The Portrayal of Healthcare Professionals in the Media

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Abstract

Because of their influence on the general public, the media can impact organizational and professional behaviour within health care. News reports can provide an implicit criteria for evaluating performance (Emanuel and Emanuel, 1996) which can impact how accountability is understood by the public. The media is capable of affecting the reputations of both individuals and organizations, who in turn can influence the actions of those people that are creating safety in healthcare for everyone. For this reason, the role of the media is critical. Media reports can help bring a greater understanding of healthcare and how incidents there are being dealt with; however, it can also limit trust both inside and outside the organization. Ultimately, the perception of risks and benefits are likely to be moulded by the media (Lewison, 2008). Thus, this thesis explores whether the news media in Canada represents healthcare professionals in a way that promotes trust. Using qualitative research methods, healthcare-related news articles were gathered from the online archives of the major Canadian news sources; 75 articles were included in the analysis focusing on mastectomy errors (n=22), the H1N1 pandemic (n=26) and pathology scandals (n=26). The data set was enriched through semi-structured interviews with three experienced reporters. The results showed that the dominant theme throughout the articles and the interviews was accountability. The frequency of an occurrence of a medical error in combination with an impact on the public were the causal conditions that influenced reporting of accountability. Access to care, transparency, internal incident reporting, disclosure, and apologies were the specific strategies discussed with regards to accountability. While legal action, reviews into the incidents and the disciplinary actions taken were the consequences that follow

from how the conditions of accountability were managed. Whether each of these issues are seen from a systems viewpoint, or the individualistic ways of the older view of safety, influenced the context and set the tone of the articles. In each case, a perceived lack of accountability increased the media's attention on the issue. Media articles showed that in cases where there is direct experience with medical errors, the patients had an even more heightened sense of risk; the result was greater emphasis on the patient and their families responsibility to be aware of what is going on with their care. Ultimately, the public needs to trust healthcare professionals, but not so much so that healthcare professionals remain on a pedestal. A certain level of mistrust, which is reinforced through the media's articles on medical errors, can be beneficial if it leads patients to take their own rights and responsibilities regarding healthcare more seriously than they seem to do at present.

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Introduction

The creation of both risk and safety is achieved by individuals at all levels of the organization often through goal trade-offs that are legitimate and beneficial within the work setting (Dekker, 2006). Research shows that in order to maintain safety it is critical to find a balance between safety and accountability; within a just culture an account of failure will both satisfy demands for accountability and contribute to learning and improvement (Dekker, 2007a). A just culture has benefits that are threefold (Dekker, 2007a). First, a just culture is beneficial because it enables the regulator to monitor the safety of the organization and understand the capability of both the individuals and organization so as to effectively meet problems that arise. Second, a just culture is beneficial for those inside the organization because they can feel free to focus on doing their job well rather than on trying to limit personal liability; this empowers individuals to point out weaknesses within the organization and thus actively play a role in improving safety. Third, a just culture is beneficial to society because in the long run, consumers will be better cared for in an atmosphere where the workers are focusing on doing quality work and thus constantly improving safety. The goal of achieving a just culture is challenging, but necessary in order to learn from incidents and continuously create safety in safety-critical professions. An additional benefit from a medical management perspective, is that reducing adverse events is central to efforts to improve quality and lower costs in healthcare (Barach and Small, 2000).

In achieving a just culture it is important to understand the effect of outside factors have on such a project. The quality of the norms, standards of practice,

expectations and values are driven not only by standards of practice, but by economic and social factors. “Media, advocacy, and others also influence organizational and professional behavior, but do so indirectly, often working through other parties that have direct influence, such as purchasers and consumers” (Kohn et al., 2000, p. 20). In other words, through their influence on the general public, the media can impact organizational and professional behaviour within health care. News reports can provide an implicit criteria for evaluating performance (Emanuel and Emanuel, 1996) which can impact how accountability is understood by the public.

Interactions between health care institutions and the media are not only inevitable, but necessary. The Canadian Institutes of Health Research (CIHR, 2008) listed three main reasons why professional interactions with the media are essential. First, media coverage of health research plays a critical role in the translation of research. Popularizing the research through the media provides researchers with important public feedback, and a mechanism for cross-disciplinary communication. It also provides greater information to both decision-makers and the public. Second, the media can significantly influence funding decisions for universities, hospitals and research-granting agencies. Positive media coverage of CIHR and its grant recipients also helps promote federally-funded research. The third reason cited by the CIHR for the relationship between researchers and journalists is public interest; Canadians want to hear about current research and the media are the public’s single most important source of information on science and health. As Eurocontrol (2008, p. 16) put it “what the media reports, influences the perception of the general public. the media can be

seen as the gateway to the public - educating them will improve the knowledge and expectancy of the public at large."

The News Media

The news provides an outlet through which the public can gain information about what is going on. But the news is first and foremost a social institution because it gives a public character to an event; it is rooted in relationships with other institutions and maintains the right to interpret everyday events to the public (Tuchman, 1978). Despite the fact that journalists may set out to tell the public the truth, "they continue to be primarily messengers who mainly simplify and dramatize what their sources say and do" (Gans, 2004, p. xviii). Furthermore, news organizations seek to disseminate information that the public want, need and should know; in doing so they both circulate and shape knowledge (Tuchman, 1978). However, with many sources available for news including televised newscasts, newspapers, the radio, and now more than ever, the internet (each of these includes dozens, if not hundreds of possible sources within each category) the pressure is on to present the most interesting stories to audiences within a limited amount of time (Gans, 2004). To meet the needs of news organizations a story must have wide appeal and must be able to generate public interest. Among journalists, "professionalism is knowing how to get a story that meets organizational needs and standards" (Tuchman, 1978, p. 66). Thus, in such a highly competitive field, the risk to a just culture is that the media will present the stories of human error in a way that places blame simply to generate the most public interest.

In its most basic form, the media can be an avenue for gossip. Like the media, gossip expresses the norms, values and ideologies of the community (Hunter, 1994). As the most rudimentary form of modern journalism, gossip functions to assist in the circulation of information as well as to ensure appropriate standards of behavior within the community through sanctions on individual conduct (Hunter, 1994). By disseminating information to a mass audience, gossip in ancient Athens for example, "allowed the lower classes to judge the correctness or otherwise of individual conduct, thus exerting some control over the elite" (Hunter, 1994, p. 118). Consistently, news disseminated by the nineteenth century town crier was gossip as a form of knowledge in order to keep track, offer help, or criticism to members of the community as deemed necessary (Tuchman, 1978). The way in which the media functions today is not that different; information can still empower the people. However, blaming individuals is not in the best interest of the public in general; blaming will not improve safety.

The Impact

The effect of articles pointing the finger could be quite damaging for the reputation of any health care professionals named. "When information is widely disseminated, harms to reputation carry great weight because one can neither live them down nor escape them" (Nock, 1993 as cited in Sage, 2004, 166). More importantly, such an article could misdirect attention away from the real problems resulting in the loss of a learning opportunity for those in the system. Such losses to learning can happen when stories are positive as well. In organizations that emphasize extraordinary individual performance, like healthcare, "hero stories become epics that define

organizational culture" (Rochlin, 1999, p. 1554). This detracts confidence from the collective by focusing on individuals being sought out and nurtured as potential heros (Rochlin, 1999). The success of the healthcare system however, is dependent on the team, not just individuals.

It is important to understand that journalists have been said to consider themselves to be objective and nonidealogical, whether this is true or not, when it comes to deciding what is news, and how it should be reported (Gans, 2004). Given the breadth of the audience which they can reach, the media can have a significant impact on how adverse events are perceived and handled in safety-critical work. If the media reports are distorted (e.g. through the hindsight bias), then the solutions that are proposed can be counterproductive in two ways: first, they could break the flow of information necessary to promote learning about systematic vulnerabilities; and second, they can create new difficulties to change everyday practice (Woods and Cook, 2002, p. 138). This highlights the necessity of media reports being accurate, however, with reporters' tight deadlines absolute accuracy can be difficult to achieve. The factual error rate in media reports is, in part, dependent on how well prepared the reporter is for the subject matter (Eurocontrol, 2008, p. 16). This raises the question of how familiar and knowledgeable most reporters are with the complexity of the healthcare system.

The media is capable of affecting the reputations of both individuals and organizations, who in turn can influence the actions of those people that are creating safety for everyone. For this reason, the role of the media is critical. Eurocrontrol (2008) lists the most compelling reason for competent media relations as the need to deal with legitimate press interest in the wake of an incident or accident. If an organization

chooses not to comment about an event the media can not only report the story anyways, but the withholding of information could impact how both the incident and the organization are portrayed. By ignoring the need for media relations, the organization risks unnecessary damage to their credibility, and their reputation for competence can take years to repair (Eurocontrol, 2008).

In general, when a story breaks about safety, it is told as a ‘first story’, which is an over-simplified account of causation (Woods and Cook, 2002). The ‘first story’ is an account of the event told often with the bias of hindsight. The problem with the hindsight bias is that it can distort and narrow ones perspective; stripped of all context, the first story appeals to people because it points to the cause of failure in practitioners directly involved in the issue (Woods and Cook, 2002). The result is that “there is a premature closure on the set of contributors that lead to failure; the pressures and dilemmas that drive human performance are masked; and how people and organizations work to overcome hazards and make safety is obscured” (Woods and Cook, 2002, p. 137-8). Appearing in the media, first stories influence the public, legal, and regulatory reactions to failure; however the distortions reported can lead to weak or even counter-productive proposals for ‘solutions’ (Woods and Cook, 2002, p. 138). Real progress on safety begins with discovering the ‘second stories’. The dilemma is that the hindsight bias expressed in first story, especially when widely disseminated among the public, often impedes deeper investigation into understanding the second stories.

On the positive side, the media is able to help instigate change. In the United States, media reports on cases of medical error helped prompt the Institute of Medicine to conduct intensive research into adverse medical errors. Their findings were

documented in the report, *To Err is Human: Building a Safer Health System*. The recommendations made by the report resulted in further media attention in 2000 and contributed to President Clinton and subsequently Congress addressing the issues and pledging to reduce medical error by fifty percent over five years (Sharpe, 2003). By bringing attention to the issue, the media succeeded in forcing both researchers and political figures to take action. This is consistent with the indications that the topics given the most coverage by the news media, are considered by the public to be the most important issues of the day (Tuchman, 1978). On the surface this seems good, however there are many unknowns in the impact of the media. Looking at the big picture, the media reports attracted attention to the problem of medical errors, however the influence on the day-to-day actions of health care workers are not known or even well documented. In other words, what effect did it have on the people that create risk and safety within particular organizations?

The Culture in Healthcare

Although a variety of models of accountability exist, at times simultaneously in Western society, in healthcare, the traditional model of accountability has been the professional model (Emanuel and Emanuel, 1996). In the professional model, healthcare is a professional service in which the professional is dedicated to the well-being of the patient; this model relies on trust, collaboration and shared interests among and between individual actors/practitioners. Emanuel and Emauel (1996) also discuss, first, the economic model which focuses on maximizing financial success wherein patients are seen as consumers and healthcare as a commodity; and second, the

political model, which adapts the mechanisms of accountability in the political sphere to healthcare. In the political model, “individuals are neither trusting patients nor price-conscious consumers but are more akin to citizen-members” (Emanuel and Emanuel, 1996, p. 233). However, despite the competing goals of the various models working simultaneously, the result of the emphasis on the professional model is that when something goes wrong, the reaction is that someone must be to blame.

The existing blaming culture within the healthcare delivery system can generate fear and destroy trust (Harber and Ball, 2003). A just culture, which puts aside blaming, should have an active role in the Canadian healthcare system; the Canadian Medical Protective Association actively supports the continuous effort to develop a just culture. Accreditation Canada also works to assess and improve the services provided to patients based on standards of excellence. However, within the healthcare system there is still a silence when it comes to error and mistake. “Medicine, like other professions, has a long tradition of self-policing errors and closing ranks against external accountability” (Sage, 2004, p. 165). Despite the benefits of a just culture, the memory of fear created by the blame and shame culture still exists hindering the establishment of a different way of thinking about safety. The more the media focuses on the shame and blame approach, the more the media creates fear of reporting of safety issues within the hospital and this further impacts public opinion.

Insufficient incident reporting within the hospital or network can exasperate issues with the media. Specifically, if incidents are not reported and the people in charge of media relations do not have sufficient information about an event when the

media inquires, the lack of information could be perceived as a cover-up (Eurocontrol, 2008).

> When trust evaporates, the media abandon the search for information in favour of searching for the people to blame. This would be a disaster for Just Culture, because an organization that is perceived as being intent upon an information cover-up, is also seen as the type of organization that would use the Just Culture philosophy as a system for preventing the media getting at the truth about mistakes that have been made in the past (Eurocontrol, 2008, p. 24).

This highlights the importance of the system being open and honest in order to effectively establish and maintain a just culture. However, a conundrum exists in how to satisfy the media's need to see that the healthcare system is open and honest, when healthcare professionals cannot be open and honest until they believe that they will not be blamed for honest mistakes and dragged into the news or even court.

In a review of the criminalization of medical mistakes in Canada it was noted that unlike the United Kingdom, where charges laid against healthcare professionals has significantly increased in the past 20 years, the rate of charges in Canada has remained relatively low and in fact has not increased over the past two decades (McDonald, 2008). The difference in the rate at which criminal charges have been laid are explained by cultural factors. Specifically, the public's level of trust in healthcare professionals has decreased substantially in the U.K. likely as a result of patients dying because of negligent acts or omissions in several high profile events. The effect of these deaths has been seen as responsible for an increased pressure from both the media and the public

for accountability and the assignment of blame by police and prosecutors. Yet despite the low rate of criminal charges in Canada:

> It is unlikely that Canadian society has been immune amongst western countries in experiencing the types of cultural change associated with a generalized loss of trust and an increased desire for accountability and blame. However, this generalized mistrust does not yet appear to be associated as strongly with health systems and health professionals as it does in other countries (McDonald, 2008).

This statement shows that people do not feel that healthcare professionals are immune to mistakes and there is a desire for accountability and blame. In Canada this loss of trust and increased need for blame could potentially result in an increase in both media attention and criminal charges of negligence as it has in the UK.

The Understanding of Accountability

When an event such as human error is seen as a crime, culpability is only one of the possible languages that could be used, one perspective among a multitude of possibilities according to the social constructionist view (Dekker, 2008). As Dekker points out, “observers are not passive recipients, but active creators of the empirical reality they encounter... objective, impartial access to the world is impossible” (2005, p. 65-6). The implication is that everyone from sources, journalists, editors and consumers interprets the information presented to them from their own perspective. “The reality of an observation is socially constructed” (Dekker, 2007b, p.179). Thus, truth does not inherently exist, meaning is merely enforced and passed down (Dekker, 2007b, p. 180).

As a result, a single adverse event can be interpreted in countless ways. For example, a medical error may be "framed as technical error by medical culture, as risk management by hospital administrators, as moral error, injustice, perhaps even sin, by patients, as spiritual and psychological devastation by the individual clinicians involved" (Berlinger, 2004, p. 120). The implication is that the media can present one or two sides, or versions of the story without taking into account all the other factors in play, ones that they may be unaware of. By presenting stories this way, the media can bias the public into believing some simplified version of the story. "The way the media report the situation has a major influence on the reaction of the public, the Government and even the Judiciary" (Eurocontrol, 2008, p. 26). Thus a situation which would not have originally garnered interest from the judicial system could result in charges being laid because of the way in which the story was represented in the media.

By believing that one version of an event is true, it hampers the ability to see other possible interpretations that could be more constructive and more analytically precise (Dekker, 2008). If that happens than opportunities for understanding the underlying systemic problems and thus learning from mistakes can be lost (Dekker, 2007a). The effect can then be detrimental to the establishment of a just culture because it places accountability largely outside of the organization. In other words, the line between culpability and accountability which is critical in establishing a just culture is left in the hands of the media. This is not to say that the media sensationalizes every story and misrepresents the truth, the point is simply that they possess the power to (re)write history on a day-to-day basis. This, compounded with the difficulties of

establishing accountability necessary to create a just culture, makes the public perception which is left by the media of the utmost importance.

Yet, media relations can be conducive to the establishment of a just culture within the Canadian healthcare system. A just culture balances safety and accountability and "calls for accountability themselves are, in essence, about trust" (Dekker, 2007a). Media reports can help bring a greater understanding of healthcare and how incidents there are being dealt with; however, it can also limit trust both inside and outside the organization. Ultimately, the perception of risks and benefits are likely to be moulded by the media (Lewison, 2008). As this thesis' literature review revealed, the media can impact the reputation of both individuals and organizations (e.g., Eurocontrol, 2008), the willingness of individuals to report incidences within the organization (e.g., von Thaden, et al. 2006), and pressure the police and prosecutor to lay charges (e.g.., McDonald, 2008). Therefore, the potential impact on the development of just culture within healthcare can be contingent upon how media stories are presented. The way in which stories are presented is a critical issue to understanding the potential impact the media can have on just culture. Although the impact of the media has been discussed in the literature, the way stories are presented by the media, and thus the level of trust that is expressed for healthcare professionals, has not received much attention.

Research Question

Does the news media in Canada represent healthcare professionals in a way that promotes trust?

Method

Database

A qualitative approach was used to look at the research question empirically. To understand media reporting, data was compiled through both news articles and interviews. By looking at how healthcare was presented by the media from the outside looking in, better indicates the messages that are given to the public. Healthcare-related news articles were gathered from the online archives of the major Canadian news sources, including CTV News, Global News, the National Post, and the Globe and Mail. These sources were chosen because they represent what is generally regarded as the most legitimate news sources available across Canada. Articles from these sources are available to the public through each organizations website and include articles from major city newspapers within the parent organizations. Articles were found using the search terms, “medical” and “mistake” or “error” and “patient safety”. Only articles from Canada and about healthcare in Canada, published between January 2008 - March 2010 were included in the study for analysis. Articles were sorted according to topic and the dataset was narrowed down to 75 articles, involving mastectomy errors (n=22), the H1N1 pandemic (n=26) and pathology scandals (n=26). Within the category of pathology scandals, the articles focused on cancer tests in Newfoundland (n=10) and Quebec (n=3), Winnipeg (n=8) and New Brunswick (n=5). The remaining articles were used as reference material to ensure that the data set was sufficiently saturated to draw conclusions from the analysis. The articles included in the analysis came from Global News (52%), CTV News (27%), Globe and Mail (12%) and the National Post (9%).

Participants

The data set was enriched through interviews with three experienced reporters. Participants were recruited from Ottawa news stations on a voluntary basis with the permission and assistance of their network President. Reporters were recruited from the Ottawa region for convenience-sake, however all participants have at least 10 years of experience in news reporting. Interviews were semi-structured and used open-ended questions which included background questions, general questions on the role of the media, and how stories are gathered, as well as healthcare-specific questions. Prior to all interviews, written informed consent was obtained and all participants were free to end the interview at any time. See Appendix A for the informed consent form. Interviews were 30-45 minutes in length and were recorded using a digital recorder and transcribed afterwards. A copy of the interview questions is included in Appendix B. Participant names were coded upon transcription and no identifying information was included in the thesis in order to maintain informant anonymity. This was done to increase the participants' comfort level, and their willingness to share information without fear of negative consequences. The questions for the interviews were added, modified or deleted during the course of the interviews as deemed appropriate.

Analysis

Consistent with grounded theory, data analysis proceeded in several stages (Creswell, 2007). First, the data was read and re-read to identify categories formed about news reporting in healthcare through open coding by segmenting information. Within each category, several properties, or subcategories were identified to show the

extreme possibilities on the continuum of reporting. Second, in order to demonstrate relevance, categories were 'saturated' with many appropriate cases (Silverman, 2010). To do so, the data was assembled in new ways for axial coding; here a central phenomenon was identified and causal conditions were explored, then specific strategies and the context conditions were identified followed by descriptions of the consequences (Creswell, 2007). Third, selective coding connected categories into a more general analytic framework with relevance outside the setting (Silverman, 2010). Recurring issues were compared and contrasted both within the articles and interviews as well as between them to identify significant patterns. Few inconsistencies were found between the four different news sources with regards to how the news was reported.

News articles are referenced as follows: (e.g. GMPS-01/01/10), wherein the first two letters refer to where the article was published (GM = Globe and Mail, NP = National Post, GN = Global News and CN = CTV News), the second two letters refer to the category (PS = Pathology Scandals, SF = Swine Flu, aka H1N1, and ME = Mastectomy Errors), and the numbers refer to the date the article was published (month/day/year)

Results

The dominant theme throughout the articles and the interviews was accountability. Accountability, in the most general of terms, "is about individuals who are responsible for a set of activities and for explaining or answering for their actions" (Emanuel and Emanuel, 1996, p.229). Consistent with the findings of Emanuel and Emanuel (1996) within the news articles the professional model was most

emphasized but economic and political models of accountability also played a role. However, for the purposes of this thesis, the professional model is the main focus because of its emphasis on trust in healthcare professionals.

From a journalistic point of view, reporting incidents and accidents in healthcare was “absolutely about accountability.” Reporters felt that it was their obligation to “keep [the healthcare system] in check at all times...because of how important healthcare is to people...We’ve got to understand how it works, how it’s working for people and how it’s failing people at the same time.” Thus the media’s strategy according to these informants was to empower the public through providing information on the issues that affect them. One reporter interviewed went on to explain that “things like [dosing mistakes and the botched breast cancer tests] terribly terribly shakes people’s faith in something that they think should be there for them all the time and should be, I mean the healthcare system is about our lives.” Thus, in order for the public to trust healthcare professionals, they must see them as being accountable. However, it is important to note that journalism, as one reporter described “has become very reactionary rather than proactive in digging into the system and figuring out how it works.” This impacts the tone of the articles and the issues that are discussed which puts greater pressure on the healthcare system, and healthcare professionals to be accountable at all times in part because any given incident can be taken to the press by a patient.

“Accountability is about learning, truth and continuous improvement” (Harber and Ball, 2003). As such, issues in these areas spur greater media attention. Within the articles, accountability was the central category. As shown in table 1, the occurrence of

a medical error in combination with an impact on the public were the causal conditions that directly influenced reporting of accountability. Access to care, transparency, internal incident reporting, disclosure, and apologies were specific strategies discussed with regards to accountability. While legal action, reviews into the incidents and the disciplinary actions taken were the consequences that followed from how the conditions of accountability were managed. Whether each of these issues is seen from a systems viewpoint, or the individualistic ways of the older view of safety, influenced the context and set the tone of the articles. In each case, a perceived lack of accountability increased the media's attention on the issue.

Table 1. Axial coding of themes within the articles

Central Phenomenon	Accountability
Causal Conditions (conditions that influence the phenomenon)	Impact on Public
	Medical Error
Specific Strategies (the actions or interactions that result from the central phenomenon)	Access to Care
	Transparency
	Internal Incident Reporting
	Disclosure
	Apologies
Conditions and Context (conditions that influence the strategies)	Systems View
	Old View
Consequences (the outcomes of the strategies)	Reviews
	Legal Action
	Disciplinary Action

Access to Care

Access to care was listed as one of the domains in which healthcare professionals, and especially doctors can be held accountable to patients (Emanuel and Emanuel, 1996). In Canada's publicly funded system, it is expected that everyone should have equal access to care. The more barriers to accessing care, such as long line-ups or wait-times, doctor shortages, bed shortages, etc, the more media stories discuss this issue. In the H1N1 articles, the long line-ups and vaccine shortages were a frequent focus, with more than half the articles mentioning issues with access. Significant media attention was dedicated to issues like queue-jumping, e.g. the preferential treatment of certain groups, such as hockey teams and hospital board members in gaining access to the vaccine. Within the H1N1 cases, issues of access and availability were emphasized because of the large impact on the public; in general, the proportion of people that were affected by the issue was reflected in the number and kinds of articles that appeared on the issue.

Within healthcare articles, both positive and negative aspects of accountability were discussed. So although a lack of access resulted in media attention, especially when other issues related to accountability (i.e., disclosure, transparency, etc) were questioned, access to care was used by the healthcare officials as positive evidence that the system was being held accountable. Specifically, with the pathology articles, hospitals gave priority in appointments and treatment to those patients whose results were changed when the tissue slides were retested. Thus in this case, access to care signaled that patient safety was indeed made a priority.

Transparency and Incident Reporting

The media and by extension the public, expect transparency from hospitals; being open to public scrutiny demonstrates that the system is accountable for its actions. When the media discovers a lack of transparency, say an attempt to hide information that impacts the public, there is a drastic increase in the number of articles written about the subject. In the articles concerning a mistaken mastectomy in Windsor, the hospital only learned of the doctors' mistake three months after the fact through an inquiry from the media. The lack of incident reporting between doctors and management within the hospital added to the newsworthiness of the story when a previous patient, who was also mistakenly given a mastectomy by the same doctor, came forward after the hospital had told the media that the incident in 2009 was the doctors' first error. The fact that the hospital was unaware of either incident until informed by the media, escalated the interest of reporters and resulted in nearly daily updates on the story.

Articles also highlighted the fact that the pathologist who wrote the report that the surgeon later misread, had been previously suspended and was under review, despite the fact that her report in this particular case was correct. The issue was that the public was not notified that her pathology tests were already under review, rather than any wrongdoing in this particular case. Still this increased media attention. The lack of transparency on the part of the hospital thus increased the newsworthiness of the incident. As one reporter said "it's just fundamental that any time that there is a problem in the system, the only way it is going to be fixed or to be improved upon is by awareness." Thus, transparency is considered critical in order to better the system.

Disclosure and Apologies

Disclosure is an important aspect of demonstrating accountability to patients. The majority of both physicians and the public favour disclosure, believing that physicians should be obligated to inform patients of errors that occur under their care (Blendon, et al., 2002). In the mastectomy cases, both patients were informed of the error by their doctor shortly after the incident. In this respect, the doctor was being accountable for her actions and as a result, this aspect of the story garnered less attention in the media's reports. Compared to the issues with transparency, the act of disclosing the incident was mentioned half as often in media accounts.

In comparison, with the articles on the pathology scandal in Newfoundland, Canada, disclosure was a major issue in the public's perception of both doctors and the health authorities' level of accountability. An investigation into the botched breast cancer tests revealed that patients did not learn of the change in their diagnosis results until two years after the tissue samples had been retested. In one article, it was written that during the inquiry, one patient said that "she cannot forgive the health authorities for not telling her sooner her tests were wrong" (NPPS2-03/20/08). The lack of trust that ensued was not the result of the pathology test being wrong so much as the lack of disclosure about it.

Although problems were found with pathology reports in other provinces, in these cases changes in results were disclosed to patients earlier and as a result, there were less negative repercussions. In one incident, an error was made during a patient's surgery, leaving forceps in her abdomen, however, the article stated that "by taking a principled approach of quickly disclosing medical errors and apologizing to patients,

health officials hope to restore dignity in their dealings with them" (GMPS23-11/16/09). When the surgeon offered to transfer her care to another doctor she replied " 'No, 'I trust you, you did a good job in my surgery" (GMPS23-11/16/09). These findings are consistent with research that has shown that "full disclosure results in a more positive response on the part of the patient or family member in terms of satisfaction and trust, and reduces the likelihood of changing physicians" (Mazor, et al., 2006, p. 707).

Still a culture of silence which discourages healthcare professionals from informing patients about problems related with their care exists in part because of the threat of medical malpractice (Sharpe, 2003). A similar silence has been observed in how cautious healthcare providers can be about contributing information that could be used against them later. "The potential for litigation may sometimes significantly influence the behavior of physicians and other health care providers" (Kohn et al. 2000, p. 110).

Legal Action

Emanuel and Emanuel (1996) describe professional competence and legal and ethical standards as the primary domains of accountability within the professional model, with licensure, certification and malpractice suits as the primary procedures for professional accountability. Such procedural actions for accountability are also emphasized in media reports. The logic for laying charges against healthcare professionals or other professionals in safety-critical fields is that it provides a sense of accountability. From this perspective the belief is that something went wrong, therefore there must be someone to blame. No criminal charges were mentioned in any of the

articles, however civil suits were filed against both doctors and the hospitals in the pathology and mastectomy cases. "Studies have found that patients and family members pursuing legal action subsequent to an error are often motivated by the desire for explanations and apologies" (as reported in Mazor, et al., 2006). In all of the articles in which legal action is mentioned, issues with accountability are present - whether they are with transparency, disclosure, apologies or a combination therein. In other words, legal action is often one of the strategies used to create accountability as is shown in table 1. Consistently, research suggests that when patients and their families have a positive, open and honest relationship with their healthcare provider, they are less likely to file a lawsuit (Levinson et al. 1997, as cited in Liang, 2004).

According to Dekker (2007a), involving the legal system in the wake of failure can be decidedly unjust on several levels. Generally, victims feel under-compensated and dissatisfied with having gone to trial; the practitioner is a scapegoat and feels singled out; the organization receives unduly negative media attention; the legal proceedings itself becomes more about enigmatic legal issues and procedures and therefore does not seem to do justice to the actual content and operational subtleties; finally there is always a losing side. By solving problems of accountability in this way, justice is often not served, nor is safety improved. In fact, safety agendas almost always suffer because afterwards practitioners tend to take defensive approaches in order to protect themselves and information about safety is not reported for fear it will be used against them (Dekker, 2007a, p. 21).

Families resort to legal action because the organization was not forthcoming in giving answers (Dekker, 2007a, p. 108). Such actions were evidenced in the

mastectomy case in Windsor; a multi-million dollar lawsuit was only filed against the doctor, pathologist and hospitals after the patient learned of the previous incident which the organization was not even aware of. When organizations are open and honest with patients and their families, lawsuits are less likely to occur. For example, a hospital in Kentucky made disclosure standard, requiring that physicians inform patients about "unanticipated outcomes" associated with their care (Sharpe, 2003, p. 6). By showing patients that they were open and accountable, the hospital ultimately saved money while creating an open atmosphere of professionalism and trust.

Reviews into Incidents

When issues of accountability within healthcare become public it often prompts an internal and/or external review into the incident. Thus, like legal issues, reviews are related to the process of accountability. Each time a review was mentioned, the public was assured that the inquiry would get to the bottom of the matter. However, in reality the scope of the reviews often seem limited. In the H1N1 cases, investigations only went as far as finding the person or persons who erred, giving the public the illusion that the problem was fixed while leaving others in the system virtually unaccountable for its or their role in the incident. In the pathology cases, despite problems arising with testing nationwide, half of the administrative reviews focused on a single pathologists' work. Only in Quebec, was the review done proactively as a result of problems noted in other provinces. Because the story there started with an emphasis on a systems approach, the accountability of individual physicians was never called into question. In contrast, accountability was in question in Newfoundland, where the pathology tests received the

most media attention because the problems had so multiplied. The large scale review that was conducted as a result, specifically stated that multiple factors within the system contributed to problems. However, the media also reported the opinions of politicians within the opposition who laid political blame, calling for the Health Minister to be fired despite the fact that the review specifically did not blame any one individual. The controversy increased the number of articles that appeared in each of the news sources.

Accountability involves one party providing a justification for procedures and processes and being held responsible for its actions by another party that has a vested interest (Emanuel and Emanuel, 1996). As such, blaming and shaming often becomes a primary focus when an error has occurred. Furthermore, given the publics belief that when an error occurs the doctor is most responsible (Blendon, 2002), it is not surprising that institutions, in order to satisfy demands for accountability, often focus on individual practitioners. Especially when public outcries demand accountability, there is a tendency to blame an individual. In one case where a child was given the adult dose of the H1N1 vaccine, the father was outraged after a review into the incident, because the nurse was not punished more severely. The father “was told the nurse now has been retrained on the proper procedure. “I was absolutely shocked,” he said, that the nurse was still giving flu shots. He said he thinks the nurse should lose her license, noting someone who accidentally shoots someone with a gun would likely go to jail” (GMSW16-11/08/09). Given that his daughter only experienced mild side effects from the vaccine, his reaction does seem extreme and he went on to advise other

parents to check the dose themselves which shows that his trust in healthcare professionals had been affected.

Reporters themselves seem to embrace neither the old view or new view way of thinking regarding safety in the articles that they write. However, as shown in table 1, the views expressed create the context and/or conditions that can lead to reviews, legal action, and disciplinary action. Whether statements express systems thinking or, like the old view rely on blaming and scapegoaing, depends the most on whose perspectives are included in the report. As one reporter explained “objectivity is crucial in reporting, in telling the story itself... to ask questions, to find out the facts, to present the facts and to present the different views and to let people come up with their own conclusions.”

Disciplinary Action

The way in which organizations administer discipline also indicates whether they take a systems or blaming approach in dealing with incidents. On one end of the spectrum, individuals who a review revealed to have erred were fired. Specifically in the H1N1 articles, two individuals were fired in an attempt by the organization to prove that they had dealt with the matter. However, similar incidents of queue-jumping occurred in other provinces. This suggests that the problem was not localized, and potentially points to a number of systems issues. Frequently during reviews, the healthcare professional in question was suspended. In the New Brunswick pathology scandal, only one doctor was under review and the public was given reassurance that he had been suspended and no other doctors’ work was considered to be inadequate. The doctor however, “has maintained his work was not as flawed as the inquiry was told, and he portrayed himself

as the victim of a hospital administration that was out to get him" (CNPS-12/12/08). The accuracy of this doctor's perception of being used as a scapegoat was not questioned in the media. Letting the blame rest on a single doctor was apparently enough reassurance for the public that the issue had been dealt with, despite similar problems in pathology tests across the country. On the other end of the spectrum, some pathology reviews in other provinces resulted in little to no disciplinary action against specific doctors, and instead, problems in the system were the main focus.

Public Perception

Public interest impacts news stories; issues that are perceived to be of greater interest to the public get more attention within the media. Stories are often made more newsworthy by adding a human element. As one reporter explained "when you're doing a healthcare story, the very first thing you're going to see is... there's a human element to every story." Another reporter explained:

> As long as you can get that human element, tell the story in a way that it impacts people using an individual or a couple of individuals as examples, that makes for a powerful medical story... Putting that human face on the story so that people know what impacts that individual and then we can extrapolate over the whole population, hey if it affects you, it can affect you, and if it can affect you, it can affect me.

By adding the human element, the public is able to see how their own lives could be affected.

Stories on medical errors represent the minority of healthcare-related articles presented in the news. Healthcare stories range from breakthroughs in research and technology, to information about heart attacks, strokes, and other medical conditions, to medical errors, to political and budgetary concerns regarding the healthcare system. The result is that a relatively small proportion of articles focus on errors made by healthcare professionals. One reporter stated that "for the most part, I think that the majority of stories about healthcare are favourable stories, good stories, where we tell about doctors and researchers about the good things they do." However, when articles focused on medical error there was almost always multiple articles on the incident and each one would refer back to previous incidents. Such articles and article lineages are not only crucial in our notion of how reality is constructed, but can also have a significant influence on public perceptions of some of the most pressing issues of the day (Berry, Wharf-Higgins and Naylor, 2007). These factors can impact how the public perceives healthcare professionals.

After experiencing a medical error in their own care, or in the care of a family member, individuals often mentioned the patient's reaction to the incident. For example, one woman who was misdiagnosed with cancer resulting in a mastectomy said that "since the mistake, she does not undergo any medical procedures without a second opinion" (CNME9-02/25/10). Being affected by an error made patients more cautious; patients were more likely to ask more questions or ask for a second opinion after they had been impacted by an incident while none reported such caution prior to the incident. Despite the fact that the professional model of accountability considers the patient as a participant-recipient of professional services (Emanuel and Emanuel, 1996), the

patient's role and responsibilities was not mentioned in the articles on the mistaken mastectomies and pathology scandals unless it is brought up by the patient interviewed. Even then, the patients' responsibilities were only mentioned in 10% of the articles examined. The role of healthcare professionals however, was the main focus of these articles and as such, media articles focus public attention away from what the public can and should do themselves, and onto the healthcare professionals. Such perceptions could potentially increase the desire to personalize the healthcare system and assign blame to individual actors.

Discussion

Ultimately, accountability boils down to a matter of trust; trust that the organization takes problems seriously (Dekker, 2007a, p. 23). The way that the media learns about stories, the actions of both healthcare professionals and the healthcare system all impact the tone and content of the media's reports. Overall it was found that when those in the healthcare system do not act in accordance with the expectations of the public, trust is negatively affected. The media and the public expect accountability and when the healthcare system falls short there is public outcry and greater demand for information about what happened. Because of the "after the fact" nature of the news, stories tend to appear only when something happens that impacts the public. Thus there is a greater chance of mistrust developing when the public only sees the negative side of things. Whereas when healthcare professionals are perceived as being accountable there is no impact on the public and thus no story. That is not to say that healthcare professionals are only mentioned in articles in which there are issues with

accountability. In fact, in the majority of healthcare-related articles, doctors are mentioned for their positive contributions or expert opinion.

By looking at the issues in healthcare from the outside, and specifically from the reporters' perspective, this thesis was able to examine the messages that the public receives through the media. Therefore the issues presented in the articles do not necessarily reflect the most important problems within healthcare, but rather the issues as seen by the media. Articles that are newsworthy are interesting and have appeal to the public because they present issues the media believe impact people. Consistently, it was found that increasing news coverage of SARS was closely correlated with an increase in the number of deaths (Chan, et al., 2003, as reported in Lewison, 2008). The media will report the stories that the public demands more information about and healthcare stories are high in public interest.

Currently, understandings of accountability differ greatly between individuals and this is reflected in the media's articles. In a study conducted in the United States, it was found that both physicians and the public hold the surgeon responsible for errors with a smaller proportion holding the hospital responsible (Blendon, et al., 2002). However, 50% of the public surveyed, considered suspending the licenses of healthcare professionals as an effective way to deal with medical errors compared to only 3% of physicians (Blendon, et al., 2002, p. 1936). It was also found that the public thought that to effectively reduce medical errors hospitals should be required to report errors to a state agency, that voluntary reporting to state agencies should be encouraged and that hospital reports should be made public. The physicians surveyed were more skeptical about the effectiveness of such approaches. Instead, doctors believed that the only

effective ways to reduce medical errors were to require hospitals to develop systems for preventing medical errors, and increasing the number of nurses (Blendon, et al., 2002, p. 1937). These findings indicate a wide difference in how healthcare professionals and the public feel that safety problems should be dealt with. Both groups believe in the importance of accountability, but their perspectives on how to achieve greater safety are very different. Within the present research, there was also a large variation within the publics perspectives reported in the articles.

In the blame and shame approach to safety culture, “attempts to “correct” the error are entirely reactive, focusing on preventing the error from being repeated by the specific person who made it” (Liang, 2004, p. 63). This can also be found in the news stories that focus on the front-line worker in the incident or accident making headlines. The tendency towards blaming in media articles starts with the way the organization addresses the issue. When organizations are willing to look past individual examples of human error as the cause of incidents and accidents and recognize that human error is often a symptom of systems problems, the media reflects this. When the emphasis is on the systems view, there is less stress on the human element and less drama to the story, thus potentially limiting the newsworthiness of the follow-up articles that come with stories about blaming an individual practitioner.

With the prevalence of the old view approach to safety, one important concern that healthcare professionals face with regards to reporting incidents in which there was an impact on patient safety, is the fear that someone will be blamed (von Thaden, et al. 2006). However being accountable is not as straightforward as it seems from outside the situation. Broadly speaking, the rationale for individuals to fear the consequences of

reporting include legal, organizational, managerial, cultural and the media (Eurocontrol, 2008). More specifically, reasons for not reporting include extra work, skepticism, lack of trust, fear of reprisals and lack of effectiveness of the present reporting systems (Barach and Small, 2000). All of these factors pose a threat to safety reporting habits because professionals fear that they will be blamed for honest mistakes; a just safety culture is on the other hand built on openness and information sharing and can be beneficial for both the individual and organizations involved (Eurocontrol, 2008).

Incentives for reporting exist for the public, and as an extension, the media as well, including accountability, transparency, enhanced community relations, and sustaining trust and confidence in the healthcare system (Barach and Small, 2000). Researchers have suggested that "to ease the implementation of incident reporting systems, the community must be involved in system oversight, support, and advocacy" (Barach and Small, 2000, p. 763). Since the media is part of the community, they too must play a role in the efforts to improve safety through incident reporting. By involving the media and the public, a greater understanding of the issues within healthcare could counter the negative impact on trust and lessen the need to blame.

Healthcare stories were mentioned by each of the reporters interviewed as the most interesting, and or the most important areas of journalism because of the impact healthcare has on the public. However, research has shown that the frequency with which some health topics are mentioned was disproportionate to the risk posed to the general public (Berry, Wharf-Higgins and Naylor, 2007). After the SARS crisis, an analysis of the news articles showed three categories of risk were mentioned; first and foremost articles emphasized issues and risks to human health, second, financial losses

and third, political action (Lewison, 2008). These findings are consistent both with the findings of this study, as well as with Emanuel and Emanuel (1996) who found that professional accountability was emphasized and used more often within media accounts of healthcare than the economic or political models of accountability. With all the different models of accountability playing a role in the healthcare system, clear priorities need to be defined between multiple competing goals. In fact, one limitation of the present research was the emphasis exclusively on the professional model; all aspects of accountability have the potential to impact the publics trust and as such further research needs to examine the extent of this impact.

The systems approach to safety has gained support over the past several decades; within this approach individuals should not be considered the cause of harm, rather, human error should be regarded as the effect of complex causation (Sharpe, 2003, p.8). The shame and blame approach, which is still part of the culture in healthcare, destroys trust while the systems approach can help foster it. Both views were presented in the articles since reporters consider it their job to report all sides of the story and believe it is up to the public decide. Thus the systems view can only impact the publics' perception of healthcare workers if these views are expressed to the media. However, research suggests that even when news coverage is balanced, reassuring claims may not counter the effects of fear or risk messages" (Berry, Wharf-Higgins and Naylor, 2007). Furthermore, the social amplification of risk hypothesis posits that when there is no direct personal experience of risk, the news media increase the volume, dramatization and symbolic connotations of information can be presented, resulting in an amplified perception of risk (Berry, Wharf-Higgins and Naylor, 2007).

Furthermore, research has found that healthcare stories were discussed in terms of risks nearly three times more than in terms of prevention (Berry, Wharf-Higgins and Naylor, 2007). Such a focus can increase public anxiety over the issue; by emphasizing risk over preventative measures, the media in short can increase fear and while decreasing public responsibility. In this way, media stories can influence the publics trust in healthcare professionals.

In order to establish a just safety culture, issues of accountability must be dealt with in way that satisfies the needs of professionals within the industry as well as everyone from the police, the lawyers, the media and the general public. But finding such middle ground is easier said than done. Media reports will continue to present multiple perspectives in order to give the public as much information as they can; however it seems the challenge of demonstrating accountability and developing a just culture is in the hands of the healthcare system. It is the responsibility of the healthcare system to be accountable professionally, economically and politically, which includes managing public relations with the press. Further research could examine whether cities or institutions with strong press relations are better able to mediate the negative tone of articles compared to cities or institutions with poorer media relations.

A certain level of mistrust in healthcare can be beneficial as well. Media articles showed that in cases where there is direct experience with medical errors, the patients had an even more heightened sense of risk; the result was greater emphasis on the patient and their families responsibility to be aware of what is going on with their care. It has been argued that “by integrating providers and patients, each with rights and responsibilities, and by promoting communication between the two as equal partners,

safety in health care can be advanced and a greater therapeutic relationship attained" (Liang, 2004, p. 60). Ultimately, the public needs to trust healthcare professionals, but not so much so that healthcare professionals remain on a pedestal. A certain level of mistrust, which is reinforced through the media's articles on medical errors, can be beneficial if it leads patients to take their own healthcare rights and responsibilities more seriously than they often appear to do at present.

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Appendix A

INFORMED CONSENT STATEMENT

The Portrayal of Healthcare Professionals in the Media
Investigators: Kelly Dewan (Masters thesis student, Lund University School of Aviation)
Dr. Jim Nyce (Thesis supervisor, Ball State University, visiting professor at Lund University School of Aviation)

You are invited to participate in a research study. The purpose of this study is to investigate the way in which healthcare professionals are represented within the media. Kelly Dewan, a Masters student in Human Factors and System Safety, will be conducting the research study under the advisement of Dr. Jim Nyce, a visiting professor to Lund University.

INFORMATION

You are invited to participate in an interview. This study will be conducted in a mutually agreed upon location that offers a quiet atmosphere with limited distractions or interruptions. In addition to a few questions about your career and background, you will be asked about your thoughts and opinions related to how issues in healthcare are reported in the media. The interview will last approximately half an hour and will be digitally recorded. Only Kelly Dewan and Dr. Jim Nyce will have access to the original recordings, which will later be transcribed; both the original recordings and the transcriptions will be locked up in a safe place. Each participant will be assigned a unique ID number for data analysis. No names or other identifying information will be included in the transcripts. A total of five interviews will be conducted; additional data for this study will include news articles from various Canadian news sources.

RISKS

There are no physical risks associated with participating in the current study. It is possible that some participants may experience fatigue as a result of their participation. However, all participants are free to end the interview at any time.

BENEFITS

One of the benefits of participating in the study is increasing your awareness of Healthcare human factors, just culture, and how news is presented by the media and its impact. In addition, by participating in this study, you help us gain a better understanding of how healthcare workers are portrayed within the media.

CONFIDENTIALITY

Only Kelly Dewan and Dr. Jim Nyce will have access to the raw data including both original recordings and the transcripts. Both of which will be stored in a locked cabinet

to which only Kelly Dewan has access to. The stored data will not contain your name. You will be assigned a unique ID number and it will be used for data analysis. The computer on which the transcripts are stored is password protected. The original recording will be destroyed in five years' time from the study's completion date (i.e., June of 2015).

CONTACT

If you have any questions at any time about the study or the study or procedures, (or if you experience any adverse effects as a result of participating in this study), you may contact the researchers, Kelly Dewan at 613-204-6718 or kellydewan@gmail.com and Dr. Jim Nyce at jnyce@rocketmail.com.

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate or, if you decide to participate, you may withdraw at any time. If you withdraw from the study before data collection is complete your data will be destroyed. You have the right to refuse to answer question(s) that you choose.

FEEDBACK AND PUBLICATION

The final thesis will be posted on the school website: http://www.lusa.lu.se/student/student-thesis. For any other possible publications, permission will be requested from you on a case-by-case basis. However, no identifying information, including your name, or where you work will be included and as such your anonymity will be maintained. A copy of the thesis can be requested at the bottom of this form and will be sent out by June 25th, 2010.

CONSENT

I have read and understand the above information. I have received a copy of this form to keep. I agree to participate in this study.

Participants name (please print) _____

Participant's signature _____Date _____

Investigator's signature _____

If you would like a copy of the final report please supply an email address to which it can be sent.
Email: _____

Appendix B
Interview questions

Background Information:

What is your role at work?
Can you briefly describe your day-to-day work?

General Questions:

What do you see as the role of the media in the creation of justice?

Gans (2004) wrote in a sociological study of the media that journalists consider themselves to be objective and nonidealogical in the process of deciding what is news, and how it should be reported. What are your thoughts on this?

Do you trust that other reporters are objective and nonideological? Why or why not?
How can you tell when they are not?

How is the accuracy of sources information checked?

How do you deal with personal biases when you write news reports?

Questions related to Healthcare:

Can you briefly describe the kinds of health-related stories you have reported on?

Is the reporting of incidents and accidents in healthcare important from a journalistic point of view?

Do you think healthcare workers are accurately/fairly represented within the media?

Do you trust healthcare professionals and the healthcare system i) as a patient, ii) as a reporter? Why or why not?

Is justice being served when healthcare professionals are criminally charged for endangering patient safety? (i.e. when a nurse is charged for giving a patient the wrong drug/dose and the patient dies as a result)
Does that improve patient safety or safety within the organization?

What makes a potential healthcare story “stand out”?

How much follow-up is there on healthcare-related stories?