When small bandages fail:

The field-level repair of severe and protracted institutional breaches

Andrea Herepath

Lancaster University Management School, Lancaster University, UK

Martin Kitchener

Cardiff Business School, Cardiff University, UK

Abstract

We present the first elaboration of the field-level institutional repair work enacted by government inquiry reports into severe and protracted breaches of the institution of medicine in the English National Health Service. Our examination of the interplay between the rhetorical argumentation strategies communicated, the modes and types of institutional work conveyed, and the institutional pillars targeted for repair enhances understanding of field-level institutional repair work in three ways. First, our analysis of

forensic and deliberative rhetoric reveals how these communicate aligned ethos, logos, and pathos appeals in a tactical buttressing manner that simultaneously harnesses maintenance, adapted creative and disruptive modes of institutional work. Ensuing repair work is primarily directed to the regulatory and normative pillars of the breached institution, though their consequential effects seek to realign the cultural-cognitive pillar. Second, adapted creative and disruptive modes interact to generate *elaborative* and/or *eliminative* institutional work. This fosters a dynamic form of institutional maintenance, wherein the breached institution evolves in order to endure within the changing terrain of the field. Finally, our elaboration of field-level institutional repair work offers insight into the relative plasticity of the institution of medicine, and contributes to understanding of the dark side of institutional work.

Introduction

Within institutional analysts' efforts to elaborate maintenance work (Lawrence, Suddaby, & Leca, 2009), recent empirical studies have enhanced our knowledge of the repair work enacted in response to 'breaches' of an institution's rules, normative behaviours, and taken for granted beliefs (Clark & Newell, 2013; Heaphy, 2013, p. 1292; Micelotta & Washington, 2013). Previously, breaches were most typically portrayed as opportunities to turn institutional 'wrinkles' into more significant 'tears' that could justify or enable change to existing arrangements (Reay, Golden-Biddle, & Germann, 2006, p. 994). More recent investigations of institutional breaches suggest that relatively minor cases are typically 'patched up' (Lok & de Rond, 213, p.186) or 'ironed out' (Dacin, Munir, & Tracey, 2010) through situated (local) institutional repair work that contains the breach so that institutional change does not occur.

The few, recent, studies of more major institutional breaches report that complex restorative interventions are required to achieve situated repair. These can include justifying the breach in terms of unique contextual circumstances (Lok & de Rond, 2013), negotiating the regeneration or recreation of institutional arrangements (Currie, Lockett, Finn, Martin, & Waring, 2012), and reversing an imposed institutional change to re-establish the *status quo ante* (Micelotta & Washington, 2013). Despite some variety in the nature of the major breaches reported, the outcomes are typically portrayed as 'success stories' involving the 'institutional workers' directly implicated

in, or affected by, the breach achieving situated repair (Kraatz, 2011, p. 59; Micelotta & Washington, 2013, p. 1159). Left unattended are situations where attempts to put 'a small bandage on a gaping wound' not only fail to repair the breach but enable its continuation (Clarke & Newell, 2013, p. 129).

We lack understanding of the institutional work required to repair the most severe and protracted institutional breaches, where the loss of legitimacy of the social actors deemed to be responsible, compounded by reputational damage to the institutional field, render situated repair untenable (Desai, 2011; Lok & de Rond, 2013). Once publicly disclosed, such severe breaches function as highly disruptive field-wide events that can, in some contexts, prompt repair efforts by external actors through government inquiries (Elliott & McGuinness, 2002).

In this paper, we examine institutions' 'inner mechanisms' during the process of repair (Suddaby, 2010, p. 17). Our empirical focus is the field-level institutional repair work enacted by the 'active' texts of government inquiry reports: an approach that recognises the underlying agency of their authors (Brown, Ainsworth, & Grant, 2012, p. 316; Cooren, 2004; Warner, 2006, p. 225). Although research centred on this genre of texts has primarily contributed to enriching our understanding of their role as artefacts of authoritative sensemaking (Boudes & Laroche, 2009; Brown, 2004; Brown & Jones, 2000; Weick, 1993), their suitability for the study of institutional work has been demonstrated (Brown et al., 2012).

We undertake a comparative case study of six government inquiry reports into 'iconic scandals' in the English National Health Service (hereafter NHS), which, due to their severity and protracted nature, entered the collective memory as socially constructed metaphors for the failings of this healthcare system (Butler & Drakeford, 2005, p. 154). As these cases involve the murder, sexual abuse, and untoward deaths of patients, our study responds to calls to develop a more nuanced understanding of institutional repair work (Micelotta & Washington, 2013), notably in healthcare (Heaphy, 2013), through the use of extreme cases (Martí & Fernández, 2013).

We employ Aristotle's (1959) three classical rhetorical justifications: *ethos* (appeals to morality), *logos* (appeals to logic), and *pathos* (appeals to emotion). However, we focus these through forensic rhetoric (used to explain the causes of the severe breach) and deliberative rhetoric (used to convey the recommendations to effect repair) to examine the field-level institutional repair work enacted by government inquiry reports into severe and protracted breaches of the institution of medicine in the English NHS. In doing so, we analyse the interplay between the rhetorical argumentation strategies communicated to delegitimate and relegitimate breached institutionalised medical practices (Aristotle, 1959), the modes and types of institutional work conveyed (Lawrence & Suddaby, 2006), and the institutional pillars targeted for repair (Scott, 2008) to develop a deeper understanding of how institutional repair work is conducted at the field-level.

Our contribution enhances understanding of field-level institutional repair work in three ways. First, our analysis of forensic and deliberative rhetoric reveals how these forms of rhetoric communicate aligned ethos, logos, and pathos appeals in a tactical buttressing manner that simultaneously harnesses maintenance, adapted creative and disruptive modes of institutional work to rewrite the performance scripts of severely breached institutionalised medical practices. The ensuing repair work is primarily directed to the regulatory and normative pillars of the breached institution, though their consequential effects also seek to realign the cultural-cognitive pillar. In doing so, we demonstrate how texts enact 'theorization' to link cause to recommended repair in a one-to-many manner that increases the density of the repair to mitigate future breaches (Lawrence & Suddaby, 2006, p. 221). We also demonstrate that through teleological rhetoric these texts function as inter-field institutional arbiters to broker 'advocacy' for repair with and through other organisational actors embedded in the field.

Our second contribution develops a deeper understanding of how maintenance, adapted creative and disruptive modes of institutional work interact, through forensic and deliberative rhetorical appeals, to foster field-level institutional repair. We theorize that the latter two modes interact in *elaborative* and/or *eliminative* institutional work. These do not undermine the main architecture of the institution or re-establish the *status quo ante*. Instead, elaborative and/or eliminative field-level institutional repair work function to bring about incremental refinements to the breached institution, so that a

dynamic form of institutional maintenance results, enabling the breached institution to evolve and endure within the changing terrain of the field. Finally, our elaboration of field-level institutional repair work also offers insight into the 'relative plasticity' of institutions (Lok & de Rond, 2013, p. 205), and contributes to the literature on the dark side of institutional work by exemplifying the malign consequences of failures in situated repair.

The remainder of the paper is presented in four sections. First, we discuss recent developments in the study of institutional repair work, and outline the need for greater understanding of field-level institutional repair work. Second, we explain our comparative case design together with our approach to data collection and analysis. We then present two main sets of findings: (i) the forensic rhetorical appeals used to explain the causes of the severe and protracted breaches of the institution of medicine in the English NHS, and (ii) the deliberative rhetorical appeals used to effect field-level institutional repair. Finally, we present our elaboration of the field-level institutional repair work enacted by government inquiry reports, define our theoretical contribution, outline policy and practical implications, and make suggestions for further research.

Institutional Repair Work

Institutions are resilient, taken-for-granted, social prescriptions—the 'habitualized actions' (Berger & Luckmann, 1967, p. 54), 'performance scripts' (Jepperson, 1991, p. 145) and 'templates for action, cognition, and emotion' (Lawrence et al., 2011, p. 53)—

which guide the behaviour of actors (Greenwood, Díaz, Li, & Lorente, 2010; Suddaby & Greenwood, 2005). Simultaneously symbolic-linguistic and practice-material (Sillince & Barker, 2012), institutions may be viewed analytically as being composed of regulative, normative and cultural-cognitive 'pillars' that, together with associated activities and resources, provide stability and meaning to social life (Scott, 2008, p. 51, 79).

The regulative pillar is indicated by rules and laws, it draws on expediency as the basis of compliance, and claims legitimacy through legal sanction. The normative pillar is symbolised by values, norms and social expectations. These are exemplified by the practices defined in certified occupational standards, wherein compliance and legitimacy are anchored to social obligation and the moral appropriateness of action. The cultural-cognitive pillar is indicated by common beliefs, scripts and symbolic systems, which guide behaviour to foster adherence to socially constructed orthodox schemas (Scott, 2008). One important, yet sometimes overlooked, outcome of the understanding that the three pillars have discrete bases of action, compliance, and legitimacy, is that once breached, they may warrant different forms of institutional work to effect repair (Lawrence & Suddaby, 2006).

In response to the tendency toward structural determinism within early institutional analysis of organisations, the notion of 'institutional work' directs attention to the role of reflexive agency in creating, maintaining and disrupting institutions

(Lawrence & Suddaby, 2006; Lawrence et al., 2011; Lawrence, Leca, & Zilber, 2013). Within this foundational typology of institutional work, repair work has been conceptualised as a function of institutional maintenance work, and is integral to the support and recreation of the social mechanisms ensuring compliance with an institution's constituent pillars (Lawrence & Suddaby, 2006, p. 230; Scott, 2008).

Subsequent elaborations of the typology have linked three types of maintenance work with the repair and restoration of the regulatory pillar: 'enabling' (the creation of rules that facilitate, supplement and support institutions), 'policing' (ensuring compliance through enforcement, auditing and monitoring), and 'deterring' (establishing coercive barriers to institutional change). These are complemented by three further types directed to the normative and cultural-cognitive pillars: 'valourizing and demonizing' (providing positive and negative examples of the normative foundations of an institution), 'mythologizing' (preserving the normative underpinnings of an institution by creating and sustaining myths), and 'embedding and routinizing' (infusing the normative foundations of an institution into participants' day-to-day routines and organisational practices) (Lawrence & Suddaby, 2006, p. 230).

The 'simultaneous occurrence' of maintenance, creative and disruptive modes of institutional work draws into question their potential interplay in repair work (Empson, Cleaver, & Allen, 2013, p. 811; Micelotta & Washington, 2013, p. 1158). Creative institutional work is exemplified by three categories of activities: 'vesting', 'defining',

and 'advocacy' (overtly political work in which actors reconstruct rules, property rights and boundaries that define access to material resources); 'constructing identities', 'changing norms', and 'constructing networks' (actions in which actors' belief systems are reconfigured); and 'mimicry', 'theorzing', and 'education' (actions designed to alter abstract categoorisations in which the boundaries of meaning systems are altered). In contrast, disruptive institutional work is exemplified by: 'disconnecting sanctions' (working through state apparatus to disconnect rewards and sanctions from some sets of practices, technologies or rules); 'disassociating moral foundations' (disassociating the practice, rule or technology from its moral foundation as appropriate within a specific cultural context); and 'undermining assumptions and beliefs' (decreasing the perceived risks of innovation and differentiation by undermining core assumptions and beliefs) (Lawrence & Suddaby, 2006, p. 220-221, 235).

A recent study reveals that some forms of creative institutional work—'theorizing', 'defining', 'educating' and 'constructing normative networks'—are associated with institutional maintenance and repair work (Currie et al., 2012, p. 956). Similarly, disruptive work, enacted by undermining assumptions and beliefs to create 'safe spaces' for actors to work together, has been found to foster situated repair (Zietsma & Lawrence, 2010, p. 212). We therefore sought to further elaborate the nature of repair work, and its interplay with maintenance, creative and disruptive modes of institutional work.

From situated repair to field-level repair

When an institution and its associated practices are enacted in everyday praxis, the agency of actors may give rise to situated improvisation and institutional variation as they 'muddle through' their everyday actions (Raaijmakers, Vermeulen, Meeus, & Zietsma, 2015, p. 88; Smets, Morris, & Greenwood, 2012). This may occur inadvertently (Smets & Jarzabkowski, 2013), or with more purposeful intent (Reay et al., 2006). Variations viewed as beneficial to participants, once honed through collective experimentation and reflexive theorisation (Reay, Chreim, Golden-Biddle, Goodrick, Williams, Casebeer, Pablo, & Hinings, 2013), become embedded as a normal aspect of practice in that social context. Over time, they may be reinterpreted or redeployed to different arenas (Powell & Colyvas, 2008). But if the variation is perceived to breach one or more of the institution's pillars, focally implicated actors undertake varying degrees of situated repair work in order to 'mend' the unfolding situation and maintain the institution (Ramirez, 2013, p. 865).

The form of repair enacted is contingent on the context, nature and process history of the breach. For breaches that are relatively minor, isolated events, repair work is commonly enacted through a process of 'containment' (Lok & de Rond, 2013, p. 197). Here, the actions constituting the breach are simply ignored or tolerated within actors' reflexive normalisation and negotiation work. However, as institutions are interpreted and reinforced through individual observation and experiential learning (Dacin et al.,

2010), this minimal form of repair work may be perceived by actors to tacitly condone, and thus legitimise, institutional malpractice (Clark & Newell, 2013; Sminia, 2011).

A more effortful response to contain a minor breach is that of 'custodial work' (Dacin et al., 2010, p. 1407). In this form of situated repair, actors draw on social 'censorship mechanisms' to reinforce institutional expectations. This can occur through recourse to rules, normative role-based behaviors and authority structures, and culturally legitimate concepts and linguistic practices to maintain institutional arrangements (Bjerregaard & Nielsen, 2014, p. 986; Heaphy, 2013).

In more major breaches, where containment is untenable, situated repair work can be enacted through a process of 'restoration' (Lok & de Rond, 2013, p. 199). Here, once again, custodial work is undertaken through actors' self-policing of rules, and self-corrective actions in relation to such rules, though now these actions may be supplemented by formal disciplining. During restoration, actors' reflexive normalisation work also centres on 'excepting and co-opting'. These actions depict the breach as a 'necessary, justifiable exception to a rule that still holds', and that has arisen due to unforeseen extenuating circumstances (Lok & de Rond, 2013, p. 205).

Restoration work, complemented by negotiation work to reverse institutionally divergent decisions, enables an institutional template for action to be 'temporarily stretched'—through 'institutional plasticity'—so that breaches of institutional practices may be condoned without causing permanent structural change (Lok & de Rond, 2013,

p. 205). This characterises institutional pillars as mutually reinforcing and interconnected 'elastic fibres' and begs the question: what happens when they are stretched beyond the limits of their elastic tolerance? (Hirsch, 1997; Hoffman, 1999; Scott, 2008, p. 49).

Two studies have begun to explore this issue though empirical analysis of coercive policy reforms that fundamentally breached extant institutional arrangements. Currie et al. (2012, p. 958) show how elite professionals enacted institutional restoration, primarily through 'theorizing' and 'defining', to 're(generate) or re(create) institutional arrangements' in a manner that enhanced, as opposed to simply maintained, elite professionals' status. In the second study, Micelotta & Washington (2013) demonstrate how professionals reconstituted institutional arrangements by re-asserting the norms of interaction and re-establishing the balance of institutional powers. They therefore depict repair work as a maintenance function that enables the 'disruption of institutional arrangements to be reversed and the *status quo* [*ante*] to be re-established' (Micelotta & Washington, 2013, p. 1157).

Although these studies have clearly enriched our understanding of successful repair work, they have not illuminated cases where 'small bandages' have failed to address a 'gaping wound' in institutional arrangements (Clarke & Newell, 2013, p. 129). It is circumstances of this nature, which require field-level institutional repair work, that form the focus of our study.

We examine six of the most severe and protracted breaches of the institution of medicine in the English NHS; exemplified by the murder, sexual abuse, and untoward deaths of patients due to serious professional misconduct and gross neglect. In these breaches, following failed attempts at situated repair, field-level institutional repair work is enacted through government inquiry reports. These challenge the undermined legitimacy of the institutionalised order and recommend changes to assuage societal concerns (House of Commons Public Administration Select Committee, 2005). Such field-level institutional repair work is, therefore, a rhetorical construct used to change the regulative, normative and cultural-cognitive pillars of the institution of medicine (Brown, 2004; Brown et al., 2012). Our study builds upon others who have examined the complex rhetorical argumentation strategies used to foster legitimation (and delegitimation) in active texts to challenge institutional arrangements (Brown et al., 2012; Erkama & Vaara, 2010; Green & Li, 2011; Harmon, Green, & Goodnight, 2015; Suddaby & Greenwood, 2005). We therefore ask: *how is institutional repair work conducted at the field level?*

Research Design

The Case Studies

In the United Kingdom (UK), the Government, or one of its Ministers, may institute a public inquiry or an independent private inquiry in the aftermath of a 'precipitating event': a natural disaster, major accident, policy failure or severe breach of

institutionalised practice (Turner, 1976, p. 381). Typically, a severe breach involves failed attempts at situated repair resulting in the loss of implicated actors' legitimacy and significant reputational damage to the field (Sulitzeanu-Kenan, 2010). Although not adversarial in nature, inquiries are inquisitorial in substance and form (Howe, 1999). Once instigated, an independent body is tasked to provide an impartial assessment of the facts. This activity provides scope to hold those responsible to account, thereby laying blame, while conveying politicised reassurance of repair to signify closure (Elliott & McGuinness, 2002; Walshe & Higgins, 2002).

A UK government inquiry report sets out the 'provenance claim' of the inquiry—defining its commission, terms of reference, operative legislation, chair and assessors—and 'comprehensiveness' through an analysis of the nature of the severe breach (Brown, 2004, p. 100). These two aspects are complemented by rich description of the 'internal workings' of the organisation under scrutiny that is punctuated by the testimonies of witnesses (Wicks, 2001, p. 670). Such reports provide an authoritative 'meta-narrative' of the actions of individuals and organisations involved in a severe breach (Brown & Jones, 2000, p. 658). Inquiry reports, therefore, represent a comprehensive repository of data and analyses, consolidated through targeted recommendations. They allow 'little scope for disagreement' and constitute part of the requisite processes of 'cultural readjustment' in the aftermath of a severe breach (Brown et al., 2012, p. 301; Turner, 1976, p. 378). Government inquiry reports, as external field-level evaluators, thus assert

the 'official position' (Boudes & Laroche, 2009, p. 377; Bitektine & Haack, 2015), and function hegemonically to enact institutional repair work under their mask of ministerial authority (Brown, 2004; House of Commons Public Administration Select Committee, 2005).

As detailed case studies are required to examine institutional work (Currie et al., 2012; Lawrence et al., 2009), we employed a comparative case study design with government inquiry reports as our unit of analysis (Yin, 2009). This enabled a replication logic to be used in our within and cross case analysis to confirm or disconfirm the inductive inferences we developed (Eisenhardt & Graebner, 2007). Emergent theory for such a research design is typically more generalisable and better grounded than theory from single-case studies, and may therefore be more amenable to extension and validation with other methods (Davis & Eisenhardt, 2011).

Following Currie et al (2012), in selecting our cases we adopted a purposeful theoretical sample on the basis that each case may reveal similar or contrasting forms of rhetoric and institutional work for predictable reasons. For example, similarities arising from exogenous institutional forces in the medical policy or professional domains, and variations due to the nature of the severe breach, implicated focal actors, and local context. To ensure variation, the six cases selected for in depth examination were 'polar types' (Eisenhardt, 1989; Eisenhardt & Graebner, 2007, p. 27). Each focused on a different severe breach of the institution of medicine, with three cases addressing the

actions of isolated individuals, and the remainder wider departmental and organisational failings. Nonetheless, the selected cases were similar in two key aspects. First, each addressed a severe, and in some cases an extreme, breach of the institution of medicine that caused public, professional, and political loss of confidence in the English NHS. Second, the severity of each breach was compounded by their protracted nature, during which attempts at situated repair (of the forms described in previous studies) had not been successful. An outline of each case is presented in Table 1.

\<Table 1\>

Data Collection and Analysis

We obtained all but one of the government inquiry reports from the UK Government's National Archive (http://www.nationalarchives.gov.uk/webarchive/). The report into the Mid Staffordshire NHS Foundation Trust (Francis, 2010, 2013) was obtained from the inquiry web site (http://www.midstaffspublicinquiry.com). As indicated in Table 1, collectively these reports consisted of 7,659 pages of text and 954 recommendations. In essence, we took an iterative approach to theory building, moving between data and theory, involving both induction and deduction (Eisenhardt, 1989). This process was undertaken in overlapping phases, the most important of which are summarised below.

First, the government inquiry reports were read, and reread, to gain an understanding of each text. We then undertook a more detailed narrative analysis to discern how meaning was constructed with respect to the manifestation of each severe

breach (Brown, 2004). We identified and abstracted summaries of the key explanatory arguments within each text. Each centred on the focal cause of the severe breach, and the reasons forwarded to explain why situated repair had failed following their disclosure. A complementary analysis of the accompanying recommendations was then undertaken to align them to each argument. In so doing, we sought to identify the theorization enacted by each text through 'chains of cause and effect' (Lawrence & Suddaby, 2006, p. 221).

To further refine our understanding of each text we identified and abstracted the discrete storylines and perspectives of different social actors (Boje, Luhman, & Baack, 1999; Boyce, 1995). These actors included the perpetrators, their supporters and critics, and patients as victims of the severe breaches. We sought to identify exemplars of 'opposition' embedded within each text, wherein 'a storyteller can create a sense of what is right about something without ever talking about it, only by talking about what is wrong with its opposite', focused on juxtapositional arguments of perceived acceptable and unacceptable medical practice (Feldman, Sköldberg, Brown, & Horner, 2004, p. 151). This helped to clarify how the need for repair was identified and communicated to promote learning and change in the English NHS (Rhodes & Brown, 2005).

Next, we examined the rhetorical strategies used in each text. This centred on the use of forensic rhetoric to explain the causes of the severe breaches, and the use of

deliberative rhetoric in the recommendations (Aristotle, 1959; Corbett, 1999; Leach, 2000). We attributed rhetorical appeals to ethos, logos or pathos, consistent with other researchers in the field (Brown et al., 2012; Erkama & Vaara, 2010; Green, 2004; Suddaby & Greenwood, 2005). Rhetorical appeals were coded to ethos if they primarily served to build moral legitimacy through connections with judgements about the 'character' and 'rightness' of the repair work (Green, 2004; Green & Li, 2009). Appeals were coded to logos if they were rooted in pragmatic legitimacy (here, a desire for effective and efficient repair work) and concerned with the rational calculation of means and ends. Appeals were coded to pathos if they primarily served to construct pragmatic legitimacy through emotional justifications for the proposed repair work (Aristotle, 1959). The appeals were reviewed and, after deliberation and debate between the authors, consolidated to identify the key rhetorical argumentation strategies communicated in each text.

Finally, guided by Lawrence and Suddaby's (2006) typology, each rhetorical appeal was analysed to identify the type of institutional work communicated and the institutional pillar targeted for repair. Our within and cross case analysis was therefore based on the key rhetorical argumentation strategies and modes of institutional work enacted by each text (Eisenhardt, 1989).

Field-level institutional repair work

We present the findings of our comparative case analysis in two stages. First, we

illustrate the forensic rhetoric used to explain the causes of the severe and protracted breaches of the institution of medicine in the English NHS, and then the deliberative rhetoric communicated in the recommendations to effect field-level repair. We demonstrate that the overarching institutional work enacted by government inquiry reports was 'theorization' (the development and specification of abstract categories and the elaboration of chains of cause and effect), underpinned by 'advocacy' (the mobilisation of political and regulatory support through direct and deliberate techniques of social suasion), to delegitimate, repair and relegitimate institutionalised medical practices (Lawrence & Suddaby, 2006, p. 221). We also demonstrate that more tactical repair work was conveyed through complex patterns of institutional maintenance, adapted creative and disruptive work. Recommended direct actions were targeted predominantly to the normative and regulatory pillars of the breached institutions, though their consequential effects also sought to realign the cultural cognitive pillar.

Forensic rhetorical appeals used in the inquiry reports to explain the causes of the severe and protracted breaches in the English NHS

Ethos

Our comparative case analysis identified two ethos argumentation strategies— incompetence and maleficence—which were used to explain the causes of the severe and protracted breaches of the institution of medicine in the English NHS. Each strategy was crafted through the skilful use of forensic rhetoric to underscore the ineptitude or

malice of specific actors. Individual incompetence was asserted in the *Incompetent Surgeon* case and individual maleficence in the *Sexual Abusers* and the *Mass Murderer* cases. The remaining cases depicted collective incompetence. We therefore present a comparative account of the aforementioned cases to demonstrate the ethos appeals used to communicate incompetence and maleficence.

We illustrate how the government inquiry reports enacted one form of institutional work previously attributed to maintenance, demonizing (purposively deconstructing perpetrators' professional medical identity), and one previously attributed to disruption, disassociation (of medical practice from the moral, ethical, and cultural sensibilities of the profession). Moreover, through the skilful use of opposition, adapted forms of creative institutional work deconstructed and delegitimated extant policing practices across normative medical management networks.

Individual incompetence

In the *Incompetent Surgeon* case, the ethos appeal was declared through a critique of Ledward's professional performance. Ledward was demonized as 'not committed to his work' and his surgery 'too fast to be safe' as he adopted the 'quickest and shortest way of getting things done' irrespective of the outcome for the patient (Ritchie, 2000, p. 26-27, 52, 113). In the inquiry report, a catalogue of surgical complications caused by Ledward was presented to communicate the scale and scope of his incompetence—'a perforated bladder', 'a perforated bowel', and 'a severe haemorrhage requiring the

transfusion of six pints of blood'—thereby deconstructing Ledward's professional identity as a surgeon (Ritchie, 2000, p. 95, 148, 172). Ledward's surgical skills were viewed to have deteriorated over a fifteen-year period but his 'appalling attitude and arrogance', and ability to 'work around any criticism', rendered him blind to these problems (Ritchie, 2000, p. 118, 188). The ethos appeal of the inquiry report, therefore, portrayed Ledward's incompetence as a severe moral, ethical, and cultural breach of professional values and normative standards of surgical practice that had manifested due to his professional hubris. Ledward's incompetent surgical practice was thus delegitimated through this value-based theorization.

Individual maleficence

In the *Sexual Abusers* and the *Mass Murderer* cases, the ethos appeal of maleficence was used to define the cause of the severe breaches enacted by Kerr, Haslam, and Shipman. As medical professionals, each was vigorously demonized through a mythopoetic moralisation that delegitimated their actions by portraying them as 'medically qualified sociopaths' and a 'habitual killer' (Pleming, 2005, p. 403; Smith, 2005, p. 81). They were vilified for their established criminality; exemplified by Kerr's removal from his former post for 'inappropriate sexual conduct with a patient' (Pleming, 2005, p. 6), and Shipman's conviction for pethidine abuse (Smith, 2002, p. 11). Once again, their professional identities as doctors were deconstructed through a catalogue of their crimes: Kerr—the sexual abuse of patients A4, A5…A40; Haslam—

the sexual abuse of patients B1, B2…B12 (Pleming, 2005); Shipman—the murder of Eva Lyons in 1975…through to that of Kathleen Grundy in 1998 (Smith, 2002, p. 2). The purposive work communicated through this ethos appeal exposed severe breaches of the law and of professional regulations, boundaries, and normative standards of medical practice. This was used to underscore the disassociation of the perpetrators' practice from the moral, ethical, and cultural sensibilities of medicine (Pleming, 2005, p. 21, 594; Smith, 2002, p. 190).

Collective incompetence

In the three remaining cases, the ethos appeals communicated the collective incompetence of actors who occupied senior medical and general management roles in the English NHS. The roots of their collective incompetence lay in their mismanagement of events after a severe breach had been disclosed. Though benefiting from the role position power to challenge such breaches, their failure to adhere to legal and professional regulatory and normative standards of practice permitted each breach to continue. This use of opposition exposed the inadequacy of policing and sanction across normative medical management networks.

   In these cases the demonization of focally implicated actors was mitigated by an aligned criticism of the prevailing culture of the English NHS. This culture was portrayed as one that 'did not listen to complaints', was 'defensive and secretive' and adhered to attitudes of 'paternalism' and 'self-protection' (Francis, 2013, p. 246;

Kennedy, 2001, p. 271; Redfern, 2001, p. 284). Accordingly, 'the system as a whole' had 'failed in its most essential duty', namely 'to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital' (Francis, 2013, p 13-14). Therefore, in this ethos appeal, a value-based theorisation was asserted, and paralleled by that for logos, defined below, that centred on the illegitimacy of the 'institutional reaction at all levels in the healthcare system' to defend professional and organisational reputation 'before taking steps to protect patients from risk' which resulted in the 'tolerance of poor care' (Francis, 2013, p. 32, 461).

Logos

Our comparative case analysis identified one overarching logos argumentation strategy: the protection of the medical professional, and their profession, as opposed to the protection of patients. This strategy was used to augment the causal explanation of the severe breaches of the institution of medicine, and pass considered judgment on why situated repair had failed following their disclosure. This was communicated through the perpetrators', and others', defensive denial and abuse of hierarchical medical professional power, and compounded by the inadequate professional oversight of the quality of care. This logos appeal constituted the core of each inquiry report with the notable exception of the *Mass Murderer* case.

We illustrate how, through the skilful use of opposition, the government inquiry

reports enacted one form of institutional work previously attributed to disruption, undermining assumptions and beliefs (of medical practice) to delegitimate medical professionals' defensive institutional work and inadequate policing due to weak professional regulatory oversight and censure. Through such opposition, adapted forms of creative institutional work also deconstructed normative medical associations and networks. In addition, the reports enacted one form of institutional work previously attributed to maintenance, valorizing. Through this, an innovative form of situated repair, circumvention work, was also communicated.

Perpetrators' defensive denial and abuse of hierarchical medical professional power

In each case, value-based theorization was used to depict the perpetrators', whether individual or collective, concealment of a severe breach of the institution of medicine as malign. This problematized healthcare professionals' defensive institutional work, and the ineffectiveness of extant policing practices (Francis, 2013, p. 139; Kennedy, 2001, p. 170; Pleming, 2005, p. 483; Redfern, 2001, p. 170; Ritchie, 2000, p. 300; Smith, 2002, p. 177). Hence, the assumption and belief that, when confronted by accusations of a breach, all the perpetrators had to do was simply refute such claims to foreclose further action was delegitimated.

The *Sexual Abusers* case illustrates the ease with which such denial was achieved. Kerr and Haslam were protected by a culture that demanded 'clear, unequivocal and incontrovertible evidence' of patients' complaints of sexual abuse. In sharp contrast, the

'mere denial' by a consultant was sufficient to ensure 'the matter [would] not proceed' (Pleming, 2005, p. 13, 358). Such was the depth of denial, managers, psychiatrists and general practitioners, who were aware of patients' disclosures of abuse, considered Kerr and Haslam's actions to have been merely 'foolish' and therefore 'did nothing to alert the responsible authorities to the potential risk of danger to other patients', 'closed ranks' and enacted a 'cover-up' (Pleming, 2005, p. 15, 200, 304, 453). The few healthcare professionals who spoke out, typified, in this case, by the 'whistleblowing' actions of Nurse Linda Bigwood (Pleming, 2005, p. 8, 173-234), were valorised for their courage and persistence in the face of professional vilification. Honed through the use of opposition, the logos appeal thus conveyed 'something akin to maladministration' that was aided by the 'us' and 'them' culture that privileged 'the word of a doctor' over that of a patient (Pleming, 2005, p. 236, 802).

Others' defensive denial and abuse of hierarchical medical professional power

Defensive denial was depicted through the actions of others who protected the perpetrators. For example, in the *Incompetent Surgeon* case, despite awareness among surgical colleagues that Ledward was 'a danger to patients' (Ritchie, 2000, p. 209), other colleagues, notably medical managers and eminent surgeons, denied awareness of any issues with Ledward's performance (Ritchie, 2000, p. 27, 51-56). They asserted the belief that 'any consultant must, almost by virtue of his appointment, be good at his job and beyond challenge' (Ritchie, 2000, p. 18). Moreover, a 'climate of fear and

retribution was engendered by senior members of the [surgical] profession', so that those who sought to expose Ledward's incompetence were left in no doubt by their eminent colleagues that 'they would find themselves ostracised', unable to 'continue to be employed in their present positions, and might find it difficult to find an alternative post' (Ritchie, 2000, p. 322). Defensive institutional work, communicated through the misuse of hierarchical medical power across normative associations and networks, was depicted to have prevented Ledward's colleagues from speaking out.

In acknowledging these circumstances, the inquiry report valorized those who took action to mitigate the harm inflicted by Ledward. Such purposeful circumvention work was led by some of Ledward's medical colleagues who 'stopped referring their patients' to him for surgery, and by nursing staff who purposively adapted their praxis, undertaking post-operative observations of Ledward's patients' vital signs 'every half hour for 3-4 hours not just for the normal 2 hours' (Ritchie, 2000, p. 51, 114, 216). Others' attempts to circumvent harm thus highlighted the 'abdication' of responsibility demonstrated by senior medical managers and NHS management (Ritchie, 2000, p. 260).

This combination of denial, inaction, obfuscation and delay was evident throughout the other cases. In the *Failure of Medical Management* case, those who sought to expose the breach to effect situated repair met with overt obstruction because 'this is not how we [medical managers] do things' (Kennedy, 2001, p. 139, 165).

Similarly, in the *Systemic Failure of Hospital Care* case, the 'culture of denial' that 'permeated and persisted in the Mid Staffordshire NHS Foundation Trust's leadership' was viewed to have led to the failure to address significant and concerning 'mortality figures' and 'patient complaints' due to its 'lack of openness' (Francis, 2013, p. 139, 180). The logos appeals, therefore, undermined the assumptions and beliefs of medical practice to delegitimate medical professionals' defensive institutional work, and deconstructed normative associations and networks by depicting them as being in need of repair.

In stark contrast, in the *Mass Murderer* case, Shipman had so carefully created his professional reputation as 'the best doctor in Hyde', who would willingly 'go the extra mile for his patients', that the idea that he was killing them was utterly 'unthinkable' (Smith, 2002, p. 13; 2004a, p. 152; 2004b, p. 347). Hence, there were no accusations for Shipman to deny, and his murderous activities remained veiled and unchallenged for decades until Shipman's 'grossly incompetent forgery of Kathleen Grundy's will' led to their exposure (Smith, 2002, p. 200).

Another important difference in this case was that Shipman worked in isolation as a 'single-handed' (solo practice) general practitioner (Smith, 2002, p. 105). His professional peers were not embedded within a cohesive hierarchical organisational culture as they worked in different local primary care provider organisations. This limited the potential for the misuse of medical power across normative associations and

networks. Unhindered by hierarchical relational ties, Linda Reynolds, a doctor in an adjacent practice to Shipman, acted on her concerns over the high number of cremation certificates she had been asked to countersign on Shipman's behalf (Smith, 2002, p. 174). Fearing that Shipman was 'killing his patients' (Smith, 2003a, p. 2), Reynolds enacted the regulatory and normative practices she perceived to be her 'professional duty' by informing the South Manchester Coroner of her concerns, who, in turn, initiated a police inquiry (Smith, 2002, p. 193; 2004b, p. 348). In this case, Reynolds was valorized for her effective peer policing across general practice networks, thereby idealizing the values and actions demonstrated.

Inadequate professional oversight

In each case, inadequate professional oversight was asserted. Due to the medical focus of the severe breaches considered, this critique primarily centred on the actions of the doctors' professional body: the General Medical Council (GMC). We illustrate this, below, through detailed consideration of the *Incompetent Surgeon* case.

Ledward's colleagues' reluctance to speak out was heightened by the regulatory constraints imposed upon them by the professional conduct and disciplinary practices of the GMC. From 1977 until 1991, the GMC held the position that 'the deprecation by a doctor of another doctor's professional skill, knowledge, qualifications or services was capable of amounting to serious professional misconduct', and that its normative focus was 'not ordinarily concerned with errors in diagnosis or treatment, or with the kind of

matters which give rise to action in the civil courts for negligence' (Ritchie, 2000, p. 66-67). Only after revision of these guidelines in 1991 was it considered 'any doctor's duty, where the circumstances so warrant, to inform an appropriate person or body about a colleague whose professional conduct or fitness to practise may be called in question or whose professional performance appears to be in some way deficient' (Ritchie, 2000, p. 249).

The value-based theorisation in this logos appeal therefore asserted that, throughout the majority of Ledward's career, 'there were no sanctions that could be used', so that his surgical skills were left to fall 'lamentably below that which the public requires and which the medical profession expects of its members' (Ritchie, 2000, p. 11, 125). In this manner, it undermined assumptions and beliefs to challenge and change the professional regulatory practices of the past. This stance was strongly asserted in the remaining cases, wherein the logos appeals refuted the 'old binary approach to discipline'—'serious or nothing', 'removal from the register or nothing' (Kennedy, 2001, p. 349)—and the 'opaque and uninterested' practices of the GMC (Pleming, 2005, p. 403) which had fostered the cultural normalisation of poor standards of care (Francis, 2010, p. 108; 2013, p. 1015; Redfern, 2001, p. 237).

Pathos

Our comparative case analysis identified shame as the overarching pathos argumentation strategy. This augmented the ethos and logos appeals to persuade the

readers of each inquiry report of the need for field-level change to repair the severe and protracted breaches of the institution of medicine in the English NHS. Pathos appeals were value-based and conveyed in two distinct forms. In the *Incompetent Surgeon*, the *Sexual Abusers*, and the *Systemic Failure of Hospital Care* cases, anonymised catalogues of patients' harm were used. But in the *Mass Murderer*, the *Failure of Medical Management*, and the *Illegal Removal and Retention of Body Parts* cases, detailed personal narratives of harm, typically centred on the death of a patient, communicated the impact of the severe breach upon the bereaved.

We demonstrate our findings through a comparative account of the pathos appeals conveyed in these groups of cases. We illustrate how, through the skilful use of opposition, the government inquiry reports enacted one form of institutional work previously attributed to disruption, disassociation, to reassert the moral, ethical, and cultural sensibilities of the profession of medicine.

Shame

In the first group of cases, which addressed Ledward's, Kerr and Haslam's surviving victims, together with patients treated at the Mid Staffordshire NHS Foundation Trust, each narrative was anonymised and presented as an account of the harm inflicted. The cataloguing of repeated accounts of the same adverse outcomes—'incontinence and urethro-vaginal fistulae', 'perforated bladder', 'perforated uterus' (Ritchie, 2000, p. 43, 95, 104); 'feelings of guilt, lack of self-worth, embarrassment, and humiliation'

(Pleming, 2005, p. 61, 236); and patients left 'unwashed', 'covered in faeces' in a ward 'so dirty that the family had to clean it themselves' (Francis, 2010, p. 13, 23, 26)—overwhelmed the 'defensive institutional instinct to attack those who criticise' (Francis, 2013, p. 993) in a powerful pathos appeal that demonstrated profound professional shame.

> 'The hospital of death, headlines in the paper. It was just dreadful to be
> associated with the [Mid Staffordshire NHS Foundation] Trust, really'
> (Francis, 2010, p. 169).

In the second group of cases, personalisation, as opposed to anonymisation, was harnessed through mythopoetic narrative accounts of the deaths of named patients—'Kathleen Grundy' (Smith, 2002, p. 13); 'Joshua Loveday' (Kennedy, 2001, p. 25, 163); 'Stephen White' (Redfern, 2001, p. 46)—humanising the consequences of each severe breach. A highly emotive message was conveyed through this form of appeal, frequently via the voice of the bereaved.

> 'We cremated our son in two separate boxes 31 years apart' (Redfern,
> 2001, p. 20).

These forms of pathos appeal therefore also delegitimated more diffuse normative healthcare associations by challenging the 'insidious negative culture' (Francis, 2013, p. 9), where 'not telling tales [was] powerful and superficially attractive' (Ritchie, 2000, p. 303), to demand that 'those who work within the system place the safety of patients

above other considerations, such as professional loyalty', and focus their actions on the 'resolution of patient complaints' (Pleming, 2005, p. 696).

Deliberative rhetorical appeals used in the inquiry reports to repair the causes of the severe and protracted breaches in the English NHS

The second stage of our analysis focused on the rhetorical argumentation strategies used in the recommendations forwarded in each inquiry report to repair the severe and protracted breaches of the institution of medicine in the English NHS. Recommendations were conveyed through deliberative rhetoric; predominantly rational and valued-based logos appeals augmented by ethos with limited recourse to pathos, which collectively fostered advocacy for change.

Our comparative analysis maintained its focus on the issues identified in the first stage of our analysis. However, we found high levels of consistency in the rhetorical appeals communicated across the cases. We therefore present a general account of the cumulative refinements to field-level repair work set out in each inquiry report, thereby illustrating an inter-textual legacy effect that amplified such repair work. In so doing, we illustrate that the government inquiry reports enacted two forms of institutional work attributed to maintenance: policing, and embedding and routinizing. These were supplemented by interwoven forms of adapted creative institutional work including: (re)educating, (re)defining regulations, and normative standards of practice, and (re)constructing normative networks and associations, through which repaired

institutional practices were relegitimated.

Logos and Ethos

Repairing individual and collective incompetence

Two logos argumentation strategies—individual appraisal and continuous professional development (CPD)—were recommended as the means to identify, repair, and prevent individual incompetence. However, these were supplemented by audit, performance monitoring and aligned corporate and clinical governance processes to correct and prevent collective incompetence. A culture of continuous improvement across the English NHS was therefore fostered by institutional maintenance work (policing, embedding and routinizing), and institutional creation work (education directed to the repair of normative standards of healthcare practice), and consolidated through regulatory change.

In the *Incompetent Surgeon* case, for example, the 'annual appraisal' of consultants was recommended to 'assess their performance', together with any 'complaints and claims involving their work'. It was recommended that the medical director of each NHS Trust lead this development to embed and routinize this policing practice at the apex of the medical hierarchy. Although ultimate accountability for the knowledge, skills, and performance of doctors employed lay with the chief executive (Ritchie, 2000: Recommendations 27-31).

These logos appeals and types of institutional work were also reflected in the

Failure of Medical Management, the *Illegal Removal and Retention of Body Parts*, and the *Systemic Failure of Hospital Care* cases, which addressed breaches of a collective nature. For example, in the *Failure of Medical Management* case, it was recommended that policing through individual performance appraisal become 'compulsory for all healthcare professionals', part of their 'contract of employment', and supplemented by 'all healthcare employees' engagement in 'compulsory CPD' (Kennedy, 2001: Recommendations 45, 82, 85). Moreover, such changes to normative practice were consolidated within new overarching regulatory frameworks for the individual revalidation and re-registration of health care professionals to 'assure the competence of healthcare professionals' (Francis, 2013: Recommendation 229; Kennedy, 2001: Recommendations 69, 88, 90).

In each case, the logos appeals sought to foster the policing of collective practice and performance through the embedding and routinizing of audit, performance monitoring and aligned governance processes across the English NHS. For example, despite the *Incompetent Surgeon* case addressing the focal acts of Ledward, the recommendations asserted that 'all doctors, including consultants, must participate in clinical audit', so that any 'untoward events that have been recorded' were to be openly 'discussed and investigated' to identify 'how practice should be altered'. Again, each NHS Trust was tasked to appoint 'a clinician to be the head of audit' with this role to be accountable to the 'clinical governance committee of the NHS Trust' and 'answerable

directly to the chief executive' (Ritchie, 2000: Recommendations 8, 10, 13).

Similarly, in the *Failure of Medical Management* case, audit was recommended as 'compulsory for all healthcare professionals', and was to be refined through the creation of 'national standards of clinical care' to facilitate the 'monitoring of clinical performance at a national level' (Kennedy, 2001: Recommendations 125-127, 143-147). Indeed, further refinement emerged in the *Systemic Failure of Hospital Care* case, wherein it was recommended that the 'regulators of healthcare providers' use their 'own powers of intervention' when concerns arose about organisational performance to 'take whatever action within their powers [was] necessary to protect patient safety' (Francis, 2013: Recommendations 31-32).

Repairing individual maleficence

The aforementioned logos argumentation strategies were reasserted in the *Sexual Abusers* and *Mass Murderer* cases, which sought to repair the maleficent acts of Kerr, Haslam, and Shipman. For example, in the *Sexual Abusers* case, the inquiry report recommended that the scope of healthcare professional appraisal be extended to encompass the 'full range of physical, psychological and complementary therapies used'. The aim, here, was to better ensure the policing of 'new or unorthodox treatments' to prevent sexual abuse veiled by 'fringe treatments': a defence that had been used by Haslam (Pleming, 2005, p. 279: Recommendations 3-5). In addition, in these cases, the logos appeals recommended clarification of regulatory and normative

standards of practice. Hence, adapted forms of institutional creation work were fostered to redefine regulations and reconstruct normative associations, especially with regard to the moral and cultural foundations of breached medical practices, each enabled through the re-education of healthcare professionals.

Furthermore, in the *Mass Murderer* case, redefinition of rules for 'deaths which were, or might [have been], caused or contributed to by medical error or neglect' were recommended, together with the requisite re-education of general practitioners in the appropriate use of the Coroner's Service (Smith, 2003b: Recommendations 33, 34, 35). Similarly, it was reasserted that it was a 'criminal offence for a doctor to prescribe a controlled drug for [themselves] or to self-administer a controlled drug'. This measure served to highlight extant rules in the Misuse of Drugs Act 1971 (Smith, 2004a: Recommendations 3, 4, 7). Nevertheless, in this case, an aligned ethos appeal tempered these recommendations by acknowledging that there was 'little that would have deterred Shipman from killing' as the institutional regulations, normative standards, and culture of medicine posed no impediment for a 'serial killer' (Smith, 2004b, p. 15, 176).

Repairing individual and collective denial

In each case, a value-based ethos appeal sought to change the culture of individual and collective denial that pervaded the English NHS by valorizing openness. In the recommendations set out in the *Incompetent Surgeon*, the *Sexual Abusers*, and the *Mass Murderer* case, NHS staff were tasked to speak out once they realised that 'something

[had] gone wrong'. This was exemplified in the *Incompetent Surgeon* case by clear advocacy for 'whistleblowing' when confronted by the denial of others (Ritchie, 2000: Recommendations 19, 46). However, in the *Sexual Abusers* case, this recommendation was expanded in scope to enable 'any person with a concern about the safety and effectiveness of the NHS' to be allowed to voice their fears (Pleming, 2005: Recommendation 30-31). Change to the National Health Service (Complaints) Regulations was also recommended to facilitate such actions in general practice (Smith, 2004b: Recommendations 1-10).

Importantly, in the *Failure of Medical Management* case, this notion was redefined through a cogent ethos appeal that valorized the 'duty of candour'—defined as 'a duty to tell a patient if adverse events have occurred'—that was 'owed by all those working in the NHS to patients' (Kennedy, 2001: Recommendation 33). This was reiterated in subsequent inquiry reports, and embedded in the NHS Constitution to encourage the values of transparency and honesty in care (Francis, 2013: Recommendation 2, 178).

Our comparative case analysis identified two complementary logos argumentation strategies that were recommended to support the duty of candour and enhance patient safety: the redesign of the complaint procedure, and the development of systematic identification and reporting of adverse events. In these ways, institutional maintenance work through policing, embedding and routinizing, together with creation work through

redesign and definition of systems were fostered by each inquiry report. Once again, repair work centred on normative standards of healthcare practice, consolidated through regulatory change, to foster a culture of continuous improvement across the English NHS.

In the *Incompetent Surgeon* case, for example, it was recommended that 'patients who have concerns about their care must be able to raise the matter while they are in the hospital and be given a full and proper response at the time'. This sought to address patients' 'real fears' that if they 'question, challenge or complain' about medical treatment when they are in hospital the care they received would be 'adversely affected' (Ritchie, 2000, p. 188, 289: Recommendations 9, 15-27). Similarly, in the *Sexual Abusers* case, new policies and practices were recommended to ensure that psychiatric patients who raised 'concerns or complaints in relation to allegations of abuse' were not treated in ways that were 'less favourable'. Given psychiatric patients' vulnerability, it was recommended that 'frontline staff' were placed under the 'express obligation to report' the 'suspicion of the abuse' as opposed to a 'formal complaint of abuse' by a patient (Pleming, 2005: Recommendation 12, 33, 37).

This goal was further refined in the *Failure of Medical Management* case through the recommended introduction of 'independent advocacy services' for patients (Kennedy, 2001: Recommendation 36). Following the publication of Francis (2013), NHS Trust boards were tasked with the 'coordinated collection of accurate information

about performance'—including 'incidents, complaints and their investigations'—which were to be made 'available to providers, commissioners, regulators and the public'. Critically, in this regard, 'to make or be party to a wilfully or recklessly false statement as to compliance with safety' was positioned as a criminal offence (Francis, 2013: Recommendations 36-41).

In the second part of this logos appeal, the systematic identification and reporting of adverse 'sentinel events' was recommended to enhance patient safety (Kennedy, 2001: Recommendations 107-120). It was recommended that themes and trends arising from the data of 'complaints, incidents, and patient and carer feedback' should be analysed on a regular basis 'to give early warning of emerging patterns of risk behaviour' (Pleming, 2005: Recommendation 35). Again, heightened policing was recommended through the formation of new regulatory oversight bodies, to be 'independent of government', and to act in a co-ordinated manner to monitor the quality of care (Kennedy, 2001: Recommendations 39, 106-111). Finally, in the *Systemic Failure of Hospital Care* case, it was recommended that these regulatory bodies be consolidated to establish 'a single regulator dealing both with corporate governance, financial competence, viability and compliance with patient safety and quality standards' for all NHS Trusts to overcome barriers to communication and co-ordinate the quality and safety of care in the English NHS (Francis, 2013: Recommendation 19).

Repairing individual and collective abuse of professional power

In each case, a logos appeal sought to change the imbalance of power that had manifested through doctors' abuse of patient consent. As a result, adapted institutional creation work was directed towards redefining normative practices concerning securing informed consent, and re-educating staff on its appropriate use. This precipitated normative, regulatory and cultural change across the English NHS.

In the *Incompetent Surgeon* case, guidance on 'informed consent to surgery' was recommended (Ritchie, 2000: Recommendation 91) and catalysed a debate that impacted the other cases. For example, in the *Failure of Medical Management* case, it was recommended that informed consent be considered as 'a process and not a one-off event consisting of obtaining a patient's signature on a form' and 'should apply not only to surgical procedures but to all clinical procedures and examinations which involve any form of touching' (Kennedy, 2001: Recommendations 23-26). Furthermore, in the *Illegal Removal and Retention of Body Parts* case, the need for 'strict compliance' with the regulatory requirement to obtain 'written consent' before the retention of histopathology samples or organs as defined in the Human Tissue Act 1961 was reasserted. Amendment of this Act was also recommended to 'provide a test of fully informed consent', complemented by 'training for all those involved in obtaining fully informed consent' (Redfern, 2001: Recommendations 51-60).

The most notable challenge to the imbalance of power between healthcare professionals and patients was asserted in an ethos appeal in the *Failure of Medical*

Management case. Here, the concept of 'a patient-centred healthcare service' was forwarded. This was underscored by 'the notion of partnership', whereby the 'healthcare professional and the patient meet as equals with different expertise'. Moreover, it was recommended that the various bodies responsible for the regulation of healthcare professionals be tasked to 'involve the public in their decision-making processes', so that the collective voice of patients, consumers and citizens, would be focused toward the future 'development and planning of healthcare services', including the 'regulation of safety and quality, the competence of healthcare professionals, and the protection of vulnerable groups' (Kennedy, 2001: Recommendations 1-3, 157-166).

This value-based appeal was reaffirmed in the *Systemic Failure of Hospital Care* case through the recommendation that the 'core values expressed in the NHS Constitution'; namely, that 'all who work for [the English NHS] must adopt and demonstrate a shared culture in which the patient is the priority', so that 'everything done by the NHS and everyone associated with it should be informed by this ethos' (Francis, 2013: Recommendation 2, 4-5).

Repairing inadequate professional oversight

In each case, the logos appeal built upon the recommendations illustrated above and sought to enhance the quality and safety of healthcare through redefinition of accepted normative standards of practice, the heightened policing of such practice, and a commitment to the provision of on-going education of each professional group (Francis,

2010: Recommendation 4; Pleming, 2005: Recommendation 60; Ritchie, 2000: Recommendation 1; Smith, 2003b: Recommendation 37). However, it was recommended that in medicine, the culture of professional 'mutual self-protection' be brought to an end:

> 'There can be no room today for the protection of colleagues where the safety and welfare of patients is at issue' (Smith, 2004b, p. 23).

It was therefore recommended that the GMC still be tasked with defining the 'ethics and the duties of a doctor', advancing 'good standards of medical practice', and addressing 'cases of professional misconduct' (Ritchie, 2000: Recommendation 86, 101; Smith, 2004b: Recommendation 53). However, it was resolutely recommended that 'the GMC's primary role should be one, not of remediation of doctors, but of the protection of patients', so that doctors who did not meet the required levels of performance would no longer be permitted to 'limp on' with 'no real hope of meeting the standard' and would be removed from practice in the English NHS (Smith, 2004b: Recommendation 94).

Discussion and Conclusion

We examine the field-level institutional repair work enacted by government inquiry reports into severe and protracted breaches of the institution of medicine in the English NHS. In doing so, we analyse the interplay between the rhetorical argumentation strategies communicated to delegitimate and relegitimate breached institutionalised

medical practices (Aristotle, 1959), the modes and types of institutional work conveyed (Lawrence & Suddaby, 2006), and the institutional pillars targeted for repair (Scott, 2008) to develop a deeper understanding of how institutional repair work is conducted at the field-level.

Our comparative case study makes three contributions to the institutional work literature. The first contribution stems from our analysis of forensic and deliberative rhetoric (Aristotle, 1959; Corbett, 1999; Leach, 2000). This bifurcated approach, illustrated in Figure 1, differs from that of others who have contributed to the broader understanding of the role of rhetoric in processes of institutional maintenance and change (Brown et al., 2012; Erkama & Vaara, 2010; Green & Li, 2011; Suddaby & Greenwood, 2005). By considering the rhetorical argumentation strategies used to convey cause and aligned recommended repair, it responds to calls to 'more clearly distinguish between the different modes (and types) of work appropriate to different institutional goals', so countering a perceived deficit in institutional work research (Nilsson, 2015, p. 387).

<Figure 1>

As illustrated in Figure 1, we demonstrate that forensic and deliberative rhetoric are communicated through ethos and logos, with limited recourse to pathos. Field-level institutional repair work is conveyed through moralization, pragmatic and mythopoetic modes of legitimation, honed through the use of opposition (Feldman et al., 2004). In

our study, the lack of emphasis placed on pathos reflects the constraints on emotion associated with the 'hidden curriculum' of professional socialisation in medicine (Vaidyanathan, 2015, p. 160). Nonetheless, pathos appeals are purposively used to express the harm inflicted through severe breaches of institutionalised medical practice. They broker 'systemic' and 'episodic' professional shame to foster medical practitioners' self-surveillance and self-regulation to prevent future breaches (Creed, Hudson, Okhuysen, & Smith-Crowe, 2014, p. 280).

Our findings demonstrate that forensic and deliberative rhetorical appeals blend ethos, logos, and occasionally pathos in a tactical buttressing manner to effect field-level institutional repair. For example, in the *Incompetent Surgeon* case, rhetorical argumentation strategies used to repair and maintain appropriate professional standards of surgical practice were conveyed through: (i) forensic rhetoric—ethos (opposition) and logos appeals employing demonizing and valorizing to reassert the normative and cultural-cognitive pillars of surgical practice; and (ii) deliberative rhetoric—ethos and logos appeals employing policing, embedding and routinizing to foster audit, appraisal, and CPD practices to heighten professional regulative and normative standards. Hence, our bifurcated approach clearly demonstrates how forensic and deliberative rhetoric enact institutional maintenance work in different but complementary ways to rewrite and repair the performance scripts of breached institutionalised medical practices.

In considering forensic and deliberative rhetoric, we also elaborate the roles of

'theorization' and 'advocacy' through which government inquiry reports enact field-level institutional repair work (Lawrence & Suddaby, 2006, p. 221). Theorization and advocacy are focused through rational, value-based arguments, which problematize specific practices implicated in the facilitation and protraction of the severe breaches. We demonstrate that theorization links cause to recommended repair in a one-to-many manner, thereby increasing the density of the field-level institutional repair to mitigate future breaches. In this manner, government inquiry reports function as inter-field institutional arbiters, inducing the repair of breached institutionalised medical practices to legitimate change, while passively maintaining untarnished aligned practices within the institutional field.

Advocacy is brokered with and through other organisational actors embedded in the field—the UK Government, Secretary of State for Health, GMC, Medical Royal Colleges, and NHS Trusts—with all collectively tasked to repair the breached institution of medicine. We found an inter-textual legacy embedded within the government inquiry reports examined. Each report, as a proxy of the UK Government, sought to build advocacy for heightened government control over the medical and other healthcare professions (The Stationery Office, 2007). Such advocacy therefore reflected teleological rhetoric: 'that certain events must occur within the context of some "grand plan" or ultimate objective' to legitimate change to create the momentum for field-level institutional repair (Suddaby & Greenwood, 2005, p. 46).

Our second contribution responds to calls to develop a deeper understanding of how the different modes and types of institutional work interact to effect institutional repair (Heaphy, 2013; Micelotta & Washington, 2013). As depicted in Figure 1, our findings demonstrate that field-level institutional repair encompasses maintenance, adapted creative and disruptive modes of institutional work. Having commented on institutional maintenance work, below, we offer further insight into the complex interplay of these latter two modes.

Adapted creative and disruptive modes of institutional work, when expressed through forensic rhetoric, are used to deconstruct aspects of breached institutionalised medical practices. This occurs primarily through undermining the assumptions and beliefs that facilitate the enactment of the breach to aid the disassociation of the moral, ethical, and cultural sensibilities of the profession from the breached practice. Following such disconfirmation, deliberative rhetoric communicates adapted creative institutional work (re-education, redefining, reconstructing) to incrementally refine the regulative, normative and cultural-cognitive pillars of the breached institution.

We found that these incremental refinements occur through *elaborative* and/or *eliminative* modes of institutional work. In the former, refinements to aspects of the breached institution's constituent pillars enhance and relegitimate the rules, normative behaviours, and taken for granted beliefs. In the latter, the opposite manifests. As depicted in Figure 1, this occurs across a spectrum that, in extremis, results in

institutional creation or deinstitutionalisation. Our findings in relation to the institutionalised medical practice of securing informed consent in the *Incompetent Surgeon*, *Failure of Medical Management*, and the *Illegal Removal and Retention of Body Parts* cases, exemplify this bi-modal field-level institutional repair work. Elaboration fostered heightened regulation and fundamental changes to normative practice. Elimination delegitimated the paternalistic medical practice of presumed consent. Collectively, these actions brokered a patient-centred culture in healthcare, epitomised by the mantra: '*no decision about me*, *without me*' (Department of Health, 2012).

Our findings demonstrate that these incremental refinements transpire in a manner that does not undermine the main architecture of the institution of medicine. However, due to the severity and protracted nature of the breaches we examined, they do not re-establish the *status quo ante*. Instead, elaborative and/or eliminative field-level institutional repair work cause the breached institution's pillars to undergo structural change through a process of 'evolution' (Hoffman, 1999, p. 353). This action enables the institution to be repaired, creatively refurbished and 'rebuilt' (Micelotta & Washington, 2013, p. 1160), so that it remains fit for purpose, and thus legitimate, within the changing terrain of the field. A dynamic form of institutional maintenance results—as opposed to passive or static reproduction (Jepperson, 1991)—that enables the institution to evolve in order to 'endure' (Giddens, 1984, p. 24). Our findings

therefore refine the traditional portrayal of institutional repair work as merely a function of maintenance work that 'preserves and/or restores' the institutional *status quo ante* (Lawrence & Suddaby, 2006; Micelotta & Washington, 2013, p. 1159).

In addition, our rhetorical analysis and examination of institutional work responds to calls for more detailed consideration of the 'interplay between the three pillars' to foster healthcare reform and repair (Caronna, 2004, p. 55; Heaphy, 2013). We demonstrate that government inquiry reports focus the efforts of their field-level repair work toward the regulatory and normative pillars of the breached institution, though their consequential effects also seek to realign the cultural-cognitive pillar. Attempted field-level repair of breaches which have arisen, in part, due to the prevailing culture of the English NHS—one that did not listen to complaints, was defensive, secretive, and self-protective, resulting in the tolerance of poor care (Francis, 2013; Kennedy, 2001; Redfern, 2001)—are therefore repaired only indirectly. This underscores the salient argument of Glasby, who comments that: '*the trouble with culture* [in the English NHS] *is everyone blames it when things go wrong but no-one really knows what it is or how to change it*' (Glasby quoted in Francis, 2013, p. 1358). Appreciating that NHS healthcare organisations do not reflect a 'single culture of care' (Herepath, Kitchener, & Waring, 2015, p. 3), how to achieve effective cultural change within NHS England remains a priority for research and policy.

Finally, our elaboration of field-level institutional repair work contributes to the literature on the dark side of institutional work by exemplifying the adverse consequences of failures in situated repair. In our empirical study, we depict the condoning of a severe breach, through defensive denial and abuse of professional power across the medical hierarchy, as a malign form of 'custodial work' (Dacin et al., 2010, p. 1407). We also demonstrate that situated 'containment' to effect minimal repair through concealment (Lok & de Rond, 2013, p. 197), when enacted in severe breaches of institutionalised medical practice in the English NHS, leads to the institutionalisation of misconduct.

Indeed, this occurrence also arises following situated repair enacted through 'restoration' (Lok & de Rond, 2013, p. 199). Excepting and co-opting a severe breach as a justifiable exception to a rule that still holds—as exemplified by general practitioners' depiction of Haslam's sexual abuse as a 'one-off' wherein he had merely been 'foolish' (Pleming, 2005, p. 453)—particularly when self-correction is not enacted by focally implicated actors, does not achieve repair. To paraphrase Burke: *the only thing necessary for the triumph of evil in the English NHS is for good men and women to do nothing*. Our findings, therefore, also offer insight into the 'relative plasticity' of institutions (Lok & de Rond, 2013, p. 205). Institutionalised medical practices are, of necessity, relatively inelastic: enact practices outside the limits of their elastic tolerance and patients may die, suffer abuse or irrevocable harm.

Our study has important limitations. Although government inquiry reports serve a powerful political role (Brown, 2004, 2005; Brown & Jones, 2000; Brown et al., 2012; Howe, 1999), the rhetorical field-level repair they communicate may, nonetheless, be little more than illusory: the empty promise of a fantasy document forwarded to assuage public, professional, and political loss of confidence in the institutions concerned (Elliott & McGuinness, 2002). Our study elaborates 'why and how' such reports enact purposive institutional work to effect field-level repair (Lawrence et al., 2011, p. 57). However, it does not investigate whether such rhetorical repair was effectively translated into policy and practice to deliver the recommended regulatory, normative and cultural-cognitive refinements across the institutional field.

Further outcome-focused research is therefore warranted to: (i) ascertain the overall effectiveness of government inquiry reports as a means of achieving field level repair; (ii) discern how government inquiry reports may more readily effect field-level repair through cultural change; and (iii) to examine whether the inter-textual legacy, evident across each report's recommendations, manifested to reinforce field-level repair initiated by earlier reports or to address failings in the effectiveness of the field-level repairs arising from the recommendations defined in earlier reports. Addressing these questions will further our understanding of field-level repair work, and may help improve the effectiveness of government inquiry reports in fostering field-level change

in the English NHS at the policy level and, more importantly from the perspective of patient safety, at the practice level.

To conclude, we assert that field-level institutional repair work, when enacted by UK Government inquiry reports into severe and protracted breaches of the institution of medicine in the English NHS, employ interwoven rhetorical argumentation strategies in their theorization of change to build advocacy for repair. Elaborative and/or eliminative evolutionary change is enacted through the interplay of maintenance, adapted creative and disruptive modes of institutional work, directing change to the regulatory and normative pillars of the breached institution to foster cultural change across the English NHS.

Aristotle, (1959). *The art of rhetoric*. London: William Heinemann.

Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge.* New York: Doubleday.

Bitektine, A., & Haack, P. (2015). The "macro" and the "micro" of legitimacy: Toward a multilevel theory of the legitimacy process. *Academy of Management Review, 40*, 49–75.

Bjerregaard, T., & Nielsen, B. (2014). Institutional maintenance in an international bureaucracy: Everyday practices of international elites inside UNESCO. *European Management Journal*, *32*, 981–990.

Boje, D.M., Luhman, J.T., & Baack, D.E. (1999). Stories and encounters between storytelling organizations. *Journal of Management Inquiry*, *8*, 340-360.

Boudes, T., & Laroche, H. (2009). Taking off the heat: Narrative sensemaking in post-crisis inquiry reports. *Organization Studies*, *30*, 377-396.

Boyce, M.E. (1995). Collective centring and collective sense-making in the stories and storytelling of one organization. *Organization Studies*, *16*, 107-137.

Brown, A.D. (2004). Authoritative sensemaking in a public inquiry report. *Organization Studies*, *25*, 95-112.

Brown, A.D., & Jones, M. (2000). Honourable members and dishonourable deeds: Sensemaking, impression management and legitimation in the 'Arms to Iraq Affair'. *Human Relations*, *53*, 655-689.

Brown, A.D., Ainsworth, S., & Grant, D. (2012). The rhetoric of institutional change. *Organization Studies*, *33*, 297-321.

Butler, I., & Drakeford, M. (2005). *Scandal, social work and social welfare*. Bristol: The Policy Press.

Caronna, C.A. (2004). The misalignment of institutional pillars: Consequences for the U.S. health care field. *Journal of Health and Social Behavior*, *45*, 45-58.

Clark, C.E., & Newell, S. (2013). Masquerading in the U.S. capital markets: The dark

side of maintaining an institution. *Business and Society Review*, *118*, 105–134.

Cooren, F. (2004). Textual agency: How texts do things in organizational settings. *Organization*, *11*, 373-393.

Corbett, E.P.J. (1999). *Classical rhetoric for the modern student*. New York, NY: Oxford University Press.

Creed, D.W.E., Hudson, B.A., Okhuysen, G.A., & Smith-Crowe, K. (2014). Swimming in a sea of shame: Incorporating emotion into explanations of institutional reproduction and change. *Academy of Management Review*, *39*, 275–301.

Currie, G., Lockett, A., Finn, R., Martin, G., & Waring, J. (2012). Institutional work to maintain professional power: Recreating the model of medical professionalism. *Organization Studies*, *33*, 937-962.

Dacin, M.T., Munir, K., Tracey, P. (2010). Formal dining at Cambridge Colleges: Linking ritual performance and institutional maintenance. *Academy of Management Journal, 53*, 1393-1418.

Davis, J.P., & Eisenhardt, K.M. (2011). Rotating leadership and collaborative innovation: Recombination processes in symbiotic relationships. *Administrative Science Quarterly*, *56*, 159-201.

Desai, V.M. (2011). Mass media and massive failures: Determining organizational efforts to defend field legitimacy following crises. *Academy of Management*

Journal, 54, 263–278.

Eisenhardt, K. M., & Graebner, M. E. (2007). Theory building from cases: Opportunities and challenges. *Academy of Management Journal*, *50*, 25–32.

Eisenhardt, K.M. (1989). Building theory from case study research. *The Academy of Management Review*, *14*, 532-550.

Elliott, D., & McGuinness, M. (2002). Public inquiry: Panacea or placebo? *Journal of Contingencies and Crisis Management*, *10*, 14-25.

Empson, L., Cleaver, I., & Allen, J. (2013). Managing partners and management professionals: Institutional work dyads in professional partnerships. *Journal of Management Studies*, *50*, 808-844.

Erkama, N., & Vaara, E. (2010). Struggles over legitimacy in global organizational restructuring: A rhetorical perspective on legitimation strategies and dynamics in a shutdown case, *Organization Studies*, *31*, 813-839

Feldman, M.S., Sköldberg, K., Brown, R.N., & Horner, D. (2004). Making sense of stories: A rhetorical approach to narrative analysis. *Journal of Public Administration Research and Theory*, *14*, 147-170.

Francis, R. (2010). *The Mid Staffordshire NHS Foundation Trust Inquiry: Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009. Volume I*. London: The Stationery Office.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (Volumes 1-3). London: The Stationery Office.

Giddens, A. 1984. *The constitution of society*. Cambridge: Polity Press.

Green, S.E. (2004). A rhetorical theory of diffusion. *Academy of Management Review*, *29*, 653-669.

Green, S.E., & Li, Y. (2011). Rhetorical institutionalism: Language, agency, and structure in institutional theory since Alvesson 1993. *Journal of Management Studies*, *48*, 1662-1697.

Green, S.E., Li, Y., & Nohria, N. (2009). Suspended in self-spun webs of significance: A rhetorical model of institutionalization and institutionally embedded agency. *Academy of Management Journal*, *52*, 11-36.

Greenwood, R., Díaz, A.M., Li, S.X., & Lorente, J.C. (2010). The multiplicity of institutional logics and the heterogeneity of organizational responses. *Organization Science*, *21*, 521-539.

Greenwood, R., Suddaby, R., & Hinings, C.R. (2002). Theorizing change: The role of professional associations in the transformation of institutionalized fields. *Academy of Management Journal*, *45*, 58-80.

Harmon, D.J., Green, S.E., & Goodnight, G.T. (2015). A model of rhetorical legitimation: the structure of communication and cognition underlying

institutional maintenance and change. *Academy of Management Review*, *40*, 76–95.

Heaphy, E.D. (2013). Repairing breaches with rules: maintaining institutions in the face of everyday disruptions. *Organization Science*, *24*, 1291-1315.

Herepath, A., Kitchener, M., & Waring, J. (2015). A realist analysis of hospital patient safety in Wales: Applied learning from alternative contexts from a multisite case study. *Health Services Delivery Research*, *3*(40), 1-242.

Hirsch, P.M. (1997). Sociology without social structure: Neoinstitutional theory meets brave new world. *American Journal of Sociology*, *102*, 1702-1723.

Hoffman, A.J. (1999). Institutional evolution and change: Environmentalism and the US Chemical Industry. *Academy of Management Journal*, *42*, 351-371.

House of Commons Public Administration Select Committee (2005). *Government by inquiry*: *First Report of Session 2004-05*. London: The Stationery Office Limited.

Howe, G. (1999). The management of public inquiries. *Political Quarterly*, *70*, 294-304.

Jepperson, R. L. (1991). Institutions, institutional effects, and institutionalization. In W. W. Powell & P. J. DiMaggio (Eds.), *The new institutionalism in organizational analysis* (pp. 143–163). Chicago, IL: University of Chicago Press.

Kennedy, I. (2001). *Learning From Bristol*: *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995*, Presented to Parliament by the Secretary of State for Health by Command of Her Majesty July 2001, CM 5207(I).

Kraatz, M.S. (2011). Two cheers for institutional work. *Journal of Management Inquiry*, *20*, 59-61.

Lawrence, T. B., & Suddaby, R. (2006). Institutions and institutional work. In: S. Clegg, C. Hardy, & T. B. Lawrence (Eds.), *Handbook of organization studies*. London: Sage, 215-254.

Lawrence, T.B., Leca, B., & Zilber, T.B. (2013). Institutional work: Current research, new directions and overlooked issues. *Organization Studies*, *34*, 1023-1033.

Lawrence, T.B., Suddaby, R., & Leca, B. (2011). Institutional work: Refocusing institutional studies of organization. *Journal of Management Inquiry*, 20, 52-58.

Lawrence, T.B., Suddaby, R., & Leca, B. (Eds). (2009). *Institutional work: Actors and agency in institutional studies of organizations. Cambridge*: Cambridge University Press.

Leach, J. (2000). Rhetorical analysis. In M.W. Bauer and G. Gaskell (Eds.), *Qualitative researching with text, image and sound*: 207–26. Thousand Oaks, CA: Sage.

Liberating the NHS: *No decision about me, without me*. (2012). London: Department of

Health.

Lok, J., & de Rond, M. (2013). On the plasticity of institutions: Containing and restoring practice breakdowns at the Cambridge University Boat Club. *Academy of Management Journal*, *56*, 185-207.

Martí, I., & Fernández, P. (2013). The institutional work of oppression and resistance: Learning from the Holocaust. *Organization Studies*, *34*, 1195-1223.

Micelotta, E.R., & Washington, M. (2013). Institutions and maintenance: The repair work of Italian professionals. *Organization Studies*, *34*, 1037-100.

Nilsson, W. (2015). Positive institutional work: exploring institutional work through the lens of positive organizational scholarship. *Academy of Management Review*, *40*, 370-398.

Pleming, N. (2005). *The Kerr/Haslam Inquiry. Volume 1 and 2*. Presented to Parliament by the Secretary of State for Health by Command of Her Majesty July 2005 (Cm 6640 – I). London: HMSO.

Powell, W. W., & Colyvas, J. A. (2008). Microfoundations of institutional theory. In R. Greenwood, C., Oliver, K., Sahlin, & R. Suddaby. (Eds.), The *SAGE handbook of organizational institutionalism:* 276-298. London: Sage.

Raaijmakers, A.G.M., Vermeulen, P.A.M., Meeus, M.T.H., & Zietsma, C. (2015). I need time! Exploring pathways to compliance under institutional complexity.

Academy of Management Journal, 58, 85–110.

Ramirez, C. (2013). 'We are being pilloried for something we did not even know we had done wrong!' Quality control and orders of worth in the British audit profession. *Journal of Management Studies, 50,* 845-869.

Reay, T., Chreim, S., Golden-Biddle, K., Goodrick, E., Williams, B.E., Casebeer, A., Pablo, A., & Hinings, C.R. (2013). Transforming new ideas into practice: An activity based perspective on the institutionalization of practices. *Journal of Management Studies*, *50*, 963- 990.

Reay, T., Golden-Biddle, K., Germann, K. (2006). Legitimizing a new role: Small wins and microprocesses of change. *Academy of Management Journal* 2006, *49*, 977–998.

Redfern, M. (2001). *The Royal Liverpool Children's Inquiry*. London: The House of Commons.

Rhodes, C., & Brown, A.D. (2005). Narrative, organizations and research. *International Journal of Management Reviews*, *7*, 167-188.

Ritchie, J. (2000). *An inquiry into quality and practice within the National Health Service arising from the actions of Rodney Ledward: The report*. London: South East Regional Office, Department of Health.

Scott, W.R. (2008). *Institutions and organizations*: *Ideas and interests*. London: Sage.

Sillince, J.A.A., & Barker, J.R. (2012). A tropological theory of institutionalization. *Organization Studies*, *33*, 7-38.

Smets, M., & Jarzabkowski, P. (2013). Reconstructing institutional complexity in practice: A relational model of institutional work and complexity. *Human Relations*, *66*, 1279–1309.

Smets, M., Morris, T., Greenwood, R. (2012). From practice to field: A multilevel model of practice-driven institutional change. *Academy of Management Journal, 55,* 877-904.

Sminia, H. (2011). Institutional continuity and the Dutch construction industry fiddle. *Organization Studies*, *32*, 1559–1585.

Smith, J. (2002). *The Shipman Inquiry: Independent Public Inquiry into the issues arising from the case of Harold Frederick Shipman*, Chaired by Dame Janet Smith, DBE:

   − 2002. *Death disguised*;

   − 2003a. *The police investigation of 1998*;

   − 2003b. *Death certification and the investigation of deaths by Coroners*;

   − 2004a. *The regulation of controlled drugs in the community*;

   − 2004b. *Safeguarding patients: lessons from the past—Proposals for the future*;

− 2005. *Shipman: The final report*.

Suddaby, R. (2010). Challenges for institutional theory. *Journal of Management Inquiry*, 19, 14-20.

Suddaby, R., & Greenwood, R. (2005). Rhetorical strategies of legitimacy. *Administrative Science Quarterly*, *50*, 35-67.

Sulitzeanu-Kenan, R. (2010). Reflection in the shadow of blame: When do politicians appoint commissions of inquiry? *British Journal of Political Studies*, *40*, 613-634.

Trust, assurance and safety—The regulation of health professionals in the 21st century. Presented to Parliament by the Secretary of State for Health by Command of Her Majesty February 2007 (Cm 7013). London: The Stationery Office.

Turner, B.A. (1976). The organizational and interorganizational development of disasters. *Administrative Science Quarterly*, *21*, 378-397.

Vaidyanathan, B. (2015). Professional socialization in medicine. *American Medical Association Journal of Ethics*, 17, 160-166.

Walshe, K., & Higgins, J. (2002). The use and impact of inquiries in the NHS. *British Medical Journal*, *325*, 895-900.

Warner, J. (2006). Inquiry reports as active texts and their function in relation to

professional practice in mental health. *Health, Risk & Society*, *8*, 223-237.

Weick, K.E. (1993). The collapse of sensemaking in organisations: The Mann Gulch Disaster. *Administrative Science Quarterly*, *38*, 628-652.

Wicks, D. (2001). Institutionalized mindsets of invulnerability: Differentiated institutional fields and the antecedents of organizational crisis. *Organization Studies*, *22*, 659-692.

Yin, R.K. (2009). *Case study research*: *Design and methods*. London: SAGE Publications.

Zietsma, C., & Lawrence, T.B. (2010). Institutional work in the transformation of an organizational field: The interplay of boundary work and practice work. *Administrative Science Quarterly*, *55*, 189–221.

Table 1   Government inquiries into severe and protracted breaches in the English NHS

The Incompetent Surgeon	
Breach	Mr Rodney Ledward was a consultant (a senior hospital-based medical specialist) in gynaecology and obstetrics at South Kent Hospitals NHS Trust. In 1998 he was found guilty of serious professional misconduct and struck off the Medical Register by the General Medical Council (GMC, the UK professional regulatory body for doctors), having been dismissed by the Trust in 1996. His serious breaches of the institution of medicine spanned the 16 year period from his appointment in 1980 until his dismissal, and included surgical incompetence, the removal of organs without securing informed consent, and providing misleading information to his patients to encourage them to opt for paid private treatment, as opposed to free NHS treatment, for his financial gain.
Inquiry	**The inquiry into quality and practice** **Rodney Ledward (Ritchie, 2000)** In 1999 the Secretary of State for Health set up an independent private inquiry into the quality of Ledward's surgical practice within the NHS. The inquiry, chaired by Jean Ritchie Queen's Council (QC) published its findings in one volume of 389 pages and forwarded 103 recommendations.
The Sexual Abusers	
Breach	Dr William Kerr and Dr Michael Haslam were consultant psychiatrists at York Health Services NHS Trust. Kerr was appointed in 1965 and retired in 1988, while Haslam was appointed in 1970 and retired in 1999. In 2000 Kerr was convicted in his absence (due to dementia and memory loss) on a Trial of the Facts, pursuant to Section 4A of the Criminal Procedure (Insanity) Act 1964, of one count of indecent assault. The jury could not reach a decision on ten counts of indecent assault and two counts of rape. William Kerr was granted an absolute discharge and his name was placed upon the Sex Offenders Register. Haslam was convicted in 2003 of four counts of indecent assault—a conviction of rape was quashed on appeal—imprisoned for three years and his name was placed upon the Sex Offenders Register. Kerr and Haslam's serious breaches of the institution of medicine, centred on the serial sexual abuse of female psychiatric patients, spanned 33 and 24 year periods, respectively. Both sought and were granted voluntary erasure from the Medical Register by the GMC, thereby avoiding professional disciplinary action.
Inquiry	**The Kerr/Haslam inquiry (Pleming, 2005)** In 2002 the Secretary of State for Health set up a modified form of private inquiry under Sections 2 and 84 of the NHS Act 1977 into Kerr and Haslam's breaches of medical practice within the NHS. The inquiry, chaired by Nigel Pleming QC, published its findings in two volumes, totalling 955 pages, and forwarded 74 recommendations.
The Mass Murderer	
Breach	Dr Harold Shipman was a general practitioner (a community-based primary care doctor) in Greater Manchester. In 2000 he was convicted of 15 counts of murder for which he was sentenced to 15 terms of life imprisonment. In addition, he was found guilty of forging the will of one of his murder victims, for his financial gain, and sentenced to a

	concurrent term of four years' imprisonment. In January 2004 Harold Shipman committed suicide in Wakefield Prison. Shipman's serious breaches of the institution of medicine spanned his career. They included the abuse and unlawful possession of opiate controlled drugs—diamorphine, morphine, and pethidine—which he administered by intravenous injection in lethal doses to his victims.
Inquiry	**The Shipman Inquiry (Smith, 2002, 2003a, 2003b, 2004a, 2004b, 2005)** In 2001, the Secretary of State for Health set up a public inquiry into Shipman's medical practice within the NHS. The inquiry, chaired by Dame Janet Smith, ended in 2005 following the publication of six volumes, totalling 2654 pages, and forwarded 190 recommendations for improvement. The inquiry concluded that, in addition to the 15 patients of whose murder he was convicted, Shipman had murdered 200 patients, and may have been responsible for a further 45 deaths. Shipman is recognised as UK's most prolific serial killer.
The Failure of Medical Management	
Breach	Serious breaches of the institution of medicine occurred at the United Bristol Healthcare NHS Trust (UBHT), specifically the Bristol Royal Infirmary (BRI), during the provision of cardiac surgical services for children born with congenital heart defects. In the period from 1991 to 1995, between 30 and 35 more children under one year old died after open-heart surgery in the BRI than might be expected had the paediatric cardiac surgery unit's performance been typical of other units in England at the time. However, concerns were first raised in 1986. The GMC found Mr James Wisheart (Medical Director, UBHT and cardiothoracic surgeon) and Mr Janardan Dhasmana (Associate Clinical Director in Cardiac Surgery, UBHT, and cardiothoracic surgeon), and Dr John Roylance (Chief Executive, UBHT) guilty of serious professional misconduct. Roylance and Wisheart were erased from the Medical Register, while Dhasmana was made subject to condition that he did not operate on children.
Inquiry	**The Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol (Kennedy, 2001)** In 1998 the Secretary of State for Health set up a public inquiry under Section 84 of the NHS Act 1977 into the medical management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995. The inquiry, chaired by Professor Sir Ian Kennedy, published its findings in one volume of 530 pages and forwarded 198 recommendations.
The Illegal Removal and Retention of Body Parts	
Breach	Serious breaches of the institution of medicine occurred at the Royal Liverpool Children's Hospital, and focused on the removal, retention, and disposal of human tissue and organs from children after death without securing informed consent from their bereaved parents in contravention of the Human Tissue Act 1961.
Inquiry	**The Royal Liverpool Children's Inquiry (Redfern, 2001)** In 1999 Lord Hunt, Parliament Under Secretary of State (Lords), established an independent confidential inquiry under Section 2 of NHS Act 1977 into Royal Liverpool Children's Hospital's compliance with the Human Tissue Act 1961 from 1962 to 1999, and aligned compliance with the Coroner's Act 1988 and the Coroner's Rules 1984. The inquiry, chaired by Michael Redfern QC, published its findings in one volume of 535 pages and forwarded 81 recommendations.

The Systemic Failure of Hospital Care	
Breach	Serious breaches of institutionalised practice—medical, nursing, and healthcare management—at the Mid Staffordshire NHS Foundation Trust related to inadequate standards of healthcare provided across the organisation. Critical reports by the Healthcare Commission and Department of Health reflected widespread public concern at the high mortality levels within the Trust, leading to a public loss of confidence in the Trust, its board, management, and clinical services.
Inquiry	**Independent inquiry into the care provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009 (Francis, 2010) and the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013)** In 2010 the Secretary of State for Health set up an independent inquiry into the standard of care provided from January 2005 to March 2009. The inquiry, chaired by Robert Francis, QC, published its findings in two volumes of 815 pages and forwarded 18 recommendations. Francis recommended that the Department of Health should consider an independent examination of the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid-Staffordshire NHS Foundation Trust. He was invited to undertake this inquiry, publishing a further three volumes in 2013, encompassing 1781 pages and 290 recommendations.

Figure 1 Field-level Institutional Repair Work

Forensic rhetorical appeals theorizing the causes of severe and protracted breaches to build advocacy for field-level repair of the institution of medicine

Deliberative rhetorical appeals theorizing repair and building advocacy for change through recommendations which foster field-level repair of the institution of medicine

Maintaining Institutions
- *Demonizing (Ethos Appeal/Opposition)*
  - Providing negative examples of the normative and cultural-cognitive pillars of the institution of medicine.
- *Valorizing and circumvention work (Logos Appeal)*
  - Providing positive examples of the normative and cultural-cognitive pillars of the institution of medicine.

Creating Institutions
- *(De)constructing normative networks and associations (Ethos & Logos Appeals/Opposition)*
  - Of extant policing practices across normative medical management networks and associations, which misuse hierarchical medical power, and enact defensive institutional work.

Disrupting Institutions
- *Disassociating moral foundations (Ethos & Pathos Appeals/ Opposition)*
  - Of medical practice from the moral, ethical, and cultural sensibilities of the profession.
- *Undermining assumptions and beliefs (Logos Appeal/Opposition)*
  - Of medical practice to delegitimate medical professionals' defensive institutional work and inadequate policing due to weak professional regulatory oversight and censure.

Maintaining Institutions
- *Policing (Ethos & Logos Appeals)*
  - Of institutionalised medical practices through auditing, monitoring, and enforcement of compliance with regulatory and normative standards.
- *Embedding and routinizing (Ethos & Logos Appeal)*
  - Of appraisal, audit and CPD as normative medical practices into individual praxis and organisational practices.

Creating Institutions:
- *(Re)educating (Ethos & Logos Appeals)*
  - Of medical practitioners in and through appraisal, audit and CPD.
- *(Re)defining regulations and normative standards of practice (Ethos & Logos Appeals)*
  - Of rule systems and normatively sanctioned medical practices.
- *(Re)constructing normative networks and associations (Ethos & Logos Appeals)*
  - Of medical networks and association to repair and relegitimate the institution of medicine.

Theorization

- *Field-level Repair through Institutional Creation:* Field-level repair is enacted through institutional creation, enhancing the thickness and resilience of the institutional field, to mitigate against future severe and protracted breaches of the institution of medicine.

- *Field-level Repair through Institutional Elaboration (Creative and Disruptive Work):* Field-level repair incrementally refines the institution and associated practices to relegitimate the institution's, rules, normative behaviours, and taken for granted beliefs.

- *Field-level Repair through Institutional Maintenance Work:* The normative and cultural-cognitive pillars of the institution of medicine are reasserted through valorizing and demonizing, and inculcated through the embedding and routinizing of practices which foster adherence to long established professional and social norms. Heightened policing enhances the regulative pillar to ensure that medical practice is enacted within the limits of the elastic tolerance of the institution.

- *Passive Institutional Maintenance:* Replication of the regulative, normative and cultural-cognitive pillars of institutionalised medical practices, which operated within the limits of their elastic tolerance, to maintain the stability of the broader institutional array within the field.

- *Field-level Repair through Institutional Elimination (Creative and Disruptive Work):* Field-level repair incrementally refines the institution and associated practices to delegitimate severe breaches of the institution's, rules, normative behaviours, and taken for granted beliefs.

- *Field-level Repair through Deinstitutionalisation:* Field-level repair is enacted through deinstitutionalisation to remove the breached institution and associated medical practices from the institutional field.

Advocacy for Field-level Repair to the Institution of Medicine
Government inquiry reports build impetus for change across inter-field terrain bounded by politics, policy and law; regulators; professional bodies; and the wider public.