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Constructing the health care system in Greece: responsibility and powerlessness

Vassiliki Lentza¹, Anthony J. Montgomery^{2*}, Katerina Georganta²
and Efharis Panagopoulou¹

¹Aristotle University of Thessaloniki, Greece

²University of Macedonia, Thessaloniki, Greece

Objectives. Based on health care professionals' (HPs) and patients' interviews about work demands and quality of care in hospitals, the study explores the way that patients and HPs constructed their identities to describe and construct the health care system in Greece.

Design. This is a qualitative study using a focus group (FG) design.

Methods. Seven FGs discussions were conducted: three FGs discussions were conducted for the assessment of job stressors (1 for doctors, 1 for nurses and 1 for residents) and four FGs discussions for the assessment of quality of care (1 for doctors, 1 for nurses, 1 for residents and 1 for patients). The sample consisted of health care professionals working in a teaching hospital in the region of Thessaloniki, Greece, and patients who had at least one experience of any kind in the same hospital. Transcripts of the FGs discussions underwent discourse analysis.

Results. The results showed that both HPs and patients construct the health care system based on bipolar constructions of responsibility and powerlessness. In particular, participants use these constructions to allocate the responsibility to different levels of the health care system hierarchy or to the system per se constructing, at the same time, themselves as the 'viewers' of this system.

Conclusions. The study allowed a deeper understanding of issues related to quality of care in hospitals providing context-specific information. Identity in health care organizations was inextricably linked to power and responsibility. The need to deconstruct this responsibility/powerlessness ideology is discussed.

Statement of contribution

What is already known on the subject? Relatively little is known about how both patients and health care professionals construct quality of care. Organizational cultures in health care settings are symbiotically linked with quality of care and medical errors.

*Correspondence should be addressed to Anthony Montgomery, Department of Education and Social Policy, University of Macedonia, Thessaloniki, Greece (e-mail: antmont@uom.gr).

What does this study add? The constructions of health care professionals and patients create and recreate the organizational culture organically. The present study illuminates how health care professionals and patients negotiate their identities based on passivity and rejection of accountability, which contribute to medical errors and passivity.

Organizational culture determines how individuals behave, what people pay attention to, and how they respond to different situations, and how they socialize with new members and exclude those who do not fit in (Spataro, 2005). The Institute of Medicine (1999, 2001) in the USA has repeatedly highlighted the link between patient safety, physician well-being and organizational culture. Hospitals represent a unique organizational environment and relatively little systematic research exists with regard to how this unique environment contributes to job burnout and/or quality of care (Montgomery, Panagopoulou, Kehoe, & Valkanos, 2011). Running parallel to this is that fact that health care professionals (HPs) and health care systems are under increasing pressure to provide better quality of care to patients. In essence, HP health and patient experiences are rooted in the prevailing organizational culture, but they also shape it continuously and forcefully. Thus, the actors actively create the system and are recreated by it, potentially resulting in regressive spirals towards worse quality of care and deteriorating HP wellness. In such a context, it should be no surprise that quality of care can represent a significant stressor for HPs. The aforementioned picture is one that can only be disentangled by qualitative techniques that allow us to identify the way that HP and patient identities are actively shaped by the context.

Hospitals in Greece

The following article concerns the situation in Greece, and so an overview of the health care landscape and research to date is appropriate. The Greek health care system is divided into 7 health regions and 16 administrative health prefectures (Ministry of Health & Social Solidarity, 2012). Recently, researchers in Greece have started assessing organizational culture in public hospitals. The picture that emerges from these studies is that Greek Hospitals are characterized by hierarchical or clan cultures (Papageorgiou & Chondrocoukis, 2010) where employees believe that taking advantage of opportunities, willingness to experiment and risk-taking behaviours were the values least stressed by their organization (Bellou, 2010), and that team orientation and decisiveness are not valued characteristics of public hospitals (Bellou, 2007, 2008). Congruently, employees reported that organizational culture issues like justice, performance and quality (Kastanioti, Siourouni, Mavridoglou, & Polyzos, 2011) and support for clinical governance (Karassavidou, Glaveli, & Zafirooulos, 2011) were not rated highly.

The aforementioned research also provides an interesting picture of what is valued in Greek hospitals: being careful and precise, rule orientation, showing respect for the individual's rights and being easy going (Bellou, 2010), adaptability, predictability, tolerance, and being willing to work for long-hours (Kastanioti *et al.*, 2011). Thus, Greek research is in agreement with the international literature showing that organizational culture is connected to both patient experience and organizational functioning.

Organizational Culture: A Social Constructionist Perspective

Recently, researchers using a social constructionist framework have started examining organizations as discursive constructions (Fairhurst & Putnam, 2004). Organizations are

seen, culturally and historically, as sites where individuals interact and collectively engage in the construction of a social reality (Karatas-Ozkan & Murphy, 2010). Individuals negotiate their various identities in interaction by recalling a range of linguistic and discursive resources (Burr, 2003); therefore, organizational cultures are constructed through discourses that are available in the form of theories, stories, narratives, myths and so on. In this context, the key aspects of organizational research should be how narrative, text and conversation shape organizational processes and change and how discourse creates meaning systems (Marshak & Grant, 2008). Under this lens, mainstream organizational research has been criticized as it treats organizational culture as an object of management action or as something that an organization 'has' (Alvesson, 2002). Following this social constructionist framework, hospitals are dynamic organizations where all members interact and negotiate their identities as patients, physicians, nurses, managers and so on by recalling discourses available to them and by taking on subject positions. Health care organizational culture is constructed through these discourses so attention to the prevailing discourses within health care institutions should be a central aspect of organizational research. Therefore, to study quality and safety of care, we should go beyond identifying the taxonomy of errors, and the attitudes and beliefs that may be associated with unsafe practice (Iedema & Carroll, 2010; Waring, 2009), and we should rather focus on how knowledge about safety is constructed through interaction within hospital systems (Waring, 2009).

The Present Study

This article aims at exploring hospitals as dynamic organizations where identities are formulated through interaction. Particularly, the analysis is focused on the ways that patients and health care professionals negotiate their identities in the context of Greek health care system.

The article draws upon data collected as part of a larger European Union Seven Framework Programme Project: the ORCAB Project (<http://orcab.web.auth.gr/orcab/Index.html>). The ORCAB project involves looking at the links between organizational culture, quality of care and job burnout in hospitals. To explore the stressors that health care professionals are faced with and the factors that influence the quality of medical care, the project conducted focus groups (FGs) discussions with HPs and patients. In this study, we focus specifically on how HPs and patients construct their identities when they negotiate the above issues.

Participants

Each FG consisted of 6–7 participants and discussion ran for approximately 40–60 minutes. The group of HPs consisted of the hospital medical personnel, namely physicians (six participants, mean age: 42 years), nurses (seven participants, mean age: 39 years) and residents (seven participants, mean age: 31 years). All health care professionals worked in the same teaching hospital in different units. Physicians were from the following specialties: internal medicine, cardiology, orthopaedics and endocrinology. Nurses were from the following specialties: internal medicine, intensive care and orthopaedics. Residents were from internal medicine and paediatrics. Patients (six participants, mean age: 28.4 years) came from a variety of backgrounds in terms of education (one high school graduate, two with BA degrees, two with master's degrees and one with a PhD). The patients who participated in the FGs were either chronic patients

treated at home or patients in need of emergency medical care. All resided in Thessaloniki, the second largest city in Greece.

Design

A FG design was adopted as it facilitates interaction with other participants and promotes group dynamics and a diversity of opinions (Morgan, 1988). Having in mind the segmentation of participants (Morgan, 1988), FGs were designed as homogeneously as possible. This proposed sampling strategy was based on the assumption that participants who share similar characteristics and experiences about a topic are more willing to meet and to discuss about it (Morgan, 1988). As a result, seven FGs discussions were conducted given the different subgroups of health care professionals/patients and the two topics to be investigated: three FGs discussions were conducted for the assessment of job stressors (1 for doctors, 1 for nurses and 1 for medical residents) and four FGs discussions for the assessment of quality of care (1 for doctors, 1 for nurses, 1 for medical residents and 1 for patients).

All participants were informed of the purpose of the study. All FGs discussions were tape-recorded, after requesting permission and insuring that anonymity would be preserved. All FGs discussions were conducted by a moderator, who facilitated the discussions using a protocol template consisting of questions generated from a literature review on each topic (job stressors/quality of care). However, the discussions were flexible and all participants were encouraged to bring up other issues during the conversations.

Procedure

A purposive sample of participants was recruited from a teaching hospital in the region of Thessaloniki, Greece. The inclusion criterion for patients involved having at least one experience of any kind in the same hospital. Therefore, patients were contacted while they were in hospital waiting rooms and appointments were fixed for data collection. Health care professionals were contacted personally during their shifts; however, there were difficulties related to time constraints. Therefore, it was decided that the health care professionals' FGs discussions would be conducted in the hospital, while the patients' FGs discussions were conducted in a room located in a university.

Method

Data were analysed by using thematic analysis that allows the organization of data in themes/categories (Braun & Clarke, 2006). The six-phase process of analysis as described by Braun and Clarke (2006) was followed: the analysis involved detailed and repeated readings of interview transcripts and initial coding was produced. Then, all relevant codes were collated into themes, and the data relevant to the themes were reviewed to ensure that themes worked in relation to the coded extracts. To increase the validity of the findings, the data classification had been conducted by the two first authors separately. Common themes were identified between our categorizations, and in a few cases where different categories and themes were emerged, we went back to the original data repeating the analytical process in order to finally come in a consensus. Specific extracts of the transcripts were selected and quoted for the readers to verify or question the

interpretations provided by the authors. To maintain the anonymity of research, participants' names were replaced with pseudonyms.

Theoretically, our research draws on social constructionism (Burr, 2003); therefore, the thematic analysis conducted was informed by this specific theoretical perspective. Within this context, themes are identified as socially produced but no discursive analysis is conducted (Braun & Clarke, 2006).

Results

Across the FGs, respondents constructed the identities and roles of patients and health care professionals by recalling two main themes: (1) powerlessness and (2) responsibility. These themes were used in two contrasting, bipolar ways, powerlessness versus power and responsibility versus irresponsibility, depending on the different ways identities are constructed each time.

Powerlessness

The theme of powerlessness is pervasive among discussions of patients who present themselves as the victims of the health care system. The victimization of patients is clearly presented in the following extract.

Extract 1 (Patients discussion group)

Tom: (...) there is so much tension amongst physicians and amongst nurses as well and you think that as a patient you can't speak so much because they are going to eat you alive... and in this context I feel like all women and children that during the war they have nowhere to run to.

Tom constructs patients as the health care professionals' prey (*they are going to eat you alive*) or as the helpless war victims (*all women and children that during the war*) and in this way he manages to connect the experience of being a patient with passivity. Tom manages to present patients' powerlessness by constructing the bipolar relationship between them and the health professional (the angry HP vs. the patient-victim), and he also attracts reader's empathy towards patients' position.

However, it is interesting to note the shift in patients' accounts when they talk about higher levels of the health care system hierarchy, for example managers, Ministry of Health. In this case, they change their stance towards health care professionals and they challenge the dominant construction of the powerful physician. In the next extract (3), Tolis questions the dominant construction of the powerful physician (a) by criticizing patients' negative stance towards physicians and he bases his argument on his rejection of the 'almighty god' physician construction and (b) by bringing new structural elements of the hierarchy in the health care system, which is the system per se and the hospital manager.

Extract 3 (Patients discussion group)

Tolis: ... We tend to consider physicians as small almighty gods but things aren't like that. If the whole health organization is sick then everything is sick and we have all these system dysfunctions...this is a hospital management issue; the physician experiences all the consequences of bad organization that starts from the managers.

The theme of powerlessness is recalled by health care professionals as well. In their case, they construct themselves as the victims of the health care system.

Extract 4 (Residents discussion group)

Giota: Many times the physician is seen as the scapegoat of the whole system and thus the (physician–patient) communication has a bad beginning because the patient sees in the physician all the problems of the system.

In the above extract, Giota recalls the word ‘scapegoat’ to construct physicians as the victims of the health care system. In this case, physicians recognize themselves as the scapegoats, the victims, and they manage to attribute the physician–patient communication deficits in their victimization. On the other hand, health care professionals construct patients as the claimants of the health care system aiming at patients’ empowerment.

Extract 8 (Physicians discussion group)

Pavlos: Just as anyone citizen claims better conditions in different areas of social life, so too the citizen patient can claim and impose better conditions.

Andreas: It is exactly the same experience as you go in a restaurant... so, when you visit the hospital you can’t say that they just took an X-ray and then I went home but you should be treated nicely, the hospital environment should be nice, you should have a place to leave your car etc.

The first physician challenges the patient identity as the receiver of treatment, which is connected with passivity, and he also broadens this identity out by giving a new dimension: citizenship. Patients, just like all citizens, have both rights and duties and this means that they can actively be involved in changing the received health services. The next physician draws his account from the client’s perspective. In this case, the quality of care for clients is something that should meet their perceived needs. Therefore, patients as clients should have demands both from the ‘products’ and from services they receive.

Responsibility

In the following extracts, participants negotiate patients’ and health care professionals’ identities by recalling the theme of responsibility. In their accounts, participants discuss issues related to who is more responsible in the health care system and, in a way, they connect responsibility with blameworthiness. In the next extract, a resident talks about responsibility by locating it in her relationship with the attending physicians.

Extract 5 (Residents discussion group)

Evie: There is a fallacy that the resident is completely irresponsible since the attending physician has the full responsibility and during the shifts we are always with an attending physician. However, there are many cases where the physician didn’t cover the resident for instance he said that the resident didn’t call to inform him about the patient’s condition.

Evie (*line 1*) by recalling the word ‘fallacy’ tries to challenge the dominant notion according to which residents are ‘completely irresponsible’. However, she does not accept responsibility as being part of her job but rather as being imposed as a result of physicians’ indifference. In the next extracts, both physicians and residents use their accounts to delimit their role and their responsibilities within the health care system.

Extract 9 (Physicians discussion group)

Stefanos: You do what is possible to be done, nowhere and no-one can offer everything, there is not such a thing as a God-doctor, the physician is just a human being with expertise and specific skills. I know what I can offer; I also know what I cannot offer. Many times my decisions may be taken based on what I can do today because I am given specific possibilities and I don’t have the opportunity to offer something more.

Extract 10 (Residents discussion group)

Evie: There are two pillars on which quality health care should be provided. On the one hand, you should be a qualified physician and on the other hand you should pay attention to your behaviour and be polite. If you have all these things you can provide quality health care regardless of the context, and regardless of the way the health care system is organized.

Peter: Yeah, I think these are the things that I can do on my own while the rest don’t depend on me.

At the beginning of extract 9, Stefanos projects his human dimension and he sets his boundaries as a professional. However, he avoids being accused of not providing quality health care by declaring his expertise and his awareness of the things that he can do and by attributing these boundaries to the limited possibilities of the hospital. By doing so, physicians are constructed as highly qualified practitioners limited in the context of the hospital. Physicians accept the current situation, which is constructed as restrictive, and they locate their action only in the area of their expertise.

Residents in extract 10 attempt to limit their role within the health care system by discussing their responsibility in the context of the patient–physician relationship. Once again, attention is focused on training and communication skills, and these aspects are perceived as under control by health care professionals, whereas the physician’s role is constructed as separated and distinctive from the broader context that takes place, meaning the health care system (*extract 10, line 4*). The next speaker, Peter, contrasts the things that are under physician control, meaning their expertise, to the things that are out of their control, meaning the way the health care system is organized, rejecting in this way the physician engagement with the health care system. Thus, they do not try to maximize responsibility but rather to limit their actions and avoid blame.

Patients recall the theme of responsibility when they discuss about the physicians’ role within the health care system. Particularly, patients connect physicians’ role with responsibility based on a hierarchy that they recognize among HPs, with the physician being at the higher levels of this hierarchy and therefore being more responsible.

Extract 2 (Patients discussion group)

Maria: ...But the nurse can't interfere... physicians play the most important role.

Kate: And they give the orders and because of this, sometimes the rest (hospital personnel) aren't effective enough.

Asie: yeah... physicians are more important, they take all the final decisions, they are more responsible, all the others just obey to them, they are inferior to them.

Discussion

The aim of the study was to explore the ways patients and health care professionals negotiate their identities within the Greek health care system when they interact and discuss issues related to quality of care and job burnout in hospitals. The two themes identified in patients' and health care professionals' accounts, powerlessness and responsibility, function as a way of constructing their identities based on passivity and rejection of accountability. Both patients and health care professionals connect themselves with passivity, lack of power and lack of responsibility and, at the same time, they attribute power, responsibility and blame to other parts of the system. Participants constructed themselves as the viewers of this system and not as an integral part of it, and in this way, they protect themselves against any consequences of accountability.

The themes identified are interrelated in the sense that lack of power over things is connected with less responsibility. We argue that the two themes work together as ways for both health care professionals and patients to support their attribution of blame in other parts besides themselves. The need for both patients and HPs to attribute blame is highlighted by trends such as defensive medicine, when health care personnel (doctors and nurses) order unnecessary treatments (positive defensive medicine) or avoid high-risk procedures or patients (negative defensive medicine) with the aim of reducing their exposure to malpractice suits (Anderson, 1999; Studdert *et al.*, 2005). The concept of blame is often used in the error management literature. For example, Vincent, Stanhope, and Crowley-Murphy (1999) found that the main reasons for not reporting negative events were fears that junior staff would be blamed. Waring (2007) reported that physicians can construct the health care system as a threat to patient safety in order to avoid professional blame and responsibility. The research by Waring (2007) is particularly important in that it shows that physicians can engage with systems thinking about the events in their hospital, not a result of policy or safety discourse, but via understanding that services are (dis)organized. Hoff (2008) after observing the medical personnel in three different departments in a medical centre revealed that in a workplace that was tense and characterized by hierarchy, the mistakes were attributed to the individual (rather than the system) and remained hidden. For residents, this was a result of their fear that by revealing a mistake the disadvantages for their career and their status would be serious. In these settings, the mistakes were often forgotten and not considered for future safety reasons, even when they were communicated to the group or to the person immediately higher in hierarchy. Masia, Basson, and Ogunbanjo (2010) interviewed doctors who had suffered the loss of a patient during the 48 hr before the interview and one of the reoccurring themes was blame. Fast and Tiedens (2010) showed that blaming is socially contagious, in the sense that exposure to blaming attributions regarding one event (failure) leads to blaming attributions regarding another unrelated event. However, reflecting on Waring's (2005) analysis of the cultural barriers to reporting, we suggest that blame should be seen

as the cultural product of a health care system and not just as the justification of negative events in medicine. In other words, at least in the Greek health care system, blame seems to be an integral part of patients' and health care professionals' identity formation. In the present study, participants recalled powerlessness and responsibility to reproduce blame not as a way of negotiating medical errors but as a way of negotiating their identities and their relationship with the system. The current research should be seen as a first attempt to reveal some of the understandings used by patients and professionals to make sense of their identities within the Greek health care system. More research is needed to fully capture the health care cultures in Greece and the underlying mechanisms.

This study is not without limitations. We acknowledge that we do not capture all of the various themes related to the topic. Firstly, the data are culturally specific so it is difficult to generalize the results in all health care organizations. Secondly, the present study was based on a purposive sample of patients and health care professionals recruited in one hospital in Greece; therefore, it is hard to generalize the results even within the Greek health care system. Thirdly, data were collected when participants discussed issues related to quality of care and burnout so we can assume that different themes might have emerged if the participants of our sample had been directly asked to respond about their roles in the health care system. However, the findings of this study should become the starting point of examining the related issues thoroughly because the themes identified are possible to be recalled by any other patients and health care professionals as they all have the same array of interactional competencies (Perakyla, 2004). Finally, one final reflection for future researchers is that discussions around quality of care involve the identification of mistakes and errors, and respondents in our sample were sensitive to the potential legal implications. Due to this issue, we collected very basic demographic information on the HPs to avoid loss of anonymity.

Hierarchical structures, which in most cases characterize health care organizations, favour the development of a blame culture (Khatri, Brown, & Hicks, 2009). In the present study, participants recalled hierarchy within health care systems to avoid connecting themselves with responsibility. Khatri, Brown and Hicks suggest that the shift from a blame culture to a just culture can be accomplished by applying a commitment-based management, which is egalitarian and encourages employee participation and involvement in decision-making. However, this approach assumes that organizational culture is an object of management action and imposing changes 'from above'. Taking into consideration the assumption that the health care organizational culture is a discursive product growing out of social interactions, all people engaged in health care organizations – patients, health care professionals, technical personnel, managers, the Ministry of Health – 'do' the health care system while they are speaking or writing or interacting with each other. Therefore, the constructions recalled that sustain the blame culture must change and this involves changing the narratives, texts and conversations by encouraging a dialogue among public service providers and users to generate new shared meanings and change behaviours (Marshak & Grant, 2008).

The present study has demonstrated the link between the identities of HPs and patients with the organizational culture. In terms of the hospital environment, the practical implications of this ongoing construction impact on quality of care, the point at which HPs and patients 'collide'. Unfortunately, definitions of quality of care can be broad or narrow depending on whether our perspective is that of the patient, health professional, researcher, etc (McGowan *et al.*, 2012). There is a need for researchers to understand quality of care and the health care system utilizing a collaborative approach (Brazil, Ozer, Cloutier, Levine, & Strayer, 2005) that allows the experience of relevant

stakeholders to be encapsulated (and not just the health care perspective). Put more simply, patients may have a totally different model of quality of care compared to HPs (Montgomery, Todorova, Baban, & Panagopoulou, 2012). Thus, efforts to understand quality of care must appreciate the organizational culture, the patient experience and the role of HPs within the hospital system. This paper had gone some way to achieving this goal.

Finally, a good example of the importance of narratives can be found in the recent literature review of patient empowerment of Holmström and Röing (2010), who conclude that as long as patient education skills involve information, handing out leaflets and group presentations (while important), it will not be enough. According to the authors, the narrative must include self-management education and the teaching of problem-solving skills to patients. Indeed, empowerment is an interesting way forward when one considers the evidence that greater patient participation is associated with patients' favourable ratings of quality of care (Weingart, 2011) and patient safety (Davis, Sevdalis, Jacklin, & Vincent, 2012). A different discourse can lead to a different culture.

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