Critical incident reporting and the discursive reconfiguration of feeling and positioning

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Abstract
This article analyses the emotional and generic dimensions of critical incident reports. These incident reports have been selected from the specialty of retrieval medicine; that is, a specialized service that transports patients from distant accident sites to hospitals. With its focus on emergencies in distant locations, this area of medicine and the care it provides is a hothouse for procedural difficulties, medical complications and, therefore, emotive language. The analysis demonstrates, firstly, that these reports can contain a range of evaluative expressions, including personal and depersonalized affect, interpersonal and normative judgements, and assessments of the functionality of objects. Secondly, these evaluations frequently harbour a tension between informal (private, emotional, self-oriented) and formal (public, depersonalized, formalized) discourse. Thirdly, the overall structure of incident reports is such as to effect a complex discursive transformation from personal sentiments into organizational assessments and solutions. The article concludes that incident reporting is an important post-bureaucratic technique, in that it creates a space where clinicians are invited to link experiential dilemmas to service redesign strategies, and display their commitment to the ethos and practices of organizational improvement.

Keywords: clinical incident reports; appraisal; positioning

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Introduction

This article presents an analysis of the discourse of 125 incident reports. These reports were written by doctors and nurses working in the area of retrieval medicine, the specialty that is concerned with retrieving victims by plane or helicopter from distant accident sites, such as rural villages, inaccessible mountain areas and isolated beaches. The analysis of these reports complements work done on the Australian Incident Monitoring System project or AIMS. AIMS collects incident reports and analyzes the types of errors that clinicians report. AIMS was begun in the late 1980s by the Australian Patient Safety Foundation (APSF) to begin the study of errors occurring in Australian hospitals. In 1996, AIMS was incorporated into hospital practice around Australia. More recently, the paper-based AIMS form has been redesigned into a web-based Improved Incident Monitoring System (IIMS) that is in the process of being deployed across Australian public hospitals. Both systems provide the means for clinical staff to report incidents, accidents and near-misses on a standard form. These forms are processed with a dual purpose in mind: to inform managers and policy makers about types, frequency and seriousness of incidents, and to enable them to target and rectify serious recurrent incidents by devising treatment-specific as well as hospital-wide practice improvement strategies.

In critical incident reports clinicians provide accounts of clinical processes going wrong in some way. The causes of processes going wrong are rarely simple, particularly in clinical practice which is marred by medical uncertainty (Esmail, 2006) and organisational complexity (Plsek & Greenhalgh, 2001). Depending on one's perspective, incidents may be due to 'systems problems' such as inadequate staffing levels or inappropriate procedures, individuals' (deliberate or unintentional) actions, or both. While the ostensive aim of incident reporting is to keep these issues apart and enable the targeting of systems problems, this aim is complicated by the tensions and emotions that frequently come into play. Instead of offering transparent accounts of clinical incidents, then, critical incident reports are sites where personal feelings, professional knowledge, institutional norms and work process designs intersect in intricate ways. Analysis of how these issues intersect in incident reporting is important for a number of reasons. First, emotionality in critical incident reports may provide clues as to the significance of particular kinds of failures for frontline clinicians, and the need to engage in targeted interventions. Second, emotionality may be a sign of the reporting clinicians not having been able to come to terms fully with the failures they report and therefore requiring special counseling. Third, emotionality may point to unresolved interpersonal tensions among staff and therefore to the need for interpersonal mediation (Iedema & Grant, 2004). Last,
and this is the concern of the present article, an analysis of incident reports may reveal how authors are repositioned as clinical professionals by the new discursive space opened up by incident reporting (Iedema, Flabouris, Grant, & Jorm, 2006a).

In recent years, there has been a marked rise in academic interest in the study of emotions, with scholars in philosophy (Deleuze, 1978; Schatzki, 2002), neuron-science (Damasio, 2003), cultural studies (Barker, 2000), organization studies (Ashkanasy, 2003; Fineman, 1996; Mangham, 1998) and discourse studies (Biber, 1995; Martin, 2000; Maynard, 2002) commenting on the centrality of emotions to human affairs from their different perspectives. Among these, the discourse-studies literature gives particular attention to the analysis of what it terms ‘evaluation’ in discourse: ‘evaluation is the broad cover term for the expression of the speaker or the writer’s attitude or stance towards, viewpoint on, or feelings about the entities or propositions that he or she is talking about’ (Hunston & Thompson, 2000: 5). Many challenges confront the analysis of evaluative discourse due to the often personal facets inherent in its identification and analysis (Martin, 2003). This notwithstanding, recent research into the discursive realization of evaluation has begun to yield useful strategies for exploring emotionality in language (Hunston & Thompson, 2000; Martin, 2004; Maynard, 2002; White, 2002). What is particularly interesting about this literature is its topological approach to evaluation in discourse. That is, its mapping of emotionality includes an extended range of interpersonal linguistic resources, netting in judgements about people as well as assessments about processes and objects. At the same time, this literature has begun to expand this topology in yet another direction, by venturing into the exploration of the relationships between ‘bare’ expressions of emotion and more diffuse, ‘tokenised’ and formalized semantics. In that regard, the topologies currently presented in the discourse analysis literature extend beyond the scope of discussions about emotionality conducted in other literatures.

The body of applied linguistic work that beds down these links is one which classifies evaluative discursive resources under the heading of Appraisal (Martin, 2003; Martin & White, 2005; White, 2002; White, 2003). Appraisal embodies a systemic classification of feelings; that is, a classification that works on the principle of apparent difference (‘upset’ versus ‘concerned’) and opposition (‘rude’ versus ‘kind’). This kind of classification is not absolute and fixed, but adapts to the evaluative peculiarities of specific discourses and registers. On that basis, Appraisal enables us to describe not just reporters’ overt expressions of attitudinal evaluation, but also their more formulaic or formalized evaluations. Against that backdrop, the special contribution of the present article is that it deploys Appraisal to demonstrate how the tensions
present in critical incident reports between personalizing kinds of attitudinal evaluation and more formalized kinds of discourse produce an ambiguity that is endemic to this genre, and which cannot be resolved by referring back to the original incident. This ambiguity is further shown to be inherent in the incident report’s complex staging: authors articulate their unique perspective on the incident and then reframe this into more bureaucratic and managerial discourse registers as they move through the incident report form. In doing so, we will suggest, their discourse – and potentially their positioning as professional experts – is dynamically re-configured from being attitudinal to becoming managerial.

The article is structured as follows. The next section presents the background of incident reporting and monitoring in Australian hospitals, and links the aims of the study that informs this article into the general aims of critical incident monitoring. In the section following that, the article presents an analysis of a selection of reports, outlining the analytical frameworks needed to analyze their discourse and demonstrating authors’ tendency to draw on both the personalizing and depersonalizing dimensions of attitudinal evaluation. The article then discusses the overall structure of incident reports, and considers what this structure means for how clinicians become re-positioned by the discourses they are invited to produce. The article concludes with a summary of its overall argument, and offers a consideration of what this argument means for the claim made by proponents that incident reports are instrumental in clinical practice improvement (De Rosier, Stalhanske, Bagian et al., 2002).

**Background: critical incident reporting**

Applied linguistic and discourse research in health has paid significant attention to the dynamics of doctor-patient interaction and the formal structure of medical scientific knowledge (Ainsworth-Vaughn, 2003; Fleishman, 2003). This research, in tandem with work done on organizational and professional discourses (Drew & Heritage, 1992; Sarangi & Roberts, 1999), has laid the groundwork for newly emerging questions about how clinical professionals communicate with one another and construct the patient’s trajectory through care, and about how health policy reforms are impacting on and reshaping clinicians’ (and patients’) communication with one another (Iedema, 2006; Iedema, Jorm, Long, Braithwaite, Travaglia & Westbrook, 2006c).

One significant kind of reform that began two to three decades ago has been the gradual institutionalization of clinical work process control (Degeling, Sorensen, Maxwell, Aisbett, Zhang & Coyle, 2001), an important dimension of which is incident reporting. From isolated initiatives on the part of individual ‘champions’ (Runciman, Webb, Lee & Holland, 1993), incident reporting now
forms a central part of contemporary approaches to clinical risk management (Carroll, 2004) due to rising concerns about the quality of clinical care, patient safety, and practitioner accountability. With the publication of error rates in hospitals around the world (Brennan et al., 1991; UK Department of Health/Design Council, 2003; Wilson, Runciman, Gibberd, Harrison, Newby, & Hamilton, 1995), health departments in many industrialized countries have begun to use critical incident reporting to gauge organizations’ and staff’s propensity for errors, achieve greater accountability for sub-standard care, and devise ways of improving clinical work systems (Neily et al., 2003). Incident reporting and monitoring, it is claimed, elicits ‘contextual information that gives insights into underlying human and system failure that can be used to prevent or minimize the effects of accidents’ (Beckmann, Baldwin, Hart & Runciman, 1996).

In contrast to these authors’ expectations, we know as language analysts that the critical incident report is unlikely to provide a simple and transparent account of what went wrong: language does not ‘mirror reality’ (Ellis, 1994; Rorty, 1980; Whorf, 1956). With that in mind, the analysis presented below moves on two fronts. First, by delving into how attitudinal evaluation is realized in these reports, analysis reveals the critical incident report to be an extremely complex device that at once accommodates personalizing and depersonalizing takes on the incident. We know that events tend to register as incidents when specific individuals’ frustration, sadness, guilt or anger reaches a tipping point (Hunter, 2006). These feelings do not come through in the ‘tick-box’ section of the critical incident report (see Figure 1 in the Appendix), where the reporting clinician is asked to formally categorise (elements of) the incident. Feelings are more likely to play a role in the authoring of the ‘what happened’ section of the report where clinicians provide a free-text narrative (Figures 2 and 3 in the Appendix). Second, by considering the generic structure of the incident report, it becomes apparent that it guides the reporting clinician through a series of discursive transitions, from writing in narrative terms in answer to ‘what happened’, to writing in organizational terms to respond to sections with more formal headings: ‘Describe the outcome’, ‘steps taken’, and ‘was this preventable’. These transitions require a translation of personal sentiments and professional judgements into statements about the efficacy of organizational structures, processes and procedures. These two analytical sections prepare the groundwork for the conclusion that the critical incident report is a complex ‘post-bureaucratic’ device (Iedema, 2006): it creates a space for clinicians to connect deeply-felt dilemmas to service redesign strategies; a space where clinicians’ personal positioning becomes entwined with the ethos and practices of organizational management and improvement.
An empirical analysis of critical incident reporting

The data set that this article draws on includes all paper-based incident reports (125 in total) that were submitted by critical care doctors over a one-year period (2002) to five medical retrieval organizations (which cannot be named for reasons of confidentiality). These incident reports were gathered as part of a larger study that sought to map the main problems that were evident from these reports (Flabouris, 2003). As noted and as shown in Figures 1–3, incident reports include a tick-box section and a free-text section. It is the latter free-text part of the reports that the present article is concerned with. These free-text sections were typed up from the original hand-written reports with all identifying information being deleted.

The free-text sections were analyzed using the system of Appraisal as described in Martin and White (2005). Overviews of approaches to the analysis of emotional discourse can be found in this and other publications by these authors (Martin, 2003; White, 2002). As noted, Appraisal provides a systemic map of those domains of discourse that speakers and writers draw on to do emotional work. This map covers Affect (angry, disappointed), Judgement (rude, clever), and Appreciation (well-functioning, ill conceived). In addition, Appraisal classifies the resources that mitigate and amplify these meanings (very, a little), and those that signal the degree of appropriation by the authors who deploy them (Engagement: I believe … The fact is …). Each of these five sub-systems has more delicate sub-classifications. Of these, ‘positive versus negative’ is the most prominent one, because it cuts across all sub-systems. Finally, Appraisal accounts for direct forms (‘angry’) and for what Martin and White refer to as ‘tokens of emotion’ whose interpretation is likely to encompass evaluation. Examples of such tokens found in the corpus are ‘[they were] unwilling to accept patient’ and ‘[they left the] fuel cap off’. Arguably, the first harbours a negative judgement (‘immoral’), and the second harbours negative judgement (‘unprofessional’) and negative feeling (‘frustrating’). Allowing for tokens requires ‘interpretive analysis’, and this is a double-edged sword: it has the advantage of netting in items that appear to be doing emotive work given their co-text and context, but it has the disadvantage of making the identification and analysis of emotional discourse contingent on analysts’ individual readings and ‘coding orientations’ (Bernstein, 1987).

Against the background of this explanation and caveat, we note that our interpretive analysis revealed that around 27 per cent of the corpus of 125 incident reports (that is 46 reports) contained some form of evaluative language. The remainder concerns generally short accounts of equipment
failure (‘Monitor batteries flat’, #94) that generally ended with ‘[Was this preventable?] Better check’, and problems due to the weather that no-one could do much about (‘Poor weather conditions meant helicopter transfer aborted’, #81). The analyses presented below focus (mainly) on the sub-set of 46 reports that contain evaluative language. Let us begin with contextualizing this analysis by comparing two incident reports, one recounting an interpersonal or communicative incident (report #22) and the other a patient death (report #27; see Table 1).

**Incident report #22**

**Details of what happened:**
Patient transported from regional hospital to city hospital for Neurosurgery. Met by Neurosurgical Registrar who told us to go directly to theatre from emergency department. The Registrar did not examine the patient and was not interested in the facility for transferred monitoring in theatre. After being told that theatre monitoring was necessary the Registrar told us to ‘just go to theatre’. I said in other words ‘we should tell someone who cares’. The Registrar replied that he did care and that I was a smart arse.

**Describe the outcome.**
Angry, upset concerned for patients welfare.

**Steps taken or treatment required.**

**Was this incident preventable?**
Yes – poor communication, poor patient assessment by Registrar

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**Incident report #27**

**Details of what happened:**

Subsequent demise, presumed to be of neurological cause. Later review of CXR (not looked at by retrieval team) showed ETT in oesophagus.

**Describe the outcome.**
Cardiac arrest.

**Steps taken or treatment required.**
As presumed to be neurological cause, patient already elderly and moribund, aggressive resuscitation not attempted.

**Was this incident preventable?**
Yes – always check CXR when available, re-check airway if paralysing.

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Table 1: Two retrieval incident reports

In Table 2 below, the main differences between these two reports are highlighted. As the comparison bears out, the register of incident report #22 is consistently more explicitly evaluative than that of report #27. While report #22 foregrounds the relationship between the reporting retrieval doctor and the hospital Registrar, report #27 focuses on the patient’s management, condition and outcome using abbreviated and technical expressions. This also means that report #22 talks about ‘I/we’, while report #27 backgrounds people by using the passive voice (‘not looked at by the retrieval team’, ‘Breath sounds heard … Readied for transfer’).
Incident report #22 | Incident report #27
---|---
**main issue** | interaction between colleagues | clinical management of a patient
**outcome** | impact on retrieval team's emotional well being | impact on patient
**register** | explicit evaluative language detailing what was done and said | abbreviated language following sequence of intervention
focus on the people involved | ‘registrar – I/we’ (participants identified 9 times in #22) | little reference to the participants ‘retrieval team – doctor in emergency department’ (participants identified 3 times in #27)

Table 2: Differences between incident reports #22 and #27

A brief thought experiment may serve to put the differences that are at issue here into further relief. Imagine report #22 to have said: ‘Inadequate patient assessment by hospital staff; registrar’s attitude unhelpful’. Similarly, imagine incident report #27 to have said: ‘Retrieval clinician didn’t care to check CXR. Told him ‘to get with it’. Answered that I was a smart arse. Angry, upset and distressed about patient’s decline and ultimate demise’. The fact that report #27 concerns an iatrogenic (hospital-caused) patient death while report #22 addresses a communication breakdown, and that report #22 appears nevertheless more emotional than report #27 demonstrates that attitudinal evaluation in incident reporting cannot be regarded as a simple and predictable correlate of the ‘factual’ (or ideational) circumstances surrounding retrieval incidents. It will become evident below that evaluation and ideation do rather divergent kinds of discursive work, ‘sending different messages’.

For the remainder of the present section, we will deploy the Appraisal framework, already sketched out in broad outlines above, to reveal these ambiguities. Here, evaluative discourse will be analysed drawing on the following three semantic domains, whose names act as headings for the sub-sections below:

1) personal or internal feelings (Affect);
2) evaluations about self and others (Judgement), and
3) assessments of and reactions to artefacts and other objects (Appreciation) (Martin, 2000).

**AFFECT**

Incident report #22 (already seen in the left-hand column in Table 1 above) offers an example of how the author negotiates the tension between intra-personal expressions available in what Appraisal calls AFFECT (Martin, 2003) and
more formalized organisational expressions. Under the ‘Describe the outcome’ heading of the free text component, the reporter of report #22 writes:

*Describe the outcome.*

Angry, upset, concerned for patient’s welfare.

Combinations of ‘upset’ and ‘angry’ were identified on seven occasions in the corpus. When the clinician writes about being ‘angry, upset and concerned’ in report #22, s/he can be read as complementing personalizing affect values (‘angry’) with ones that are somewhat less personalizing (‘concerned’). In combining these values, the clinician mobilizes different registers. In this case, the person appears to be hurt by the behaviour of the Registrar, while at the same time trying to raise this hurt into organisational relevance by referring to a potential threat to the patient’s welfare. One facet of this report targets (blames) an individual (the Registrar) for what happened, while another (‘concerned about the patient’s welfare’) frames the event with respect to the level of professional appropriateness of the care provided and the institutional norms governing inter-professional communication. In combining ‘angry’ with ‘concerned’, the clinician can be seen to want to reconcile her personal reaction (to the Registrar) with her moral commitment to the patient’s welfare.

Similar tensions appear in the following incident report number #14 (Table 3).

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**Incident report #22**

*Details of what happened:*
No porter and wheelchair provided by commercial aircraft. Passenger had fractured left ankle, fractured right wrist, back pain.

*Describe the outcome.*
Increased pain and suffering for patient.

*Steps taken or treatment required.*
Patient crawled to aircraft as she could not walk.

*Was this incident preventable?*
Yes, by airline providing promised service of wheelchair and porter.

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Table 3: Incident report #14

In report #14, the author notes that there was no porter or wheelchair provided. This lack was not occasioned by some individual but ‘by commercial aircraft’. Perhaps to enhance the impact of this omission on the reader the author says in graphic terms that ‘Patient crawled to aircraft’. The author finishes by saying the ‘airline’ could have provided better service. While this would not have been impossible, in none of these statements does the author identify any one person
or group of people as responsible for the absence of a porter or wheelchair. The author could have written for example: ‘The porter did not arrive’ or ‘The wheelchair had not been delivered by airline staff’. S/he would thereby have construed the possibility of personal blame and provided a rather different account of the same event (apart from potentially putting in train a different set of interpretations on the part of the analyst). Replaying the ambiguity identified above in a slightly different guise, tokenized evaluations (‘No porter’, ‘patient crawled’) accommodate both the urge to display feeling and the perceived need to limit its intensity.

**JUDGEMENT**

As noted above, Judgement is the domain of language that comes into play when judging people’s behaviour. Two incident reports are considered here to show that each realizes this domain rather differently. First, report #18 below (Table 4) yields a sense of ‘room for manoeuvre’ that clinicians have in their linguistic construal of an incident. In report #18, the ‘volume’ of Judgement is ‘turned up’ so to speak: the moral integrity as well the clinical knowledge of local hospital doctors attracts negative judgement (Table 4; Details of what happened part only). In that sense, report #18 construes the incident as resulting entirely from specific individuals’ sub-standard professional knowledge (‘claimed patient was capable of transferring’) and immoral attitude (‘all unwilling’).

**Details of what happened:**
Discussion with Resident Medical Officer, general surgeon and general practioner anaesthetist took place.
All unwilling to accept patient back to hospital, one demanding he remain on ambulance stretcher.
Advised the Medical Officers patient unsuitable for single crew transfer and too unstable for flight.
No Medical Officers willing to escort patient, did not want full medical retrieval activated.
Claimed patient was capable of transferring, did have distal pulses and therefore suitable for single crew transfer.

Table 4: Details of what happened part of incident report #18

Let us now compare report #18 to report #52 below (Table 5). In contrast to report #18, report #52 incorporates judgemental expressions whose identification requires organizational and contextual knowledge, such as expressions like ‘Items at helicopter medical equipment missing’ and ‘No check list’ to appreciate their judgemental intent.
Details of what happened:
Items at helicopter medical equipment missing
and no one notified
and (no one) recorded it.
No check list
for 2 days.

Table 5: Analysis of incident report #52

In contrast to report #18 seen in Table 4, report #52 in Table 5 depersonalizes the incident to a considerable extent: the only people mentioned are ‘no one’. ‘Items at helicopter medical equipment missing’ can be analyzed as an indirect reference to someone doing something wrong; that is, as a token of ‘organizationalized judgement’, also termed normativity (Iedema, 1996). The author is referring to a lack of appropriate organizational action, incurring a negative normative evaluation. By comparison, and topologically speaking, ‘no one recorded it’ moves slightly closer to personalizing the issue. Overall, the author of report #52 construes ambiguity by mixing personalizing judgements and organizational normativity.

From the point of view of incident reporting as a means to achieving work systems improvement, it is important to reflect on the tension that results from authors framing events in terms of both personal judgement and organizational normativity. Organizational norms are set out in policies and procedures and codes of conduct, but they are also embedded in tacit practice. As Martin notes, ‘socialization into a discipline involves both alignment with the institutional practices involved and an affinity with the attitudes one is expected to have towards those practices’ (Martin, 2000). On this reasoning, judgemental expressions referenced to organizational norms are complex things: they do not only reflect the point of view of the person making the judgement, but also carry the weight and authority of organizational norms and censures.

As the reports analyzed thus far demonstrate, reports do not just vary according to whether they frame an incident in judgemental and therefore personalizing terms, or in organizational, normative and more ideational terms. Rather, reports can also vary in the extent to which they realize ambivalence as discursive ambiguity. This raises important questions about how these reports’ meanings are interpreted by analysts whose task it is to derive conclusions for the purpose of work systems improvement. As was evident above, the discursive construction of attitudinal evaluation that appears in these reports is most likely to operate at the interstice of a range of determinants: the nature and severity of the event, the relationships between participants and their interpersonal and
organizational histories, their personal predispositions, education and experience, the system in which they are operating, and many other related situational factors. Given the unpredictable and ambiguous fashion in which the reporting clinician will weave these factors into their reports, incident report analysis is less straightforward than may be assumed by the architects and proponents of the critical incident technique (Flanagan, 1954; Runciman et al., 2000).

APPRECIATION

Finally, the corpus reveals that clinical retrieval equipment is a prominent source of problems. Overall, the incident reports studied revealed around 16 per cent emotive expressions to be positive about objects, in contrast to a total of 84 per cent that were negative. A frequent target of negative attitudinal evaluation in the corpus was the ventilator, a piece of equipment also recognized in the literature as frequently giving rise to concern (Webb et al., 1993). Other objects offered up for attitudinal evaluation include monitors and other highly specialized technological tools, and more abstract things such as facilities, systems, procedures and inappropriate levels of resource allocation (‘inadequate rest break’; report #78). These objects are ‘emoted’ about as components crucial to servicing a procedure that is comprised of specialized practices, roles and tools. The evaluation of objects, in other words, occurs most often when their functionality is impaired.

The literature defines APPRECIATION as discourse that expresses attitudes evoked by objects and artefacts. Appreciation is thus at issue in expressions such as ‘a beautiful beach’, ‘a fantastic song’ and ‘an awful day’ (Martin & Rose, 2004). In contrast to these kinds of evaluations that regard objects ‘in and for themselves’, however, the evaluations in the present corpus predominantly arise in response to objects on grounds of their inadequate functionality. In report #112, for example, a faulty bridge is reported as the cause of a procedural breakdown (Table 6).

<table>
<thead>
<tr>
<th>Details of what happened:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power supply to infant star not powering bridge.</td>
</tr>
<tr>
<td>But not powering bridge 4 to ambulance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Describe the outcome.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Steps taken or treatment required.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Was this incident preventable?</strong></td>
</tr>
<tr>
<td>No. Equipment failure.</td>
</tr>
</tbody>
</table>

Table 6: Incident report #112
The incident in report #112 is realized as being the unambiguous result of the breakdown of the bridge that links the aircraft and the ambulance and that is needed for moving the patient. The report suggests that the incident could not have been prevented by any specific person’s actions or interventions: it was the power supply that failed. Another report (#15) realizes its incident as follows: ‘Patient loaded onto aircraft. Plane refuelled proceeded to take off, fuel cap noted not to be on. 100 pounds of fuel lost. Had to land back at departing airport and do a final check again’ (Details of what happened section). While the analytical difficulties posed by personalized and emotional incident reports seen earlier centre on reconciling divergent interpersonal and organizational meanings, reports such as #112 and #15 depersonalize the incident, black-boxing the various sources of the trouble. On both counts, incident reporting remains ambiguous about the details of the problems in question.

The next section of this article turns from these discursive ambiguities to a consideration of the generic structure of the critical incident report form. This structure asks authors to shift from their direct experiences of the incident towards an analysis of and a solution to what happened. This discursive transition, we will argue, may herald a change in positioning that this new genre is inviting clinicians to enact. Put together, the ambiguities considered above and the transitions evident in the genre of the incident report may involve the author in reprocessing personal sentiments into organizational assessments. Far from providing a simple view of problems encountered ‘out there’, we will suggest therefore, the incident report has functions that are additional to those claimed for it.

**Reconfiguring feeling and positioning**

The analyses above revealed the tensions between attitudinal evaluation that remained personalized and the kind that distances itself from personal feelings and sentiments and frames itself with respect to more abstract concerns. From the point of view of critical incident reporting as a method that seeks to bring about systems-based change, it would appear that evaluations that translate intangibles such as personal feeling and chance into organizational implications are preferable. Attitudinal evaluations such as ‘angry and upset’ personalize the incident and leave undetermined whether any work process changes might prevent it from re-occurring. ‘Concerned (with patient’s welfare)’, by contrast, backgrounds personal experience and infuses the clinician’s report with institutional relevance and normativity (Iedema, 1996). In light of the intent that informs critical incident reporting and the work systems improvements that its analysis is meant to produce, this tension between personal and organizational
kinds of attitudinal evaluation might be seen to constitute a problem. Analysts have to sift through authors’ reports and decide which attitudinal evaluations arise from ad hoc, temporal personal disagreements, and which ones should be read as confirming the presence of systems problems and the need for work process redesign (Grant & Iedema, 2004).

While ambiguity may constitute a problem for those wishing to deduce organizational conclusions, further scrutiny of these incident reports reveals that their instrumental function, centred on providing insight into serious and frequent incidents, constitutes but one facet of this technique. This is because, when considered in its entirety, the calibrated structure of the incident report can elicit complex accounts, as it guides the reporting clinician through narrative identification with the incident towards a distanced appreciation of its organizational implications (Iedema et al., 2006a). Thus, the headings ‘Details of what happened’, ‘Describe the outcome’, ‘Steps taken’, and ‘Was this incident preventable’ engage clinicians in reframing the incident from radically different perspectives. In effect, the discursive shifts that these different headings evoke can be argued to engage the reporting clinician in performing a variety of stances or positionings (Davies & Harré, 1990), and these may, over time, have a bearing on their self-identity (Shotter & Gergen, 1989).

To elaborate this point, let us retrace our analysis paying special attention to the generic structure of the incident report. Following the tick box section, the heading ‘Details of what happened’ invites the reporting clinician to narrate the incident in terms that of their experiences and actions. Albeit embedded within a bureaucratic-organizational reporting device, the narrative potential of this ‘Details of what happened’ field of the incident report provides a space for the clinician to write about the incident in intimate and emotive terms. Even if this opportunity is not always taken up, it offers the clinician potential therapeutic release from the pressures of having witnessed or caused an incident and an impartial listener with whom to share the account. As example, consider report #34 (Table 7) which shows how a number of circumstantial complications (‘blood in pharynx’; ‘patient bucking’), unintended errors (‘suction failed’) and inappropriate practices (admittedly ‘make do’; ‘ambulance unit being operated by fire officer’) is further compounded by several technical problems (‘difficult vision’, ‘lots of noise’, ‘faulty Cx collar’). The evaluative syndrome that works its way through the overall report manifests a complex dynamic through which the reporting clinician appears to try to rationalize the incident.
Details of what happened:

...motor vehicle accident, trapped unconscious. Patient GCS 5 right pupil fixed, femoral and pelvic fractures, assisted ventilation with BVM, own tidal volume ok.
Initial intubation attempted cold.
Blood in pharynx.
Suction failed (ambulance unit being operated by fire officer).
Intubation proceeded without suction, difficult vision
uncertain tube placement,
patient bucking, and relaxant given.
Auscultation to confirm placement equivocal (problem with lots of noise)
Colorimetric capnograph placed on, and gastric contents regurgitated via ETT which contaminated capnocheck.
Presumed oesophageal.
Reintubated with difficulty and bougie.
Misplaced intubation roll slight delay tying ETT, compounded by faulty Cx collar (closure failure).
Placed in MAST suit to splint limbs....

Describe the outcome.
Potential compromise of patient welfare.
Other measures not performed due time lost rectifying problems.

Table 7: Incident report #34

Report #34 reads as a description of a challenging situation, and suggests the reporting clinician may have been struggling with the impact of this incident and with how to report it. The clinician may have felt that it was inappropriate to report on what happened in a more personal fashion, yet the accumulation of evaluative language in the report (‘suction failed’, ‘ambulance operated by fire officer’, ‘lots of noise’, ‘misplaced intubation roll’, ‘faulty Cx collar’) could be heard as encoding personal frustration, even if this is again underplayed by the restrained tone of ‘potential compromise of patient welfare’.

Be that as it may, the force of this evaluative dynamic then comes up against the rather more formal account required under the heading ‘Describe the outcome’. ‘Describe the outcome’ embodies a reference to the language of the New Public Management (Hoggett, 1991) and in that sense exhorts the reporting clinician to change gears from experiential narrative into a formal assessment of why their incident narrative matters in the first place: what gives it organizational significance and relevance? In report #34, ‘Describe the outcome’
brings down to earth the narrative dynamic that flourished under ‘Details of what happened’: ‘Potential compromise of patient welfare. Other measures not performed due to time lost rectifying problems’. Here, the narrative élan of the writing produced under the heading ‘Details of what happened’ is reduced to a calculation of the implications of what happened to patient care and the patient’s condition.

The section that follows on from ‘Describe the outcome’ cranks the managerialist tenor up even further, and asks for confirmation that what those involved in the incident did in response was not just according to procedure but also effective in view of containing the outcome of the incident (‘Steps taken or treatment required?’). Here, the clinician is asked to shift from evaluating what happened to stating what they did to rectify the situation. Finally, accomplishing the discursive transformation of attitudinal evaluation into organizational resolution, the last field asks the reporting clinician to make a formal assessment of whether the event would have been avoidable (‘Was this incident preventable?’). This field requires a contextualization of the incident with knowledge about organizational factors and specifics, resituating any potential misgivings within a broader space of strategic calculation and risk assessment.

In steering the reporting clinician through these discursive rapids, incident reporting as an emerging genre in health care reveals itself as a potential site of re-identification. Each of this genre’s fields produces distinct discursive opportunities, from experiential narrative to abstract, distanced assessment. And as discourse genre, the incident report constitutes much more than simply an opportunity to notify management about a problem. Currently, the functionality of the critical incident report is generally claimed to reside in the visibility it affords into organizational failure (Flanagan, 1954; Short, O’Regan, Jayasuriya, Rowbottom, Buckley, & Oh, 1996). This genre’s larger impact may well register elsewhere altogether however; namely, in the way it inducts those who use it into a discursive space where they are expected to transmute personal involvement into organizational-managerial assessment. Put in these terms, incident reporting is not just important as a form of work process analysis and organizational learning. It also plays an important role in broadening the reach of contemporary clinicians’ discursive abilities, and therefore potentially also their positionings and their self-identities.

In sum, incident reporting invites clinicians to produce meanings that go beyond private emotivity and professional expertise, and that connect with institutional normativity and organizational-procedural design. Incident reporting is not just an important bureaucratic-administrative mechanism, but also a post-bureaucratic performance (Iedema, 2003). That is, when doing the paperwork required for reporting incidents clinicians do not merely follow
health departmental protocol. They also accept the principle that clinicians must now report their own and colleagues’ incidents to an authority outside of their own professional fraternity. Framed thus, the genre of incident reporting invites clinicians to redefine their identities from being shaped exclusively by their own professional training and relationships (as is traditionally the case; Degeling, Hill, & Kennedy, 2001) to articulating a new allegiance that encompasses health managers, bureaucrats and clinicians trained in other professions (Iedema et al., 2006c). Time will tell, but this articulation, we believe, opens clinicians’ personal experience and professional knowledge up to discourses, norms and values thus far not allowed to play a formative role in the shaping of clinical identity.

Conclusion

This article has presented an analysis of a corpus of critical incident reports gathered from the field of retrieval medicine. The article has presented the argument that, as discursive construct, the incident report is a complex phenomenon. It embodies more than merely a record of errors and an opportunity for systems analysts to identify sources of work process failure. It confronts reporting clinicians with the opportunity to at once personalize and ‘organizationalize’ their evaluation and assessment of incidents. It also elicits from them perspectives on these incidents that range from classification, experiential to managerial (or ‘interventionist’). Collectively, we would argue, these ambiguities and transitions presage a subtle reconfiguration of clinicians’ discursive positioning and perhaps even their professional identification. In juxtaposing personal feeling, professional knowing, managerial monitoring and organizational planning, the reporting clinician comes to perform a conduct not traditionally associated with their clinical identity (Freidson, 1994). As performative discourse, and despite the ambiguities and ambivalences that frequently characterize it, the incident report constitutes a site where these previously incompatible positionings are woven into a single, if multi-voiced, logic.

It is this complex logic that makes the incident report the post-bureaucratic device par excellence (Iedema, 2006). While ostensibly constituting ‘mere paperwork’ that buttresses bureaucratic surveillance, the incident report is in fact also a space where clinicians are encouraged to articulate their personal-professional perspectives on what happened and anchor these with reference to their understanding of what should have happened. The significance of this does not just register in clinicians’ enunciating organizational rules of their own accord. Potentially more significant is that, in taking the opportunity to co-articulate personal sentiments with professional knowledges, institutional
norms and procedural strategies, clinicians of their own accord contrive a link between their affective world and their organization's formal logic. The post-bureaucratic turn that is at work here, then, resides in clinicians as frontline employees co-articulating and 'folding into their soul' (Rose, 1999) an organizational logic that emerges from their familiarity with and identification of local problems and their self-managed resolution of these problems (Iedema, 2003).

Alongside incident reporting, a range of recent policy initiatives aims to enhance the delivery of health care services through the analysis of facets of the clinical work (Bagian, Gosbee, Lee, Williams, McKnight, & Mannos, 2002), such as 'root cause analysis' (Iedema, Jorm, Braithwaite, Travaglia & Lum, 2006b) and 'open disclosure' (Lamb, 2004). Our research into how these initiatives are enacted in situ has revealed that their instrumental purpose of 'fixing' work process systems may become subservient to an unintended or emergent consequence: reconciling personal feeling with organizational acting. While the analysis of health care services and service errors provides important generalizing insights into the nature of the most common errors, it is the 'culture' or the attitudes and norms held by clinicians that will ultimately determine whether such insights are valued or not, and whether they are integrated into everyday practice. Seen in this light, the unintended consequence embodied within critical incident reporting – the reconstitution of clinical identity from a privatized and professionalized self into an organizationalized self – may play a more important role in transforming the complexion of contemporary health care than the formal analysis of incident patterns (Iedema et al., 2006c).

Finally, it is noteworthy in regard of this last point that the new web-based versions of the Australian Incident Monitoring System economize on the space provided for free text. IIMS, the Improved Incident Management System, significantly pares down clinicians’ opportunity to elaborate discursively on what happened (Braithwaite et al., 2006). In these newer systems, instrumental bureaucratic functionality overshadows the post-bureaucratic tactic of enrolling workers into new managerialist forms of conduct. The question that this raises is whether limiting if not entirely abandoning free text fields ultimately serves the instrumental intent that informs the incident monitoring initiative, or whether these updated report forms preclude opportunities for clinicians to identify with and inscribe themselves into the emerging post-bureaucratic regime dictated by contemporary health policy reform.
Appendix

Visual representations of the incident report form.
Anonymous
Incident Monitoring Form

Australian Incident Monitoring Study
Retrieval Medicine

- This report is ANONYMOUS. Do not identify patients or other people.
- If you are a first aider, only record the information you know.
- Please note that this report form is to be used for quality improvement purposes only.
- If more than one person is involved, please complete a separate form for each person.

Details of what happened (please continue over the page if necessary)

Ensure that any person involved is safe and that all necessary steps have been taken to support and treat this person and to prevent injury to others. Ensure medical records are current and up to date.

Diagnoses:

Location of incident (e.g., scene, helicopter, ambulance etc.):

Describe the outcome (e.g., stable, improved, complications, pulmonary oedema, hypoglycaemia, cardiac arrest):

List steps taken or treatment required:

Was this incident preventable (if yes, how; if no, why not):

Please ensure this section is completed

Time of incident (24-hour clock):

Incident occurred in: Month Year

Designation of reporter:

Set of subject of incident: D M F O not known O not applicable

Specialty involved in incident:

Age of subject of incident (if known): O not applicable

Please post in the yellow AIMS box
### Part B

**Anonymous Incident Monitoring Form**

Continue details of what happened.

<table>
<thead>
<tr>
<th>Potential for harm to person from the incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ None □ Mild □ Slight □ Significant □ Serious □ Severe</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated duration of any actual harm to the person involved in the incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N/A □ Nil Minutes: Hours: Days: Months: Years: □ Unknown □ Death</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated stay in hospital or institution as a result of this incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ N/A □ Nil Minutes: Hours: Days: Months: Years: □ Unknown □ Death</td>
</tr>
</tbody>
</table>

25/11/99 12:00
About the author

Rick Iedema has a PhD in Linguistics from Sydney University (1997). He is Professor in Organisational Communication and Associate Dean (Research) at the Faculty of Humanities and Social Sciences, The University of Technology Sydney. His research interest is how communication in hospitals contributes to the organisation of clinical work. He has (co)published three edited volumes (Hospital Communication, Palgrave-Macmillan, 2007; Identity Trouble with Carmen Caldas Coulthard, Palgrave-Macmillan, 2008, and Managing Clinical Work, Elsevier, with Ros Sorensen). He has published a single-authored book (Discourses of Post-Bureaucratic Organization; Benjamins, 2003), and is currently working on a monograph for Routledge with Carl Rhodes, David Grant and Hermine Scheeres.

Notes

1 Ethics approval was obtained for this project (SWSAHS Ethics Committee: ID HS. sbHREC98/12/4. 25[777]) on behalf of Careflight Australia, with the participating organizations remaining anonymous for reasons of confidentiality.

2 There is selection bias in this sample for the following reasons. The reports are drawn from one specialty only and the reports are all produced by doctors. No comparison has been attempted against reports from other specialties, or against reports submitted by other clinical professionals (nursing and allied health clinicians). The point of the analysis is to hypothesise that incident reporting as a general practice may affect medical clinicians’ traditional positioning and, potentially, their professional identity.

3 A Registrar is a doctor who is reaching the end of their medical specialty training.

References


