance, the inquiry courtroom was also a meeting place for two professional institutions: the legal profession and the medical profession. The 'languages' of both groups are play-out conspicuously within the transcripts.

The transcripts remain publicly available via the internet and it is thus possible to verify this research by visiting the inquiry's website. Quotations and inferences have been faithfully reproduced. The sample, whilst not fully representative of all witnesses, is nevertheless valid as it draws on a high proportion of the transcripts and it is possible to see, within the sample, the *replication* from actor to actor of commensurate forms of sensemaking. The potential for unconscious researcher bias and selectivity has also been taken into account.

The outcomes of the analysis, are not, however, immediately generalizable to other organizational situations, public inquiries or disasters. Nor do they enable us to comment on the linguistic construction of RDs. What the results do reveal, however, are some insights into actors utilization of RDs in their sensemaking; and with this, the direct and indirect bearings RDs may have had upon the tragedy, amongst the many other factors which have been identified within 'normative reanalyses' of the case (the 'Kennedy Report' 2001; Weick and Sutcliffe 2003).

Reputation Dialogues, Rhetoric, (and the Stories and Beliefs) they Created about the BRI

This section of the article concentrates on the emergence, within the transcripts, of RDs that focused on the BRI, and its reputation as (1) a provider of cardiac services to adults and children in the south-west of England; and (2) a centre for innovation in paediatric cardiac surgery. These RDs, evolved between multiple actors, who were caught-up in the tragedy at different intervals in its unfolding, between 1984 and 1995. Alongside this, the data reveals the extent to which RDs gave rise to powerful Rhetoric's of Reputational Comparison (RRCs), which were intertwined with, and kept 'in play' persistent Reputational Storylines (RSs) about the BRI. There were also a number of important Reputation Effects (REs) illustrated within the data. REs represented courses of action which were either directly or indirectly influenced by actors' engagement in RDs; and, by dint, RRCs and RSs. It is argued here that REs represent the 'bridging point' between the sphere of language, discourse, story, and rhetoric; and the sphere of action. It is also

arguable that some of these REs helped to define and shape the sensemaking and actions of those caught in the tragedy. *Figure 2* represents this process.

[INSERT FIGURE 2 HERE]

Context

Funding Changes

Before looking at patterns of RD, rhetoric, stories, and their effects in turn, it is worth exploring some points of context. The tragedy can be traced back to the reform of the market for Paediatric Cardiac Surgical services (hereafter referred to as PCS) in 1983-84; and the creation at that time of a centralized government funding scheme (known as the Supra Regional Services scheme – SRS) that encouraged hospitals engaged in PCS work to bid for 'centre of excellence' status. As the following analysis reveals, the PCS specialty emerged from this period of change as an environment predominated by RRCs within which comparisons of 'excellence' and 'non-excellence' become a central preoccupation.

Changes within the Local Health Economy

Changes to the organization and management of the local health economy, and the creation of the UBHT as a 'first wave' NHS trust also contextualised the tragedy. Under the auspices of the trust's Chief Executive, Dr. John Roylance, the UBHT became an early pioneer of 'doctors into management' (Thorne 2000). Hospitals within the trust, including the BRI, underwent a radical NPM-style transformation (Ferlie et al. 1996; McNulty and Ferlie 2004). However, these changes appear to have left old medical hierarchies and cultures intact (see: 'the Kennedy Report' – 2001).

Clinical Data

The tragedy also took place at a time when routine 'process and outcome' data were hard to come by within the PCS speciality; British PCS centres were not required to disclose information about clinical safety and performance; and the quality of surgical outcomes were considered difficult to benchmark (see: day 60, evidence of Professor Marc de Leval). There was, as a result, something of a 'data vacuum' within specialities aligned to PCS. Surgeons and cardiologists associated with PCS were extremely guarded about their

results and did not, as a rule, publicize negative outcomes (see day 84, testimony of Mr. Janardan Dhasmana). Past personal experience was seen as the best 'yardstick' a surgeon or cardiologist could use to judge the quality and reliability of their own work.

The Medico-Culture within PCS

As a medico-surgical discipline, PCS brought together a community of diverse actors that is to say cardiac nurses, surgeons, cardiologists, anaesthetists, and the 'perfusionists' who run heart bypass machines in surgical theatres. Notably, specialty demarcations lines were maintained between these groups of professionals (the idea of multidisciplinary team working being somewhat in its infancy). Actors in the PCS field, did however, invest great store in the relationships with those they had trained with, or worked alongside, within their respective medical 'firm'.

Knowledge of Performance at PCS Centres

It seems from the data, that actors formed opinions about the performance of *their* PCS service versus others mostly via informal and anecdotal mechanisms such as talking to one another in meetings, sharing gossip and hearsay with immediate 'likeminded' colleagues; reading medical publications; and by judging their own performance against what they knew of the 'national picture'. Statistical performance data was crude and unreliable at the time, and generally mistrusted (see: Spiegelhalter 1999; 2000). Crucially, in this ambiguous environment, actors could not hope to make accurate judgements about their own clinical performance or the performance levels attained at other PCS centres. This also meant that performance and safety records could not be authoritatively scrutinized nor challenged.

Main Findings

The Use of Reputational Rhetoric

The transcripts suggest that surgeons and cardiologists within the PCS specialty used talk about reputation a great deal and were both participants in, and producers of, dialogues involving RRCs. Primarily, actors utilized RRCs to judge the 'state of play' within the field; and to establish a sense of their own position within it. REs and RSs were both grounded in, and fed into, these RRCs. Overall, it is argued here that RRCs were pivotal in shaping some of the central reputational images, impression and stories that may have

influenced actors' sensemaking of the BRI's PCS service and the risks it presented. The analysis also points to the emergence of four sets of REs and RSs which were grounded within, and contributed to, these RRCs. A full account of REs and RSs is depicted in *Table 1*. A discussion of key highlights from this table and, what it illustrates, now follows.

[PLEASE INSERT TABLE 1 HERE]

Table 1 shows how each RE was constructed upon a series of storylines that created persistent images and impressions of the BRI and other PCS centre's reputations.

RE 1: 'Symbolic Hierarchies' and League Table Analogies

RE 1 involves a series of persistent images, impressions and stories of the comparative standing of British and overseas PCS centres, which arose from the exchange of four discernable RSs **[**see: ***RS 1-4*****]**. The reputations of these centres were compared, foremostly, using a 'league table' analogy – (see for instance witness contributions on days: 10, 12, 14, 15, 18, 21, 29, 31, 50, 64, 70, 87, 88, 89, and 94). Witnesses described how the PCS specialty was (and remains) divided between 'elite' and 'non elite' centres **[*RS 2*]**. The BRI was, by most estimations, a non-elite centre [***RS 3***].

In the illustration shown below, on day 13, Department of Health (DoH) official, Dr. Norman Pryde-Halliday uses the metaphor of a 'star that does not shine' to denote feelings about the BRI's standing within the PCS speciality. Note the way in which he assumes this is a consensus view and the comparisons which are made between the BRI and the 'elite centre' at Harefield:

Quotation 1

Q. Can you help me with the whole question of geographical considerations and weakness? Is what you are saying that the track record in terms of numbers of operations done was not really a justification for Bristol becoming a supra-regional centre?

A. Well, it certainly did not perform anything like on a par with the other units, no.

Q. It is very difficult to see how three open heart operations would justify that?

A. Well, if you look at those figures again, you will see it actually goes 10, 11, 3, and so on, so there might have been a good reason, a management reason, for only doing 3 that year.

Q. But if one took 10, which was the highest it had been before 1984?

A. If you take 10, then you would have to look at outstanding units such as Harefield, who only did about 10 in those years.

Q. What then did you mean by "weakness?"

A. It was a small unit. They were not doing many operations. My division kept close contact with all the professions within the various specialties, and attending meetings of the Society and the College when dealing with paediatric cardiac surgery and cardiology,
Bristol did not actually shine as a star, whereas many of the other units such as Birmingham, Harefield, Brompton, Guy's, GOS, would stand out, so it did not seem to be one of the leading lights in this area.

Q. "Shine as a star" in what sense?
A. In terms of clinical work that was going on there, in terms of research, in terms of the results that they were getting.

Q. So we have a unit which is doing a small number, and you say it may well correspond with Harefield at 10, but obviously not at 3, a unit where the view was -- I will come back to the evidence for that in a moment -- that it was not a star; and the basis that you are telling me was decided by the Group to designate Bristol was geography?

Often it was a matter of 'atmospherics' rather than any real notion of performance that separated elite centres from the non-elite **[RS *4*].** As the quotation from day 18, evidence of Professor David Baum, illustrates, excellent/elite centres were thought to 'mark themselves out from the rest'. Note also the role played by gossip and grapevines in disseminating stories and beliefs about reputation:

Quotation 2
Q. So when you say it is based on a general atmospheric judgment of "This person is a good guy; this person is not such a good guy", what information actually lies behind those judgments?

A. Many strands. They would include a reputation of diagnostic skills. And how does that reputation get about? Well, there are the value of clinical meetings, the value of first- and second-hand discussions, the gossip network. So there would be diagnostic skills; there would be matters of professional courtesy; again, the gossip vine of how they are with parents who are worried about their sick child; how they are in terms of their relationship with their firm, with their juniors, as trainers, with their colleagues….

In sum RE 1, and the RSs connected with it, framed actor's conceptions of (1) the 'state of play' within PCS, as an international specialism; (2) how 'star centres' were 'leading the game'; and (3) the actions that would need to be taken in order to improve on, or maintain their 'ranking'. RE 1 was therefore embedded within, and energised by, dialogues and stories shaped by engagements with RRCs.

RE2: the 'Ratcheting up' of Pressures to 'be Excellent'

RE 2 involved impressions and images of what made a UK 'centre of excellence'. RE 2 followed the reform the British market for PCS work (c. 1989-1984) and the creation of nationally funded 'centres of excellence' via the SRS funding scheme. In **[RS *5*]** witnesses described the impact this had upon the speciality – how it was a mark of distinction to be awarded SRS funding; the competitions and rivalries it set up; and the sense of injustice felt by clinicians whose bids for SRS funding had been rejected and where therefore working outside of the scheme. Several witnesses also alluded to 'empire building' by hospitals and leading clinicians both within and outside of the SRS scheme **[RS *6*]** - see for instance evidence from days: 12, 13 and day 61. A further reputational storyline **[RS *7*]** focuses on Bristol, and consternation over the BRI's designation as a 'centre of excellence' in PCS (c. 1984-1994); and concerns about the quality of service it provided when compared to other centres of paediatric cardiac care in Cardiff, Leicester, Oxford, and Southampton.

A further storyline, **[RS *10*],** comprised of stories concerning proliferation, attempts to control the numbers of hospitals carrying out PCS surgical work; the failure of the SRS funding scheme; and its replacement with 'purchasing and providing' in 1994. In this storyline, actors came to see 'purchasing and providing' as a system which could allow the better PCS centres to trade on reputation *and* allow under performing centres to naturally fall be the wayside (see for instance evidence provided on days: 11, 12, and 13). Overall, **RE 2** encouraged actors to make judgements about, and question the legitimacy of, the decision to fund PCS work at the BRI, as a 'non-elite' centre.

RE 3: Reputation and Sensemaking about the 'Dangers' of Surgery at the BRI

RE 3 is extremely important to the case, and centres impressions, stories and images of safety, hazard and risk. A storyline emerges from the transcripts involving health officials and planners employed within regional, local, and national tiers of the NHS and the DoH **[RS *11*]** and the use of reputational rhetoric to try to increase referrals to the BRI; improve its publicity; and relieve waiting list problems.

The transcripts also raise a further storyline about concerns and rumours heard in planning and administrative tiers of the NHS; and of direct 'tip-offs' that went unheeded (see days 67 and 80: Dr. Bolsin's attempt to 'tip-off' two officials at the DoH). Several actors describe how they decided not to act or deferred action because the rumours they had heard seemed neither real nor credible **[RS *12*]**. This is illustrated, for example, in the

following extract from day 21 evidence of Professor Gareth Crompton, who is asked to comment on criticisms levelled by emeritus cardiologist, Professor Andrew Henderson, in a document circulated in Wales in 1986:

Quotation 3

Q. He refers, then, to referrals to centres without adequate surgery, and his view of Bristol is at page 6. We can see it in paragraph 9:

"It has been suggested elsewhere that Bristol provide [the service] ... Moreover, it is no secret that their surgical service is regarded as being at the bottom of the UK league for quality, and it is difficult to see how this problem could be resolved in the foreseeable future." Those are fairly strong words about fellow professionals operating not far away, are they not?

A. They are indeed.

Q. Did you speak to him about those words?

A. I was aware of his privately expressed views before this time. The problem was that he never ever offered me, or any of my colleagues, anyone in the Welsh Office, any evidence as to why he held these views; and in the absence of evidence, one would presume that what he had was hearsay. It was no basis for us, indeed, to advise the Secretary of State for Wales to ignore the strong policy advice which the Department of Health in London were getting, and in the reasoning behind the creation of the small number of supra-regional centres.

This rhetoric hung on a belief that the BRI was a low ranking centre *with potential* and that its problems were a matter of throughput, not quality **[RS *13*]**.

Witnesses, both within and outside of the BRI, recognised that it was 'generally thought of' as being at the bottom of the league, and therefore 'open to challenge' for its referral base **[RS *14*]**. This directs us towards [**RS *15***]: the impact reputation had upon the referral choices of clinicians. Throughout the period of interest to the inquiry (c. 1984-1995), the BRI's throughput of infant PCS cases was far lower than at other centres (see: Aylin et al. 2001; Spiegelhalter 1999; 2000). This was thought to have resulted from historic ties between clinicians in the south west and cardiac centres in London, Southampton and Birmingham (see for example: days 13 and 58); and the fact that the BRI was more expensive than, for example, centres in London (see: evidence of Mr. Graham Nix, days 22 and 23).

Importantly, both referring clinicians and parents were persuaded to either choose or discount the BRI as a potential treatment centre according to the RS's they heard (see again parents' evidence: transcripts 1-5).

In [**RS *18***], a storyline emerges in which developing a national profile in PCS became symbolically important within the BRI, from around 1969 onwards (see days: 78 and 94). Mention is also made within the transcripts of hopes that the BRI would eventually become a centre for heart transplantation **[RS *19*]** (see days: 33 and 90); and attempts to recruit an academic figurehead in PCS surgery to a chair at the Trust (see days: 30, 40, 61, 63, 69, 77 79, 81, 88, 89, 90, and 94).

After 1991-2, a belief generated that cardiac services could be the Trust's "jewel in the crown" (See: evidence of Dr. John Roylance, UBHT Chief Executive, day 26). The winning of SRS 'centre of excellence' status was thus seen an important accolade of distinction for the trust, and 'established clinicians' working within the BRI and the Bristol Royal Hospital for Sick Children (BRHSC) **[RS *20*]**.

A further reputation storyline, **[RS *21*],** deals with the development, over many years of a 'halo effect' that persuaded some established clinicians at the BRI/BRHSC to feel more confident about their performance and the quality of services they provided than was actually merited (see: 'the Kennedy Report- 2001', also Weick and Sutcliffe 2003). The transcripts contain lengthy discussions of this issue, and how leading cardiothoracic surgeons' Mr. James Wisheart and Mr. Janardan Dhasmana - played down the significance of adverse surgical outcomes at several points in the development of the tragedy: in 1986-87 when complaints about the service came to light in Wales; when Dr. Bolsin began vocalising his concerns in 1989-90; on the publication of several scathing attacks on the service in Private Eye magazine (c. 1992); and when problems began to be talked about by wider audiences in Bristol, the cardiac fraternity, the NHS and national news media (c. 1992- 1995).

A storyline also emerges in which surgeons at the BRI attempted to develop parity with surgeons at other centres **[RS *23*].** This search for parity encouraged Wisheart and Dhasmana to introduce new techniques such as the neo-natal and infant arterial switch operations - but into a context where these innovations could not be sustained without major additional investments in the service *and* retraining. When problems were encountered they were attributed them to the affects of a 'learning curve' - that it was assumed other centres which had introduced the switches were also going through **[RS *24*].**

The surgeons did not recognise that their experiences were adrift from the rest of the specialty – but this is perhaps to be expected, given the contexts and cultures of the time. Assumptions were also made about the case mix of the BRI, which was thought to

be more complex and high risk than at other centres **[RS *25*].** This belief has since been revealed as something of a myth (see: Aylin et al. 2001; Spiegelhalter 1999 and 2000).

Established clinicians at the BRI also invested great faith in local experience – basing their sense of well-being and progress 'in the here and now' upon the currency of past successes [**RS *26***]. The centre demonstrated excellent results for simple open and closed operations. Principal consultant surgeon James Wisheart had pioneered the introduction of the Doppler technique into Britain in the late 1970s (see day 80, evidence of Dr. Stephen Bolsin). The storyline here is thus one in which past track records provided false comfort.

The sensemaking of established clinicians and managers at the BRI was fundamentally challenged by the arrival of 'new entrant consultants' from other adult cardiac and PCS centres (c. 1988-1995). The storyline which emerges from this involves a clash of mindsets between new and established consultant staff (**RS *27*** - see days: 63, 80, and 72). Critically, new entrant consultants began to compare practices at the BRI with those of other centres they had worked for and trained at, including the 'elites'. 'New entrant consultants' were able to spot out-dated and potentially dangerous practices that were not obvious to established clinicians and managers (see: days: 61, 63, 72, 74).

Quotation 4

As an illustration of this, on day 63, cardiothoracic consultant, Mr. Bryan, comments on the culture he found at the BRI. Note how he identifies himself as part of the 'new consultant group' and the implied use of the 'league analogy':

A. I think I would stand by that statement. In my view, at
that time, a culture existed of explaining or justifying what I would see as mediocre or poor results on the basis of case severity, rather than directing attention to producing better results.

Q. There were two paediatric cardiac surgeons?

A. I think that I would not really say that necessarily applied to just paediatric cardiac surgery. I would say that applied to cardiac surgery: adult and paediatric.

Q. In Bristol?

A. Yes, I believe it did, yes.

Q. Did it apply generally throughout the consultants who were there at that time, or is there anyone you would absolve from such a culture?

A. Not really. I think I would stand by that.

Q. Did that apply to Professor Angelini?

A. No, I think I am talking about -- he obviously did not write this. You see, what happened in 1993, and I think that this is important, was that a group people and a significant number of people came from outside Bristol. That had not happened for some years. A group of people who had been practising both in surgery and in anaesthesia in a number of major centres throughout the world, all in different areas, and they would be Professor Angelini, myself, Dr Davies the anaesthetist and Dr Pryn. This was a group of people who all had had experience of contemporary cardiothoracic surgical practice in quite major international centres, and knew what could be achieved in cardiac surgery both in adults and in children. They were familiar with contemporary cardiac surgical practice. I believe that the people that were working in Bristol at the time were not that familiar with what could be achieved, because many of them had been there for some years, many of them had not had experience in contemporary cardiac surgical practice.

It is fairly certain that the tragedy was lengthened by the intransigence that set in between new and established consultant groups, and an inability on the behalf of Mr. James Wisheart, and other established actors, to accept criticism from new colleagues (see: 'Kennedy Report' 2001; Weick and Sutcliffe 2003).

Storyline [**RS *28*]** involves a growing awareness of tensions within the consultant group and anxieties amongst nursing, managerial, and counselling staff. Several members of the BRI's nursing staff described how they became aware that the BRI 'lagged' behind other centres in some aspects of clinical practice (see days: 32, 46 and 59, evidence of Sister Kay Armstrong).

Thus we have a picture of *divided sensemaking* within the BRI and the UBHT from around 1988 onwards– which was also reflected in ongoing discussions outside of Bristol (see **RE 4**, shown below). Importantly, established clinicians and to a certain extent, some managers and nurses, did not question the safety and reliability of their performance record until they were joined by colleagues from other centres in the PCS speciality (see for instance, testimony of Dr. Masey, day 74 line 58). Established actors seem also to have held on to an image of their reputation and the 'state of play' at other centres that was outdated. They had also seemingly lost touch with the direction of change within the speciality.

RE 4: The Rumour Mill

The 'rumour mill' played an extremely important role throughout the tragedy **[RS *29*],** and was central to the garnering of concerns outside of the BRI/UBHT (c. 1984-1995). The evidence suggests that many actors outside of the BRI/UBHT heard conflicting rumours, 'grumbles' and inflammatory stories about the BRI over quite a long period of time (see, for example evidence of Catherine Hawkins CBE, day 56; and the evidence of Dr. Phil Hammond, day 64).Other witnesses do not appear to have been quite as well

'networked' into the professional grapevines that were actively disseminating gossip and hearsay (see days: 7, 18).

Quotation 5

Here, Dr. Phil Hammond, comments on his knowledge of rumours about the BRI. Note that he was the author of a series of articles published in Private Eye, and thus heavily instrumental in publicizing the case. Note also the use of 'consensus' to justify interpretation: *everybody knew* about Bristol, and, ergo, the stories must be true:

A. I would also say that when I talked to people in other units, it was quite common for anaesthetists to be operating with a surgeon and to say, "Why has this baby bypassed Bristol?" Over the years I have had this general comment from the Hammersmith, Brompton, Guys, Southampton, Oxford and Cardiff as a sender, where anaesthetists have queried why babies are not going to Bristol. There have been some quite harsh comments which I could not possibly repeat because I think they would be libellous, and there were some general comments that for this sort of operation, you do not go to Bristol, as in "everyone knows about Bristol". I do not think that people would necessarily know specific results for specific operations, but my general feeling at that time is that it was known within the community that it was not the place, for example, to send your own children.

Witnesses were also asked to comment on two 'conspiratorial aspects' of the tragedy: the leaking of rumours about the BRI to the press and specifically Private Eye Magazine (see days 18 30, 61, 64, 66, and 76); and rumours of institutional collusion and Freemasonry (see days: 18, 62, and 80). The above were catalysed within a storyline about 'whisper campaigns' and 'corridor conversations' **[RS *30*].**

Finally, the activities of Dr. Stephen Bolsin – his clandestine audit and tendency to 'talk openly' with 'likeminded people' within and outside the BRI created a storyline of its own [**RS *31*] -** see days 24, 30, 32, 41, 46, 60, 61, 62, 64, 67, 69, 72, 74, 75, 76, 79, 80, 81, 82, 83, 86, 88, 89, 90, 91, 92, 94, and especially 59, 63, 87. His raising of concerns, circa 1989-1994, led to rumours and gossip within the BRI, which was then picked up by officials at the DoH; clinicians at other centres; and by journalists in the British media (see for example days: 64, 67, and *evidence of doctors Doyle* and *Ashwell* - day 87). Dr. Bolsin's talk is thought to have fuelled many of the stories noted by Dr. Hammond and other witnesses. **RE 4** thus incurred enormous effects upon perceptions of safety at the BRI (c. 1988-1995); and how professionals and parents appraised the risks entailed by surgery and post-operative care.

Comments on the Case

Previous re-analyses of the BRI case have focused upon the operational and cultural antecedents of the disaster, and, in the case of the latter, the effects wrought by intransigence within the BRI/UBHT's austere professional and organizational hierarchies (the Kennedy Report 2001; Weick and Sutcliffe 2003). In this article, an attempt has been made to add to this existing knowledge base via a consideration of the effects rendered by RDs, RRCs, RSs and concomitant REs, involving a wide and diverse audience of actors from both within, and without, the BRI / UBHT. The research has traced the emergence of complex patternations of RDs, RRCs, RSs and REs, that spanned conventional organizational boundaries; and infused talk within numerous interpersonal actor networks.

Overall, the analysis points to the manifestation of four important REs and 31 RSs *crafted upon* and *located within* complex RRCs [see again: **Table 2**] across the timeframe of the disaster (c.1984-1995). RDs acted as creators of, and transmission belts for, the dissemination of this rhetoric, and associated REs and RSs. It is arguable, on this basis, that RDs represented important 'discursive devices' of institutionalization within the context of the tragedy (Phillips et al. 2004). So, for example, the rhetoric and storylines associated with **RE 1**, institutionalized perceptions of the excellence or otherwise of PCS centres, and helped identify the BRI as a non-elite, low ranking centre. In **RE 2**, witnesses described the effects reorganization of the market had upon the PCS speciality. This appears to have institutionalized the belief, amongst some actors, that the BRI was not a legitimate centre of excellence. Stories about the reputation of PCS at the BRI (whether good or bad) seem also to have influenced referral choices and perceptions of risk.

By the same token, **RE 3** included a number of storylines in which images, impressions and stories centring on reputation were used to assess risk and judge safety. **RE 3** also shows how 'new entrant consultants' at the BRI/UBHT worked with a different, more 'contemporary' reputational rhetoric than their established colleagues, and because of this, were better able to compare the *quality gap* between the BRI and other centres. This points to the existing of competing RDs (particularly after 1988) - one parochial and local to the BRI/UBHT; and the other situated in the 'wider field' of PCS. Critically, these RDs presented fundamentally different portraits of safety at the BRI.

Storylines associated with **RE 4** illustrate the effects gossip, rumours, and an emerging sense of conspiracy had upon the tragedy. Storylines in **RE 4** also show how damaging these rumours were to the reputations of established clinicians, managers at the BRI, and whistleblowers, such as Dr. Stephen Bolsin. Importantly, one can also note

changes in attitudes to gossip as the tragedy unfolded. To begin with, rumours and press speculation were regarded as libellous and unsubstantiated (c.1984-1993), but become more widely accepted and believed as time went on, and more actors began to raise concerns. We may also see at this juncture an emergent shift, as the old 'parochial sensemaking' associated with established clinicians was gradually censured and then replaced, by that of a new cadre of clinicians.

Taken in the round, the evidence points to an important reality: in hospital settings RRCs, RSs, REs, and dialogues about reputation represent powerful, image and 'impression-creating' institutions. In the BRI case, these institutional forces appear to have firstly helped to institutionalize 'local' beliefs about quality, safety, risk and standing (c. 1984 -1988); but also helped to alter them, after this 'cut off point' when a new corps of clinicians began to join the BRI/UBHT. RDs and their by-product seem also to have played a part in the decisions and choices made by clinicians – both established and new – and, crucially, the advice they then gave to parents of 'special heart babies'.

Theoretical Implications

The study of organizational discourses and dialogues, and the contributions both make to the creation, promulgation, and institutionalization of the institutions that influence action is a developing discipline within organization theory (Phillips et al 2004; Barley and Tolbert 1997). This study has attempted to shed some initial light upon the workings of one form of institution (the RE); arguing that it is interpretatively founded, within RDs. The article has also attempted to show how these RDs may create stories, and forms of rhetoric upon which REs are predicated. The study suggests, moreover, that REs represent the bridging points between talk and writing about reputation; the stories and rhetoric they produce; and sensemaking and action. The argue presented here is that REs come into existence when rhetoric and story are utilized 'in the moment' of decision-making. These decisions then act as preludes for actions and inactions. RES, it is argued, are the end product of a process which involves at least two other institutions – namely story-telling about reputation; and reputational rhetoric. The order in which these precursor institutions are produce may be interchangeable and context specific. Thus in the BRI case, we can conceive of a process of institutionalization that evolved along the following lines (see also *Figure 2*):

Stage 1: the evolution, over time, of 'market related' and professionally orientated patterns of RD (i.e. discussions about the quality of service provided by particular hospitals, the skills of a particular surgeon).

Stage 2: the evolution, over time, of *Rhetoric's of Reputational Comparison* (RRCs) in which the BRI's reputation was compared, often unfavourably, to those of other UK and overseas hospitals providing care for 'special heart babies'. RRCs represent 'an institution' because, in this instance, they encouraged conformity to particular ways of thinking about the BRI and its competitors; and created powerful and persistent images to support these processes.

Stage 3: involved the development, and articulation, over time, of a series of *Reputational Storylines* (RSs) about standards of care afforded to both adult and paediatric cardiac patients the BRI. These stories fed into, but were also an intrinsic to these RRCs. Importantly, as an institution, RSs created persistent images and impressions of performance, that 'stuck' with actors. However, over time, RSs that supported beliefs that the BRI was safe were replaced by countervailing stories and images that encouraged actors to believe it was unsafe. RSs were thus important to both the institutionalization of the prevailing 'local' hegemony within heart surgery at the BRI; and its eventual redundancy. (One might suggest, tentatively, on this basis that observing changes in story telling within organizations could be a good way of charting institutional change).

Stages two and three represent spaces in which powerful discourse-fashioned institutions were created, communicated, reproduced, and altered through the exchange of different forms of 'text' between actors. Talk was by far, but not always, the most powerful textual 'institutionalizing media' operating within the organizational context of the BRI disaster.

Stage 4: arose when stages two and three were combined. Together, the institutions conceived in stages 2 and 3 created REs – or powerful *images* and *impressions* that actors drew upon when making-sense of the 'state-of-play' at the BRI; and formulating judgements and courses of action (and inaction) based on this cognition.

Contribution to Wider Research

In relating this back to the wider institutionalization research, one can see within the BRI story, a general affirmation of Phillips et al. (2004) commentary on discourses and institutionalization. There is also a sense in which their model is played out in the story: an organization finds itself in crisis; and dominant institutions undergo change in order that they can survive. Old mind sets are rejected (or at least attenuated), over a long period of time; this is accompanied by concomitant changes in the discourses that prevailed at the UBHT; which now claims to be a transformed organization (Kennedy Report 2001). However, what this research really suggests it that there is scope for developing an interpretative, discourse-analytic take on institutionalization that recognises the power that story, rhetoric, and imagery have within these processes. Where RE research is concerned, the outcomes of this study suggest that it is possible to derive interpretative insights into a phenomena that has primarily been evaluated using mathematical and game theoretic approaches and methodologies.

Conclusions and Policy Implications

The reform and modernization of the UK NHS has been accompanied by a series of disasters which may lead us to doubt the salience and safety of the NPM project. In the UK NHS, hospital managers and clinicians are under increasing pressure to not only demonstrate evidence of good performance, but also 'prove their worth' and build excellent reputations. The NHS, alongside other areas of the NPM-reformed public services, is thus increasingly dominated by 'league table-ism'. This may be creating a 'ratchet effect' in which health organizations focus on doing what is necessary to impression manage perceptions of excellence, whilst in reality, services remain over-stretched and at risk.

RDs exist naturally within health organizations – they are an important feature of the organizational discourses that pervade hospitals, and health markets, and are implicit to the social construction of relationships between actors in these settings, defining, for

example whether a doctor can be 'recommended' or not. However, this 'natural' state of affairs has been altered somewhat by the introduction of the NPM, and with it discourses and doctrines of performance, change, and excellence. The NPM has set up RDs which focus not just on the clinical merits of professionals and the health organizations for which they work, but are also imbued with notions of organization prowess; and expectations of excellence that many real world organizations find it hard to live up to. It is important for policy-makers to take on board these observations when setting up agendas for change and modernization (i.e. by taking note of the reputational pressures they create).

In the Bristol case, we have an early example of the effects the introduction of NPM, and concomitant notions of performativity and excellence have had upon the construction of RDs and the roles they serve within healthcare settings. While clinicians at the BRI may always have wanted to be seen in good or excellent light by their peers at other hospitals, the introduction of the SRS funding scheme (an NPM device), meant that reputation was associated more directly with funding rationale, from 1984 onwards. The case illustrates, in many ways, how issues of reputation and performativity are closely interwoven. There is a need for further research to explore this inter-relationship. This research might also seek to identify the mechanism that translate and turn the stories, images, and effects generated by RDs into concrete beliefs about reputation and performance; and further investigate how it is that these beliefs come to underline, suffuse, and be incorporated within, performance 'league tables'.

Note on Disaster Theory

This article has attempted to show how the RE, and related discursively fashioned institutions influenced, along with other stimuli, processes of sensemaking and decision-taking in the BRI disaster. In particular, RDs, RRCs, RSs and REs, helped to create impressions and images of safety, risk, and quality that enabled established clinicians at the BRI to wrongly view their practices as safe. At the same time, new entrants to the BRI/UBHT were able to use their reputational knowledges to spot risks not seen by the established clinicians. This suggests that future research into disaster sensemaking, should include some form of analysis of the role played by 'reputational institutions' in creating sensory myopias. Furthermore, it is arguable that this research has implications for both notions of 'success breeding failure' Miller (1992) and Barry Turner's (1976) work on the 'failure of foresight' within bureaucratic (and post-bureaucratic) organizations. It is

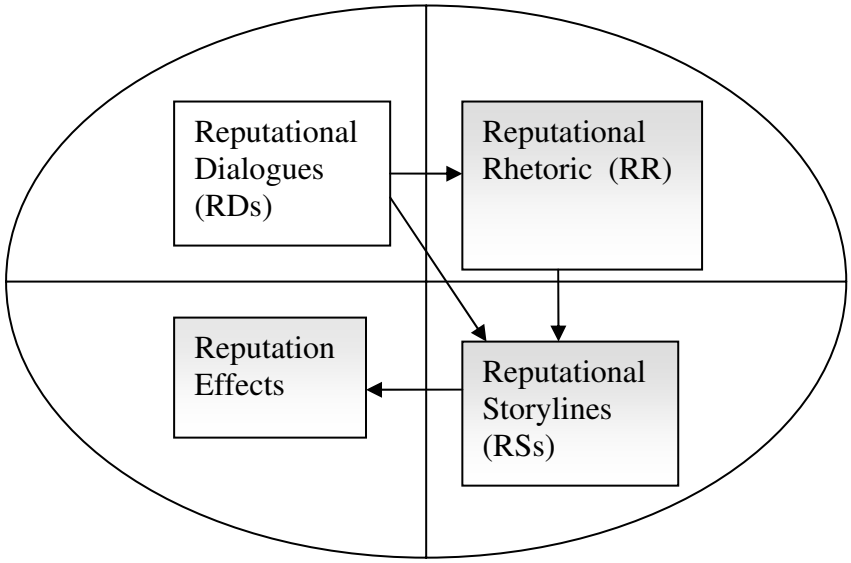
reasonable to suggest that, in some circumstances the utilization of RRCs, RSs and REs might encourage organizations to overreach; overplay hands, create crises; and, in the worst scenarios, emancipate full blown disasters. Clearly, there is a need for further research to ascertain the strengths and limitations of this observation.

Table 1: Reputation Effects and Reputational Storylines Underlining the BRI Tragedy

Reputation Effects (REs)	Reputational Storylines (RSs) crafted in relation to a 'Rhetoric of Reputational Comparisons' RRC	
RE 1: 'Symbolic Hierarchies' and league table analogies	**RS 1**- comparison of standing using a league table analogy	*These RSs were used within the transcripts to:* - justify and defend decisions on funding - determine 'notional assumptions' about quality of care - identify the 'ranking' of centres and surgeons within the specialty - explain why the BRI was thought to be at the bottom of the league/lagging behind - explain why the BRI was treated as a special case - justify favourable treatment for 'elite' centres
	RS 2 - stories about elite centres	
	RS 3 - stories about 'low ranking' non-elite centres	
	RS 4 - a question of 'atmospherics'	
RE 2: the reorganization of PCS funding	**RS 5** - the impact of 'centres of excellence'	
	RS 6 - empire building	
	RS 7 - questioning of the BRI's status as a 'centre of excellence'	
	RS 8 - the geographic argument	
	RS 9 - tolerating low throughput	
	RS 10 - proliferation	
	RS 11 - planners dismiss concerns as politicking between centres	

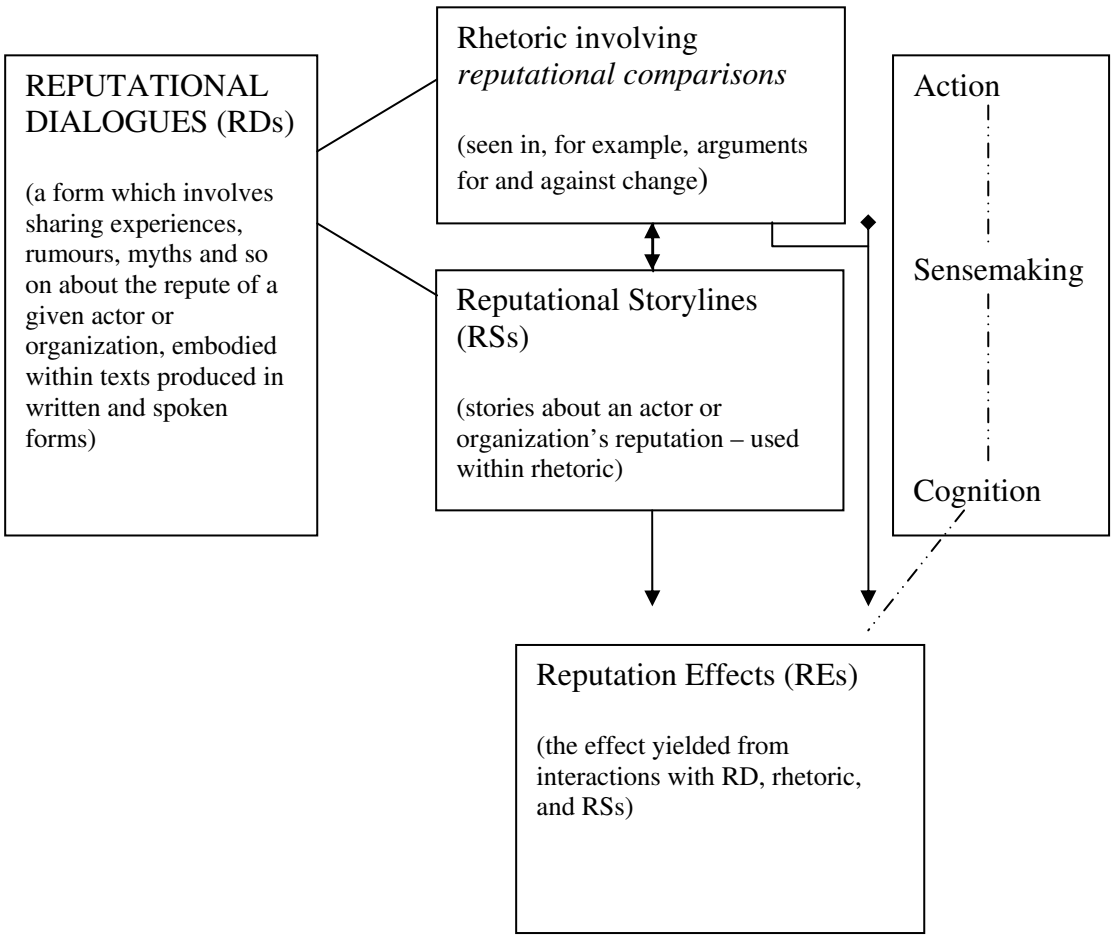
RE 3: sensemaking and recognition of dangers at the BRI	**RS 12** - Not acting on rumours	*Depending on the witness, these RSs were used to:* - develop and fulfil strategic agendas - defend decisions to either intervene, not intervene or delay action And/or to: - defend *interpretations* of statistics and other sources of 'data' about safety, risk and performance - derive comfort; - explains concerns, 'emotional states' and anxieties - defend, compare or criticise practices and cultures
	RS 13 - the BRI' s problems were a matter of throughput, not quality	
	RS 14 - the BRI becomes open to challenge from rival centres	
	RS 15 - stories about referral decisions and reputation	
	RS 16 - higher volume centres were 'safer'	
	RS 17 - the BRI treated a wider and more difficult case mix than other centres	
	RS 18 - the symbolic virtues of having a national profile in PCS	
	RS 19 - the symbolic virtues of becoming a transplantation centre	
	RS 20 - SRS status is seen as an accolade of distinction and merit/ the jewel in the crown metaphor	
	RS 21 - the halo effect	
	RS 22 - comparing track records in isolation	
	RS 23 - developing parity with surgeons at other centres	
	RS 24 - the learning curve assumed to be happening elsewhere	
	RS 25 - the BRI was thought to be doing more complex and high risk cases than other centres	
	RS 26 - past success provides false comfort	
	RS 27 - 'new entrant consultant' start seeing gaps between the BRI and other PCS centres	
	RS 28 - anxieties grow amongst managerial, nursing, and counselling staff	
RE 4: the 'rumour mill'	**RS 29** – stories and gossip which circulated via the rumour mill or grapevine	*These stories were used to:* - illustrate consensus and individual beliefs - show how concerns were dismissed/not taken seriously - explore how the situation magnified and became out of control - show how damaging rumours and accusations of conspiracy and wrongdoing affected referrals, contracts, relations between actors, emotional and cognitive states.
	RS 30 - whisper campaigns and corridor conversations	
	RS 31 - Dr. Bolsin's comments create a reputation effect of their own.	

Figure 1: Reputational Dialogues (RDs) - Creation of By-Products / Institutions



Key: Grey = an institutional by-product of RD.

Figure 2: Reputational Dialogues (RDs) and the Institutionalization of RD 'By-Products'



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