Organization Science
Vol. 24, No. 5, September–October 2013, pp. 1291–1315
ISSN 1047-7039 (print) | ISSN 1526-5455 (online)
http://dx.doi.org/10.1287/orsc.1120.0798

Repairing Breaches with Rules: Maintaining Institutions in the Face of Everyday Disruptions

Emily D. Heaphy
School of Management, Boston University, Boston, Massachusetts 02215, eheaphy@bu.edu

This study reveals the institutional work required to maintain taken-for-granted beliefs about roles in the face of everyday breaches of role expectations. Through a comparative qualitative study of hospital-employed patient advocates in teaching and Veterans Health Administration hospitals, I demonstrate that patient advocates repair breaches in the taken-for-granted beliefs about the patient, family, and staff roles in hospitals. My research shows that patient advocates skillfully used rules—or formal policies and procedures—to restore, clarify, or initiate organizational changes in rules, all to maintain institutionalized role expectations. This analysis expands our understanding of the work of maintaining institutions by specifying how constellations of roles are maintained in the face of breaches of role expectations and across different institutional contexts. It highlights the roles of pressure specialists and furthers theorizing on individual agency by specifying how rules can be source of individual agency.

Key words: institutional work; ethnomethodology; breaches; agency; rules; pressure specialists; roles
History: Published online in *Articles in Advance* February 12, 2013.

Introduction

Institutions are forms of social life that are, by definition, enduring (Hughes 1936). In recent years, scholars have largely assumed that institutions persist because they are associated with automatic mechanisms of social control (Jepperson 1991). Yet scholars remind us that the appearance of institutional stability is in fact a social accomplishment, as institutions must be transmitted over time, maintained on an ongoing basis, and persist in the face of challenges (Zucker 1988). As Lawrence and Suddaby (2006, p. 234) recently noted, "The real mystery of institutions is how social structures can be made to be self-replicating and persist beyond the life-span of their creators." However, research is relatively silent about how these activities occur, despite the importance of such research for understanding a defining characteristic of institutions (Scott 2008).

To understand institutional maintenance, one sensible place to start is at the microinstitutional level (e.g., Barley 1986, Kellogg 2011, Meyerson 1994, Reay et al. 2006). On an everyday basis, institutions are maintained through social interactions (Dacin et al. 2010), between people who occupy a structured system, or constellation, of social positions (Bourdieu 1990). Social positions, or roles (Emirbayer and Johnson 2008), provide the individuals who occupy them with resources, stakes, access, and identities in relation to others (Oakes et al. 1998). People in roles enact scripts (Barley 1986) or engage in interaction rituals (Lawrence 2004), their patterns of interaction both reflective of and constitutive of a larger social order (Barley and Tolbert 1997) in which a particular form of capital is dominant (Bourdieu 1989). Yet, despite the profound way in which institutions shape thoughts, feelings, and behavior (Lawrence and Suddaby 2006), people do not always act in ways that are consistent with institutionalized roles and interaction patterns. The actors who occupy roles in a field may dislike, reject, or not know about the expectations associated with their roles (Emirbayer and Johnson 2008, Oakes et al. 1998, Van Maanen and Schein 1979).

How are institutionalized beliefs about roles maintained? Thus far, answers to this question have fallen into two camps. First, some attention has been paid to the transmission of institutionalized roles and interaction patterns, or how they are maintained when there are regular cohorts of new members requiring socialization. For example, research has shown how institutionalized roles are transmitted through organization-level processes such as rituals and storytelling (e.g., Dacin et al. 2010; Zilber 2002, 2009). Second, there have been studies of how institutionalized roles are maintained in the face of challenges, such as one-time macro-level changes or jolts, as in the case of the introduction of a new technology (Barley 1986) or regulations (Meyer 1982). In some instances, individuals whose roles are being threatened resist these changes and fight to maintain their institutionalized roles (Kellogg 2011). However, we know less about how institutions are maintained in the face of small-scale, everyday disruptions to institutionalized roles and patterns of interaction. Such small-scale, everyday disruptions may be especially common in organizations where there is frequent turnover among the occupants of roles, as well as in organizations where there is a high degree of conflict or emotionality. These

may be reasons for which individuals may dislike, reject, or not know about certain aspects of a role. Yet the maintenance of institutions depends on actors reliably enacting their roles in a specific constellation of positions.

Institutional scholars have suggested that organizations sometimes create roles to maintain institutionalized patterns of interaction (Zucker 1991). Lawrence and Suddaby (2006) proposed that such roles might be an important part of a specific type of maintaining institutions called enabling work, or institutional work that facilitates, supplements, or supports institutions. Enabling roles may be one mechanism through which institutions can be maintained across large or dispersed fields. One role that is relevant for institutional maintenance but has not yet been explored is that of the "pressure specialist." Pressure specialists focus on handling exceptionally difficult or complex situations or problems that arise between frontline workers and their clients (Lipsky 1980). Pressure specialists interact with an organization's clients and frontline workers when these parties are unable to resolve a problem on their own. Looking closely at the work of pressure specialists, and specifically how they repair these problems, may help us shed light on how actors who occupy the pressure specialist role contribute to the maintenance of institutionalized roles. Thus, the research question guiding this paper is, how do pressure specialists maintain institutionalized roles in the face of small-scale, everyday disruptions of those roles?

Drawing on a comparative qualitative study of teaching and U.S. Department of Veterans Affairs (VA) hospitals, I argue that hospital-employed patient advocates—an exemplar of the pressure specialist role—repair what ethnomethodologists call "breaches," violations of commonly held understandings (Feldman 1995). In this case, the breaches are of institutionalized beliefs about roles. Specifically, analyses reveal that patient advocates repair breaches through their skillful use of formal rules (i.e., formal policies and procedures). Through their repair of breaches, pressure specialists enable a variety of actors to "go on" enacting their roles and thus maintain the institutionalized constellation of roles of which they are a part.

This research makes three theoretical contributions, two of which emerge from its theoretical framework—a reunion of institutional theory and ethnomethodology, and its application to the work of a particular role, the pressure specialist. In new institutional theory's foundational statement, ethnomethodology's perspective on how individuals employ and reproduce institutionalized beliefs provided an important source for scholars' theory of action (DiMaggio and Powell 1991). However, ethnomethodology has largely been left behind in the evolution of institutional theory, perhaps in part because of new institutional theory's lack of attention to individuals (Battilana and D'Aunno 2009) as well as its emphasis on the taken-for-grantedness of institutions, which, at an extreme, means individuals are viewed as "cultural dopes" (Hirsch and Lounsbury 1997). I suggest that the time is ripe for reincorporating ethnomethodology into institutional theory, because its focus on breaches and their repair is particularly appropriate for furthering our understanding of the work of maintaining institutions.

Ethnomethodology contributes to our understanding in at least two ways. First, it provides a theoretical foundation for expanding our understanding of the conditions under which institutions require maintenance, beyond conflict-free portrayals of socialization or the discussion of direct assaults on institutions (e.g., external jolts). Ethnomethodologists' account of breaches provides a means of theorizing about these smaller-scale, everyday disruptions to institutionalized expectations about roles. Second, ethnomethodology provides a theoretical foundation for understanding the work that goes into repairing breaches, thus shedding light on the agency that is required by individuals to maintain institutions. In particular, many "situational" ethnomethodologists (Douglas 1971), who often studied organizations, found that individuals used rules as tools to maintain shared understandings. Similarly, I found that patient advocates skillfully used organizational rules (e.g., formal policies and procedures) to repair breaches in institutionalized expectations of roles. By showing the patterned ways in which patient advocates use rules as tools to repair breaches, I respond to calls from scholars who have pushed for greater nuance in theorizing about individual agency, specifically in terms of how the form of agency varies depending on the situational context (Emirbayer and Mische 1998, Battilana and D'Aunno 2009). My comparative case study uncovers important sources of variation in how patient advocates repair breaches, depending on both the kind of breach confronted and the degree to which the institutionalized expectation about the role is institutionalized.

Third, this research broadens our understanding of the kinds of actors who are consequential for institutions. As highlighted by Martí and Mair (2009), most research has examined how organizations and collectives—such as the state, organizations, corporations, and professional associations—influence institutions (e.g., Dobbin 2001, Garud et al. 2002, Greenwood et al. 2002). We know relatively little about how individuals influence institutions (Battilana and D'Aunno 2009). The few types of individuals who have been studied generally come from privileged groups: researchers have focused on powerful actors—such as institutional entrepreneurs (DiMaggio 1988, Eisenstadt 1980) and occasionally managers (Battilana 2011, Reay et al. 2006)—who are either centrally located or highly peripheral and innovative, and who have control over resources (Martí and Mair 2009). In contrast, this research focuses on pressure specialists, a kind of street-level bureaucrat (SLB) (Lipsky 1980), who do not have access to these same

forms of influence. Thus, this research joins an emergent interest in low-power actors and the forms of institutional work they draw on to influence institutions (Canales 2012, Martí and Mair 2009).

In the remainder of this paper, I develop a theoretical framework for understanding the work of maintaining institutionalized roles, through relevant research from institutional theory and ethnomethodology. I then describe the research setting and methods. This leads to a presentation of the breaches of institutionalized roles patient advocates confronted, as well as how these pressure specialists used formal rules to repair these breaches. I contribute to the literature on maintaining institutions by developing a theoretical account of the answer to the following research question: How do pressure specialists maintain institutionalized roles in the face of small-scale, everyday disruptions of those roles?

Maintaining Institutionalized Roles

Institutions imbue social relationships with meaning. As Fligstein (2001, p. 108) defined them, institutions are "rules and shared meanings . . . that define social relationships, help define who occupies what position in those relationships and guide interaction by giving actors cognitive frames or sets of meanings to interpret the behavior of others." Thus institutions identify categories of social actors and their appropriate activities and relationships (Barley and Tolbert 1997). They help people understand their own roles in relation to others and help people make sense of and interpret their own and others' actions.

The relationships between the roles can vary across institutional contexts. The relationships between roles depend on what form of capital is most valued in a given field (Bourdieu 1986) and whether this capital is shared by different roles within the field (Bourdieu 1989). The capital associated with a specific position in a field provides actors who occupy it with possible strategies of action and degrees of influence within the field and in relation to others who occupy the field (Emirbayer and Johnson 2008, Oakes et al. 1998). In any given field, some form of (or combination of) capital represents power over the field, and in relation to other positions, at that given moment. That form of capital represents "the aces in a game of cards, in the competition for the appropriation of scarce goods" (Bourdieu 1989, p. 17). However, the actors who occupy positions in a field may dislike, reject, or not know about aspects of their positions.

In organizations, there are at least two reasons why actors may struggle with their positions. First, when people are new to a role, they may not know how to enact that role. Most of the existing research on institutional maintenance involves how institutionalized expectations about roles are transmitted to cohorts of new members. For example, Dacin et al. (2010) showed how dining rituals at Cambridge College have helped transform new generations of students into specific positions in the British class system over centuries. Another example is Zilber's (2002, 2009) research showing how employees and volunteers at a rape crisis center are socialized into telling particular types of individual narratives or stories, which then reinforce institutional metanarratives of empowerment.

Second, actors do not always like their positions. Actors may disagree with, resist, or contest the attributes of the position they occupy in a field. Medical residents, for example, experience identity violations when the mundane activities associated with their role are in conflict with the high-status professional identity they hold as physicians in training (Pratt et al. 2006). Nurse practitioners in Alberta, Canada, carefully resisted and eventually transformed their role in the field of healthcare, increasing the resources, stakes, and access associated with the position (Reay et al. 2006). In the mid-19th century in the United States, native-born white women withheld their daughters from domestic service as the role transitioned from one of working alongside a housewife as a helper to one that more closely resembled one of servitude, in which a young woman would work alone so that a housewife could pursue leisure activities (Wooten and Branch 2012). Perhaps paradoxically for the study of maintaining institutions, researchers have viewed challenges to institutions primarily as opportunities for those institutions to be changed or altered. Research has shown how external changes, such as jolts (Meyer 1982) or changes in technology (Barley 1986) or regulations (Kellogg 2011), have the potential to alter institutionalized patterns of interaction.

Yet the maintenance of fields depends on actors reliably enacting specific positions. Nowhere is this more apparent than in interactive services work (Leidner 1993), or healthcare and caregiving work (Kahn 2005) more broadly. Research has shown, for example, that individuals in neonatal intensive care units have to be transformed into the positions of "patients" and "family members" to be treated by high-status professionals (Heimer and Stevens 1997), and that patients work hard to be viewed credibly by consulting doctors so that they can access the resources (e.g., further treatment, prescriptions, diagnosis) available only through doctors (Werner and Malterud 2003). Yet we do not know how the structured system and constellation of roles are maintained in the face of everyday disruptions. To develop a theoretical framework for understanding such disruptions, I turn to ethnomethodology and, in particular, its approach to maintaining social order in the face of breaches.

Ethnomethodology

Ethnomethodology provides insight into how individuals maintain, elaborate, and transform social order

(Feldman 1995, Heritage 1984), including interactions, organizations, and institutions (Garfinkel 1967; Gephart 1978; Heritage 1984, pp. 179–232). Methods in ethnomethodology are not research methods but the methods engaged by people to go on in their daily lives. There is a long ethnomethodological tradition of examining how frontline workers, or organizational employees who interact with clients—such as public defenders (Sudnow 1965), lawyers (Hosticka 1979), police officers (Manning 1977), probation and juvenile officers (Cicourel 1968), reception personnel in public offices (Zimmerman 1970), and nurses (Fairhurst 1983)—influence social order.

Ethnomethodology originated in the work of Garfinkel (1964), who extended Schutz's (1962) claim that shared reality is not a given but instead is actively constructed through individuals' competent use of skills, practices, and assumptions (Hassard 1990). Through his famous experiments, Garfinkel (1967) showed that people engage in "accommodative work," or the work of assigning meaning to unfolding action to make it consistent with normative expectations, to maintain this sense of a shared social world. Because people are so skilled at and generally unaware of their accommodative work, it can be difficult to observe. One of Garfinkel's enduring insights was that to understand how individuals maintain social order, researchers should disrupt it. These disruptions, called *breaches*, are violations of common understanding (Feldman 1995), or more specifically, what Schutz (1962, p. 11–12) called the "reciprocity of perspectives." Schutz argued, "Human beings can never have identical experiences of anything, but that this is irrelevant because they continuously assume that their experiences of the world are similar and act as if their experiences were identical-for-all-practical-purposes" (cited in Heritage 1984, p. 54). Thus, when people interact, they have what Garfinkel (1964) called "interpretive trust," or trust that the other person shares the same perspective on the world—that is, that their own perspective is reciprocated by another (Heritage 1984, p. 97). When interpretive trust is violated, or when breaches occur, people are unable to interpret conduct as being in accord with normative expectations, forcing them to question whether this reciprocity of perspectives actually exists. They view these violations of the normative social order as willful and meaningful. As a result, experiencing a breach is disturbing, and people feel upset—a sense of moral indignation, disgust, fear, or surprise—because their sense of a shared social world has been disrupted. In addition, because they cannot make sense of the situation, they are, at least temporarily, caught up short and do not know how to act. Thus, breaches, which occur when interpretive trust has been violated and the people experiencing the breach are disturbed and do not know how to act, are rich sites for analysis because they expose what the taken-for-granted social order is and—of primary interest to ethnomethodologists—how people attempt to repair it.

Garfinkel (1964) and his students purposefully created breaches, willfully interrupting social order to view the process through which it is repaired. However, breaches also occur naturally in organizations. For example, Feldman (1995) wrote that researchers can become aware of breaches by paying attention to what is considered unacceptable behavior in a particular context: the cues they are given can help them understand whether actions are acceptable or not.

One way to study the repair of breeches within organizations is to study pressure specialists, who are a type of street-level bureaucrat. Street-level bureaucrats, also called frontline workers (Maynard-Moody and Musheno 2003), interact directly with citizens or clients in the course of their jobs and have substantial discretion in the execution of their work (Lipsky 1980, p. 3). They are employed by organizations that are responsible for providing public goods and services, such as healthcare, social services, and law enforcement. Examples include regulators (Fineman 1998, Nielsen 2007), police officers (Skolnick 1994, Van Maanen 1973), probation and juvenile officers (Cicourel 1968, Kunda 1986), social workers and doctors (Thomas and Johnson 1991), teachers (Maynard-Moody and Musheno 2003), and lawyers and judges (Sudnow 1965). In their interactions with clients, SLBs have to make decisions about how to treat people who are experiencing problems that are unpredictable, complex, and emotionally and politically laden (Vinzant and Crothers 1998). Pressure specialists who handle exceptionally difficult or complex situations or problems that arise between street-level bureaucrats and their clients (Lipsky 1980) are particularly relevant for understanding how individuals repair breaches.

My research aims to develop a grounded theory about how pressure specialists maintain institutionalized constellations of roles. I studied patient advocates, who are pressure specialists in hospitals. Patients, their family members, and hospital staff seek help from patient advocates when they experience problems in the hospital that they do not know how to handle on their own. With an ethnomethodological approach, I examined how patient advocates used rules to assign meaning when breaches occurred. My analyses showed that when patient advocates encountered breaches, they relied on rules to construct a common understanding of the situation. In so doing, they maintained institutionalized expectations about patient, family, and staff roles. By studying pressure specialists in two different types of hospitals, I discovered how this work was accomplished in different settings.

Research Design and Methods

Research Setting

Patient advocates are hospital employees who handle nonroutine problems experienced by patients, families, and hospital staff. Their specialty is handling problems related to the quality of care and service that patients and their families experience while in the hospital. These problems cannot be remedied through routine hospital processes because they are unusual; because they cross departments or units; because a resolution has been tried and failed; or because a conflict has developed among the patient, their family members, or friends and staff who would normally handle the problem. Patient advocates are pressure specialists because they handle particularly difficult or complex situations or problems that arise between hospital staff and patients (or their families).

The patient advocate role emerged in the United States in the 1960s and 1970s in response to criticisms that disadvantaged patients, specifically the poor, mentally ill, and children, were not receiving fair access to medical care (Hogan 1980). Over the next decade, patient advocates were described as the fastest-growing occupation in hospital settings (Mailick 1982). Scholars attribute the development of the patient advocate role to a number of historic changes, including an increased interest in equitable access to healthcare services, marked most prominently by the passage of the Medicare and Medicaid provisions under the Social Security Act of 1965 (Scott et al. 2000), and to a federal investigation that drew attention to the need for improved patient grievance mechanisms in hospitals (Hogan 1980). The patient advocate role was seen as one way for hospitals to become more accessible to patients (Mailick and Rehr 1981).

Following a strategy of theoretical sampling, in the sense of controlling similarities and differences between groups to further theory development (Glaser and Strauss 1967), I compared patient advocates in two types of hospitals: VA hospitals and teaching hospitals. In these two types of hospitals, the patient advocate role is structured similarly—a full-time role that is located in a centralized office, rather than attached to a particular department (e.g., Emergency Department). However, these two types of hospitals differed in the degree to which institutionalized expectations about roles were shared as well as which role had the most influence (or capital) in the field. There were several factors that contributed to this variation (see Table 1 for a summary of these characteristics).

The VA hospitals were filled with patients, family members, and staff who were veterans. The patient population consisted of veterans and a small number of veterans' family members, resulting in a stable and predictable patient population consisting of predominantly older men of lower socioeconomic status compared with the general population (Agha et al. 2000). VA patients also share common health issues based on their experiences in the military service, such as post-traumatic stress disorder (PTSD) or Gulf War syndrome (Sartin 2000; Institute of Medicine 2006; Wessely 2001). Many VA employees had served in the military and therefore were still on active duty (e.g., Reserves) or were veterans themselves (Department of Veterans Affairs 2007, Bilmes 2007). Indeed, all but one of the VA patient advocates and other staff I met throughout my fieldwork were veterans themselves or had immediate family members who were veterans, so they had exposure to the military and VA not only at work but also in their personal lives. Thus, patients, families, and staff in VA hospitals were members of a shared culture that derived from

Table 1 Comparison of Patient Advocates at Teaching and VA Hospitals

	Teaching hospitals	VA hospitals
Commonalities		
Patient advocate role	Full-time Work out of centralized office	Full-time Work out of centralized office
Differences		
Patient population	Men, women, and children	Primarily men, older, lower socioeconomic status
Patients' health issues	Specialty cases (e.g., referrals, emergencies)	Primary and specialty care; relatively similar health issues because of homogeneity of population (e.g., geriatric medicine; not obstetrics/gynecology) and military-related illnesses (e.g., post-traumatic stress disorder)
Relationships among patients, family, and staff	Patients/family and staff rarely have ongoing relationships	Patients, family, and staff have opportunities to develop ongoing relationships and networks to learn about each other (e.g., patients and families learn who the "good" doctors are; staff learn who the "difficult" patients are)
Participation in shared culture	No	Yes, derived from participation in military
Rules	Hospital rules, CMS, Health Insurance Portability and Accountability Act of 1996 (HIPAA), legal rules (e.g., power of attorney)	Hospital rules, HIPAA, legal rules (e.g., power of attorney), eligibility rules (set by U.S. Congress)

serving in the U.S. military. This culture was characterized by what observers have described as an "unusual bond felt between patients and their doctors . . . who are at least highly sympathetic to the experience of veterans in American society. All these bonds are a strong and important part of the culture of the VA" (Longman 2007, p. 110). In addition, patients often received their primary care at VA hospitals and therefore had more information, experience, and knowledge about how the hospital worked, as well as ongoing relationships with at least some of the hospital staff. As a result, there was ample opportunity for shared understanding about institutionalized expectations about roles to develop in VA hospitals. Thus the prominence of the patient-as-veteran role was widely shared in VA hospitals. Because so many patients, family members, and staff shared the experience of military service, the actors can be described as having close social distance (Bourdieu 1989).

By contrast, the patient population at teaching hospitals was heterogeneous, with patients varying in gender, age, and health-related issues. Patients were typically referred to teaching hospitals when they needed specialty care (e.g., surgery, a consultation, or emergency care). The specialty medical care provided by doctors and other medical staff drew a broad and diverse group of patients. As a result, patients, family, and staff were not members of the same cultural or even geographic communities. This diversity meant there were fewer opportunities for relationships to develop among the patients, families, and staff who inhabit teaching hospitals. As a result of all of these factors, the relationships between positions can be characterized as comparatively distant (Bourdieu 1989). Given the importance of the provision of specialty medical care in teaching hospitals, the doctor role was accorded prominence within the teaching hospital.

Patient advocates in these two hospital types were also subject to different regulatory environments. The most relevant differences related to the rules set by the government agencies that provide significant funding and reimbursements for the hospitals. At teaching hospitals, which are dependent on Medicare and Medicaid reimbursements for funding, patient advocates' work is influenced by Center for Medicaid and Medicare Services (CMS) regulations. At VA hospitals, which are funded by the U.S. Congress, patient advocates' work is influenced by federal rules, which dictate many aspects of life in the VA, most notably the extent of each veteran's eligibility for medical care. Patients and doctors also have different legal rights and liabilities in the two types of hospitals. In teaching hospitals, patients have the legal right to sue individual caregivers and the hospital. Physicians named in medical malpractice suits can be represented by private practice lawyers. In VA hospitals, medical malpractice suits are handled by the Regional Council, Office of General Council, and U.S. district courts. Physicians and other caregivers named in lawsuits are represented by the VA, not by individual legal representation. As a result, staff members at VA hospitals are less vulnerable to lawsuits. Given the differences between these two hospital types, specifically in the institutionalized beliefs about roles and the regulatory environments, any theory generated in these divergent settings is more likely to be robust.

Data Collection

I collected data during an 18-month period, as summarized in Table 2, which indicates the type and amount of data collected. During the first phase, I developed an understanding of the patient advocate role by interviewing 18 key informants, attending 3 patient advocate conferences as a participant observer, and collecting documents. Based on what I learned from these data—in particular, my realization that the role was consistently designed as a full-time, centralized role in teaching and VA hospitals, whereas that was not always the case in community hospitals—I refined my site selection for the second phase of data collection and decided to focus on the patient advocate role at teaching and VA hospitals. I also identified that rules were an important part of patient advocates' work. For example, conferences included presentations on the newest rules and regulations that applied to patient advocates' work. In a memo I wrote summarizing the national conferences, I noted that patient advocates lived in a "thicket of rules and regulations."

In the second phase of data collection, I used two complementary methods to generate sources of data on patient advocates' work. I conducted 31 semistructured interviews with patient advocates at 17 hospitals (20 at 10 teaching hospitals and 11 at 7 VA hospitals), which provided me with accounts of their work (Orbuch 1997). All patient advocates were employed full-time by tertiary hospitals in urban centers in three Midwestern states and worked in centralized (as opposed to department-specific) offices. Interviews lasted an average of 90 minutes. The first 26 interviews took place in the informants' offices, which provided me with the opportunity to talk informally with patient advocates' peers and supervisors and to have the patient advocates show me around their facilities. Because I was reaching information saturation (Padgett 1998), I conducted the final five interviews over the phone. After each interview, I wrote field notes about the interview, the informant's office space and its location in the hospital, my impressions of the hospital, and other topics that seemed relevant (Lofland et al. 2006, Spradley 1979). During these interviews, participants were asked to describe their everyday work, with the aim of soliciting in-depth stories about the kinds of cases they handle. I also asked them about their career paths, the hospital environment,

Table 2 Data Collection and Analysis

Type of data	Amount of data and site		Use in analysis and theory development
Phase 1	Understanding the patient advocate role		
Interviews with key informants	18 key informants, including officers of the patient advocate professional association, hospital administrators, patient advocate educators, and one vendor (sold technology used by patient advocates in hospitals)		• Provided foundational understanding of patient advocates' work and their role in healthcare context • Identified (1) similarities and differences in patient advocate role across hospital types and (2) importance of rules to patient advocates' work • Generated basis for theoretical sampling and site selection (focus on teaching and VA hospitals) for Phase 2 data collection
Participant observation at patient advocate conferences	1 three-day national patient advocacy professional association conference 1 one-day state patient advocacy professional association conference 1 two-day national VA patient advocate conference		
Documents	Collected 1,000 pages of documents from key informants, conferences, and patient advocacy websites		Added contextual depth in understanding patient advocates' work and their role in healthcare context
	The work of patient advocates at…		
Phase 2	Teaching hospitals	VA hospitals	
Interviews with informants	20 patient advocates at 10 teaching hospitals; also included tours of hospitals, informal conversations with managers and coworkers	11 patient advocates at 7 VA hospitals; also included tours of hospitals, informal conversations with managers and coworkers	Transcribed interviews and shadowing field notes coded to assist with development of rule use patterns, breaches, and their effect on the organization; ATLAS.ti used as a tool in this process; wrote memos during analysis to assist in theory development
Shadowing	5 patient advocates at 1 hospital 75 hours shadowing (15 hours/patient advocate)	3 patient advocates at 1 hospital 45 hours shadowing (15 hours/patient advocate)	

and the rewards and challenges of the work. All interviews were recorded and transcribed.[1]

I shadowed the members of two patient advocate offices, at a teaching hospital and at a VA hospital, for which I use the pseudonyms Heartland Teaching Hospital and Reveille VA Hospital, respectively. Heartland Teaching Hospital employed five patient advocates, whom I observed for a total of 75 hours. Reveille VA Hospital employed three patient advocates, whom I shadowed for a total of 45 hours. Both hospitals' Institutional Review Boards approved a means of notifying patients about my research and required that I become certified in handling confidential patient information. I began my research at both hospitals by interviewing the shadowees and their managers and administrative assistants prior to formal shadowing (McDonald 2005). While shadowing, I watched as patient advocates completed office work and visited with patients, family members, and staff in their offices and throughout the hospital. I asked the patient advocates to explain their activities as they went along, and I took extensive notes of each patient advocate's activities, including his or her interactions, use of artifacts (technology, documents, etc.), emotional experiences, and physical expressions. When interacting with people outside of the patient advocate office, I was introduced as a student who was learning about patient advocacy. After each day of shadowing, I took extensive field notes that included the patient advocate's observations, our conversations about the day's events, and my own observations and impressions. Shadowing provided me with the opportunity to collect data on patient advocates' own moment-by-moment interpretations and reflections on their work experiences, to observe patient advocates' daily work life, and to have an ongoing dialogue with patient advocates about their work.

The patient advocates at teaching and VA hospitals had similar demographic characteristics and tenures in healthcare. Two-thirds of the patient advocates I interviewed and shadowed at both hospitals were women; two-thirds of the patient advocates were white, and one-third were African American. Teaching hospital patient advocates averaged 8 years in the patient advocate role and a total of 20 years in healthcare. VA patient advocates averaged 6.5 years as patient advocates and 22 years working in VA hospitals. Three VA patient advocates had also worked for two years or less in non-VA hospitals.

Analysis

Data analysis was a three-phase process. In the first phase, I systematically explored my early field observation that rules were prevalent and important in patient advocates' handling of problems. To that end, I read through interview and shadowing data, and I identified 108 situations in which patient advocates interacted with

rules in their process of handling problems (52 at teaching hospitals and 56 at VA hospitals). The output of the first stage of the data analysis was a set of narratives composed of ordered, raw data, such as quotes from interviews, meetings, documents, and field notes, that brought together all sources of data on a situation in which a patient advocate used rules to handle a problem. To make sense of these data, I developed inductive codes that answered three analytic questions: What were patient advocates doing with the rules? Who, besides patient advocates, was involved in these situations? What kinds of rules were used? Based on these analytic questions, I wrote memos identifying four rule use patterns: (1) explaining rules, (2) coaching others about rules, (3) documenting according to rules, and (4) switching between sets of rules. However, there was wide variation in the rules that were used and the sets of people involved in each situation.

In the second phase, I introduced an ethnomethodological approach to analyzing the data, specifically examining each of the 108 situations identified above as breaches. I argue that these problems can be conceptualized as breaches because they have two characteristics of breaches: (1) they occur when one or more persons feel that they cannot go on, and (2) it causes some sense of disturbance and a resulting negative emotional reaction, such as surprise, outrage, sadness, or moral indignation. Thus, I analyze pressure specialists' responses to breaches as a way to gain insight into the problems experienced by patients, families, and staff in hospitals and how the pressure specialists repair those problems.

I asked the following analytic questions of each situation, now conceptualized as a breach, which I developed based on the recommendations of Feldman (1995): Who is experiencing a breach? What is the breach? How is the patient advocate responding to the breach? Did the rule use maintain or change local contexts? Did the rule use attempt succeed or fail? This analysis revealed six different types of breaches. At this stage, I had identified that patient advocates were using rules as tools in the repair of breaches. Patient advocates at both hospital types were using the same rule use patterns to repair these breaches. However, the breaches occurred with different frequencies at teaching and VA hospitals and with varying success. To understand the variation in the breaches, I asked the question, what is being breached?

To gain a foothold on this question, I built on my observation that in response to breaches, patient advocates appeared to be reinforcing a particular version of the position of the patient, family, or staff. I turned to Bourdieu's (1986, 1989) theories of fields, positions, and capital, in which organizations can be considered fields (Emirbayer and Johnson 2008), to understand the differences in relations between positions in the two hospital types. Specifically, Bourdieu theorized that the relationships among positions in a given field are defined by the distribution (Bourdieu 1989) and valuation (Bourdieu 1986) of forms of capital in that field. I analyzed the recurrent positions in hospitals (patients, family members, various staff members) to understand the type and value of the capital associated with each position and whether the forms of capital were shared among positions. This analysis revealed that the positions of patient, family, and staff were arrayed around a dominant form of capital. In teaching hospitals, the medical degree associated with doctors was the dominant form of capital, held in its most valued form by doctors, and typically not shared with patients and families. In contrast, in VA hospitals, it was the military service that was the dominant form of capital, exemplified by the veteran patients but shared by many of the staff and family in the field. With this analysis, it became clear that patient advocates were repairing breaches in different constellations of positions. This helped to explain the pattern of breach repair across the two hospital types, as well as the amount of effort patient advocates put into resolving breaches (e.g., resource breaches occurred primarily at VA hospitals, and patient advocates were highly motivated to repair them, given the high value they placed on honoring veterans). Based on these analyses, I developed a grounded theory of pressure specialists' maintenance of a constellation of positions. In the following section, I show how patient advocates repair breaches in the institutionalized expectations about roles held by patients, families, and staff by skillfully using organizational rules.

Encountering Breaches, Repairing with Rules

In both the teaching and VA hospitals, I found that patient advocates used rules to repair breaches—defined as violations of commonly held understandings (Feldman 1995)—in institutionalized roles. How they used rules and what they did with rules depended on the kinds of breaches of roles they encountered. Analyses disclosed three categories of breaches: interpersonal, operational, and institutional breaches. *Interpersonal breaches* occurred in interactions between two or more people. During these interactions, a taken-for-granted expectation about a role was violated. *Operational breaches* occurred when patients and their families were upset about their experiences in the hospital because of how an organizational process unfolded. These experiences violated patients and families' expectations about the role of the patient in the hospital—namely, that they would be cared for and that the members of the hospital would try to help them. *Institutional breaches* occurred when a taken-for-granted belief about the purpose of the hospital was violated. These experiences caused a violation of the patient role, specifically the extent of care patients should receive in the hospital and the lengths the staff should go to to provide that care. These beliefs were related to the

relative centrality of the patient role in the hospital, something that varied across the two hospital types. In the following section, I first describe each breach to specify what institutionalized belief was violated, and then I show how patient advocates used rules to repair these breaches. By using rules in four ways—explaining rules, coaching others about rules, documenting according to rules, and switching between sets of rules—patient advocates were able to maintain institutionalized expectations about roles.

Interpersonal Breaches

A core ethnomethodological assumption is the "reciprocity of perspectives," or that people continuously assume that their interpretations of the world are, for all practical purposes, identical to others (Schutz 1962). Interpersonal breaches occurred when one or more people suddenly realized that their expectations about their own or others' roles were not shared by the person with whom they were interacting, forcing them to question their own and others' positions in the social world of the hospital. This disrupted people's expectations to such an extent that they became upset and did not know how to continue to act. They therefore turned to patient advocates for help. Patient advocates drew on existing organizational rules, policies, and procedures to repair these breaches, restoring and clarifying the typically taken-for-granted set of role expectations. More specifically, patient advocates used a combination of three rule use patterns to repair interpersonal breaches: documenting according to rules, coaching others about rules, and explaining rules. Interpersonal breaches accounted for nearly half of teaching hospital (45.5%) and nearly one-third (31%) of VA hospital breaches.

Analyses revealed three types of interpersonal breaches. *Staff treatment* breaches occurred when patients and families felt mistreated or disrespected by staff members. *Patient threat* breaches occurred when staff members felt physically or legally threatened by patients or families. These interactions violated staff members' expectations about how a patient or family member should act—namely, that they should be compliant and willing recipients of the hospital staff's care. *Medical decision-making* breaches occurred when there were violations of patient, family, or staff expectations that they would have a say in patient care.

Staff Treatment Breaches

Patients and families came to patient advocates for help when they felt that staff members had been rude, disrespectful, or unhelpful, or were in some way harming them. In other words, the staff members were violating their expectations about the kind of interpersonal treatment they felt they deserved as patients or a patient's family members. Staff treatment breaches accounted for 13% of breaches at both teaching and VA hospitals.

Although the cause of staff treatment breaches was the same at teaching and VA hospitals—the staff's treatment of patient or family members—*what* they breached was different. At teaching hospitals, *patients and their family members were disappointed by the quality of care or personal consideration they were receiving from the medical staff. The medical staff's behavior caused them to call into question the high regard in which they held medical staff*. Patients and their families came to teaching hospitals for care by specialists and were counting on them for specialized care—care that their primary care or local doctors could not provide. When patients or their families were forced to question their medical staff's competence, it was distressing. For example, Elizabeth,[2] a patient at Heartland Teaching Hospital, learned at an appointment with her physical therapist, two months after she had last seen her doctor, that the doctor should have scheduled a follow-up appointment with her. Elizabeth thought the doctor had failed, and she was both angry with the doctor and concerned about the quality of the care she was receiving. Because the patient depended on the specialized care the doctor provided, the patient could not simply walk away from the doctor and ignore her concern and sudden distrust of the doctor. But she did not know what she could do in response; she was stuck. Not knowing what else to do, she walked into the patient advocate office and was assigned to Christina.

When patients and their families experienced staff treatment breaches in VA hospitals, they were not concerned about the quality of medical care. Instead, they felt that a medical staff person had disrespected them *personally*. That is, *a medical staff person had violated their expectations about the amount of respect that they were due as veterans.* For example, Lenora, a patient advocate at Reveille VA Hospital, reported that many patients came to her because they felt that a doctor had been disrespectful. Upon questioning, Lenora learned that they were upset that the doctor looked at the computer too much (the VA uses electronic medical records) and did not give them the eye-to-eye contact that they felt connoted respect that they deserved as veterans. In addition to feeling hurt and angry, they also did not want to continue to interact with a doctor who they felt had disrespected them. Yet they continued to need treatment from the VA, if not that specific doctor.

Repairing Staff Treatment Breaches. Patient advocates in both settings responded to staff treatment breaches by documenting according to the policies and procedures of the hospital. Documenting according to rules helped to translate the concerns of the patient or their family members into tangible, concrete problems

to which the hospital, and more specifically, some member of its staff, could respond. Patient advocates' knowledge of, access to, and use of documents unleashed resources, such as access to appointments with particular doctors, that were critical to handling patient and families' frustrations, hurt, and disappointment that resulted from interactions with staff. But the way in which they repaired the breaches maintained a particular type of relationship between patients and medical staff, which varied across the two hospital types.

In the teaching hospitals, repair meant finding ways to provide care to the patient while reinforcing the medical staff's authority. For example, in Elizabeth's case, Christina looked at the doctor's discharge note and saw that he had in fact ordered a follow-up appointment, but the clerk had failed to schedule it. Christina explained what had happened to Elizabeth, providing some sense of relief to her, and then filled out the necessary documents to schedule an appointment so Elizabeth would be seen. This both enabled Elizabeth to continue to see her doctor, by scheduling her with the needed appointment, and also gave her some assurance that the doctor was competent. As Christina told me, "She had some sense of relief that the doctor, who they had put their trust and confidence in, hadn't failed them. It was still a problem, but it wasn't the [doctor]. I've arranged an appointment and moved it up a month." As a result, Elizabeth's expectation that the doctor was competent and could be held in high regard was restored.

In VA hospitals, patient advocates also relied primarily on documenting according to rules to repair the breach of the patient's sense of respect they were due as veterans. For example, in response to patients who felt disrespected by their doctors, Lenora documented their complaints so that the associate chief of staff would know to make a decision about whether or not to reassign the patient to a different doctor. By documenting, she provided legitimacy to the patients' concerns, therefore restoring some measure of the respect they felt they were due. But she also provided these patients with access to the organizational process that could provide them with a different doctor.

In some cases, patient advocates coached others how to document, empowering them to document for themselves. At a teaching hospital, a patient came to a patient advocate in tears. The patient had come to see a doctor to get a second opinion, and thus a different diagnosis and treatment plan, for a serious illness. However, the consulting doctor had agreed with the patient's primary doctor's diagnosis, which meant that she would have a long and difficult recuperation from illness. The patient came to the patient advocate to ask if there was anything else she could do. As the patient advocate told me,

> The problem was [that] she really wanted a different answer from the doctor and the answer was, there is no different answer, and that is not what she wanted to hear. So [I tried to] be supportive of feeling sad about that, but after feeling sad, here is what the doctor recommended. I gave her some ideas about getting a copy of the exam she had here, by signing a release of information, to bring back to her primary care physician.

The patient advocate repaired the breach, enabling the patient to go on, by coaching her about what policies she needed to follow to get a copy of the doctor's opinion for her records. The patient may not have wanted to continue in this way when she walked in to the patient advocate's office, but by spending some time with the patient and coaching her about how to access documents that would smooth her return to her primary care physician, the patient advocate allowed her to, and reinforced that she would need to, move forward.

To repair staff treatment breaches, patient advocates drew on existing organizational policies and procedures to repair them. These organizational policies and procedures functioned as hospital-supplied "accounting mechanisms" for these interpersonal breaches. Patients turned to patient advocates for assistance because they themselves did not know how to respond in the face of these breaches.

Patient Threat Breaches

Staff called on patient advocates when they felt threatened or intimidated by patients or their families, because this behavior *violated their expectation of how a patient or family member should act—namely, that they should be compliant and willing recipients of the hospital staff's care*.[3] In some cases, these breaches were so extreme that even experienced staff members did not know how to respond. When this happened, staff members' fear of patients and family members got in the way of them providing care. In effect, staff members were afraid to interact with patients. Although patient threat breaches occurred at both hospitals, they were more common at teaching hospitals (17.5%, compared with 7% at VA hospitals).

The reason that these breaches were so disruptive is that hospitals depend on patients acting in predictable, compliant ways. But as Sharon, a patient advocate at a VA hospital, explained, that is not always the case:

> Well, we just assume everybody is going to behave but we have a guy right now who was being followed. He is just being the fool [using profanity, denigrating staff members]. The staff feel threatened; they are scared. They had like five staff threaten to quit in one day. Well, if you do that we are not going to be able to provide care to any of our veterans.

Repairing Patient Threat Breaches. When staff felt physically threatened or actually had been assaulted by patients, patient advocates documented the incident or coached staff on what documents needed to be filled out. By filling out the appropriate documentation, patient

advocates activated organizational processes and procedures that would help to let other staff members know that a patient might be troublesome, enabling them to be prepared to respond to breaching behavior. This had the effect of making unexpected behavior viewed as expected.

Documenting also made explicit the expectations associated with patient roles, expectations that were typically taken for granted. For example, in response to the patient who had caused five staff members to threaten to quit, Sharon planned to create a Collaborative Care Agreement, which was a document that would spell out the behaviors patients must exhibit to receive care. As Sharon explained, "I am going to give him a Collaborative Care Agreement. It will be in his progress note. . . . You are going to do this, this and this, and we are going to do this, this and this." It also meant that staff members who would come into contact with the patient would have some advanced notice about the patient's prior problematic behavior, because the Collaborative Care Agreement would be posted in his electronic medical record.

To help staff feel comfortable providing medical care under legal threat, patient advocates used the same rule use patterns—coaching and documenting—as when they faced physical threats or intimidation. For instance, one day when I was shadowing Sam, a patient advocate at Heartland Teaching Hospital, he received a phone call from a clerk who was panicking because a pediatric patient's mother had yelled at him; her daughter's medication had been changed without her knowledge. After a minute or two of listening to the clerk on the phone, Sam said, "She can't dictate how we practice medicine. Do you think she's going to call God and everyone? Does the physician know about this? Tell the doctor about it; sometimes they will make a note in the chart. You need to start a documentation trail if she calls CMS or JCAHO [Joint Commission on Accreditation of Healthcare Organizations]." Sam's coaching about how to document the incident according to specific rules helped provide the clerk greater legal protection should the patient's mother decide to lodge a complaint.

As in the repair of staff treatment breaches, patient advocates drew on existing organizational policies and procedures to repair patient threat breaches, suggesting that the hospitals expected that patients would occasionally cause such breaches. In these cases, staff members were taken aback and unsure how to respond to these problems. Because patient advocates specialized in responding to breaches, they had broader exposure and knowledge about how to reinforce the expectation that patients would be willing and compliant patients, thus enabling the staff members to go on in ways that would enable them to have interactions with patients that were more familiar and predictable.

Medical Decision-Making Breaches

Patients, family members, and staff took for granted that their wishes would be abided by or at least incorporated into any medical decisions that had to be made. But sometimes patients', their family members', or staff's *expectations that they could influence medical decision making were violated*, typically because there were conflicts about which party had the authority to make medical decisions. It could be extremely upsetting when one party realized that they did not have the authority to make decisions regarding the patient's care.

One dramatic example of this occurred at a teaching hospital, with a 75-year-old patient who had instructed his adult children that he wanted to be taken off life support under certain circumstances. However, just prior to slipping into a coma, the nurses believed that the patient indicated that he wanted to be kept alive, so they went to court to keep him on life support. His adult children were furious at this sudden turn of events. They badly wanted to follow what they perceived as their father's wishes, but they did not know what they could do in the face of a court ruling. Meanwhile, their father remained on life support.

Repairing Medical Decision-Making Breaches. Patient advocates attempted to repair medical decision-making breaches by learning about the complex policies and procedures that often surrounded decision making and then explaining the formal rules that governed these situations. For example, in a case at Reveille VA Hospital, an elderly patient was unconscious, and his son and estranged wife disagreed about whether the patient should get a tracheotomy. The doctor said the procedure might extend his life for a short period of time but would also leave him in pain. Both the patient's son and wife visited the patient advocates' office separately, each working with a different patient advocate. The patient advocates worked with the Risk Management Department to determine who had the legal right to decide whether to proceed with the tracheotomy. After clarifying that the wife was the "next of kin" and therefore had decision-making power, the patient advocates explained to the family who could legally make medical decisions on behalf of the patient. The son's patient advocate also coached him as to what he would need to do to try to get decision-making power from his stepmother. In other words, the patient advocates used explaining and coaching to legitimate the wife's decision-making power while clarifying the son's lack of power.

Because medical decision-making breaches arose out of conflicting views, one or more people were likely to be disappointed with their lack of authority to make medical decisions. It was therefore important that patient advocates explain rules in ways that would convince one or more parties to accept the expectations associated with their own and others' roles. Because different roles were prominent in each hospital type, the way

patient advocates explained rules differed in the two hospitals. More specifically, patient advocates actively reinforced the role that was most prominent. This is evident when comparing a common kind of medical decision-making breach—in which doctors did not want to provide medical care to patients—across the teaching and VA hospitals.

At the teaching hospital, Joanne was called into the Emergency Department when a patient wanted to have his catheter removed, but the doctors and nurses did not want to do the procedure. What was critical to Joanne's ability to convince the doctor to remove the catheter was that she was able to use medical criteria to frame the problem, specifically the conditions under which patients are allowed to make medical decisions: "I said to the doctor, 'He is alert and oriented, he is within his [patient's] rights to do this; just take it out.'" By explaining rules in ways that emphasized medical considerations rather than patient rights, Joanne reinforced the doctor's medical authority and was therefore able to convince the doctor to respect the patient's desire to have his catheter removed.

In contrast, at the VA hospital, the veteran role was prominent. Instead of accepting the doctor's authority as they would at teaching hospitals, patient advocates at VA hospitals were careful to honor the patient. One patient advocate told me the following story:

> We had a hospice patient. The patient is dying of cancer and we're at the point of keeping him comfortable. The patient, for whatever reason, doesn't want to be here and he's going to leave against medical advice, and the doctor says, "I don't want him leaving. He's not leaving." He wants to tell the patient that if you leave, I'm not going to give you any pain medication. [I say,] "Oh yes, you are. Just because the patient chooses not to be here, you cannot withhold that patient's treatment. The patient has rights—you have to give the patient his medication." I've had to go to the chief of staff's office regarding issues like this, but eventually he was able to leave.

VA patient advocates' advocacy on behalf of patients was fierce, and that they were sometimes required to confront doctors did not stop them.

Looking across the three types of interpersonal breaches—staff treatment, patient threat, and medical decision-making breaches—we can see that interpersonal breaches disrupted patients', their families', or staff members' expectations of their own and others' roles in the hospital, throwing their views of the social world and their places in it into question. Not knowing what else to do, they turned to patient advocates for help in figuring out how to go on. Patient advocates repaired these breaches by drawing on existing organizational policies and procedures to clarify expectations about roles and relationships between roles (e.g., the staff role relative to the patient role), expectations that were taken for granted prior to the breach. In this way, patient advocates restored and clarified a set of roles and role relations in teaching and VA hospitals, thereby maintaining institutionalized roles. They did this by using a trio of rule use patterns—explaining rules, coaching others about rules, and documenting according to rules—extending and applying a set of existing organizational rules to help to make sense of and repair breaches.

Whereas there were many similarities between the teaching and VA hospitals, there were some notable differences. First, looking at the prevalence of breaches at the two hospitals, patient threat breaches were 17.5% of observed teaching hospital breaches but just 7% of observed VA hospital breaches. This may be at least partially explained by the fact that patients and family members at teaching hospitals were often new to their roles in hospitals, because they came to teaching hospitals for highly specialized care. Facing experiences that were new, unusual, or scary may have caused them to act in ways that staff found threatening. In contrast, VA patients and families had considerable opportunities to learn how to enact the patient and family roles. A second difference between the two hospitals reflects differences in the constellation of roles in the two contexts: whereas in teaching hospitals patients experienced breaches when they felt the medical staff was not living up to their high expectations, at the VA hospitals they experienced breaches when they felt disrespected as veterans. Finally, there were major differences in *how* patient advocates explained rules to repair medical decision-making breaches. In teaching hospitals, they explained rules such that they reinforced the authority of the doctors, whereas in VA hospitals, they explained rules in ways that reinforced the predominance of the patient role.

Operational Breaches

Whereas interpersonal breaches emerged out of specific social interactions, operational breaches occurred because of how a patient or family member was treated during a process, such as a handoff between departments or the death of a patient (e.g., the process through which patients were taken off life support). Thus, operational breaches often evolved over a period of time and included multiple people who were involved (or had failed to be involved) in a specific process. Patients and family members experienced operational breaches as violations of their expectations that *the hospital was trying to help them and that by coming to the hospital they would be well cared for*. When patients and families experienced operational breaches, their worlds were disturbed abruptly because they felt that they could no longer trust that the hospital was trying to help them or that their own or their family members' well-being

would be maintained or improved by receiving treatment at the hospital. Operational breaches accounted for 37% of teaching hospital breaches and 14% of VA hospital breaches.

Patient advocates drew exclusively on explaining organizational rules to repair operational breaches. Yet the effect of patient advocates' repair work depended on the kind of breach. In novelty breaches, patients and families were thrust into situations that were new to them, triggering the experience of a breach. However, from the perspective of the patient advocate, these situations were in fact normal. To repair these breaches, patient advocates explained existing rules to patients and their families, attempting to make what patients and their families experienced as deviant an experience that was natural and/or normal (Heritage 1984). In contrast, in process breaches, patients' and family members' experiences of a breach signaled a larger, systemic problem to the patient advocates. Patient advocates agreed that patients' and family members' experiences violated the hospital's purpose of helping patients. Patient advocates explained these breaches by reinforcing the predominant role in the hospital, initiating a change that would help to maintain the hospital's taken-for-granted purpose. It is worth noting that process breaches were the only breach that resulted in enduring changes to the organization.

Novelty Breaches

Patients and their family members took for granted that *the hospital was trying to help them and that by coming to the hospital they would be well cared for.* However, patients or their family members were sometimes thrust into new, unfamiliar situations in which they suddenly questioned whether the hospital—and its staff—was caring for them effectively. Unlike in staff treatment breaches, in which there was one particular staff member who triggered the breach, novelty breaches resulted from processes that involved multiple people. Novelty breaches comprised nearly a quarter (23.5%) of all teaching hospital breaches but just 5% of VA hospital breaches.

Perhaps most profoundly, this type of breach occurred when patients died while in the care of the hospital. LaTonya echoed a familiar theme among patient advocates when she said, "Especially with patients who have something like cancer or something, you would think their family would be prepared, but they're just never prepared [for the death of their loved one]." Although not all deaths in the hospital resulted in family members coming to a patient advocate, this happened when family members were unable to account for *why* the death had occurred in the way that it had. For example, LaTonya described an incident in which the wife of a very ill patient was visiting her husband when she had an asthma attack; the patient was being treated in the Emergency Department for her asthma when her husband's health took a sudden turn:

> He coded while she was in Emergency, and of course, they didn't have time to come down and get her because she was being treated, but she heard the code and the room number over the phone, so then she ran back up to the room . . . . She just feels like something is missing. Why didn't someone come and get me when he coded?

Although it may not be obvious to the patient or family member experiencing the breach, or even necessarily to the patient advocate who hears about the breach for the first time, a defining characteristic of novelty breaches is that although the experience is anomalous and upsetting to the patient or family member, the process unfolded appropriately from the perspective of the hospital staff. This was the case with this particular story, as LaTonya explained: "Unfortunately, things moved along faster than the [family] wants, and sometimes that's just the way it goes."

But not all novelty breaches involved death and grief. Some of them involved patients being in new situations in which *they felt that the quality of their care was poor.* For example, Mr. Boland, a VA patient, was being transported from one hospital to another in an ambulance when he started having chest pains. Instead of treating him themselves, the emergency medical technicians (EMTs) drove him to the nearest hospital. After he had been released, Mr. Boland called the patient advocate because he felt that the lack of care could have endangered his life, *violating his expectation that the hospital would care for him effectively.*

Repairing Novelty Breaches. Patient advocates responded to such breaches by explaining the procedures and policies that governed the relevant area of hospital life. Sometimes, the patient advocate already knew the policies and procedures that were implicated. For example, Candace described how a patient was angry because he thought someone from the hospital had given his employer access to his personal medical information. As Candace told me,

> It took me many times of explaining that somebody from the outside can't access our medical records. And he needs to talk with his insurance company or his company if they have medical information on him. I said, "We can pull up anybody who internally has looked at a document, and some of our people inappropriately will look at a record. And it's addressed very seriously, anywhere as far as losing their job." And he couldn't understand that. He's [like], "Well, no, they don't work at your place at all." I said, "Well, then they can't get into your records." I think he appreciated that I was trying to help him, but he was frustrated that I couldn't tell him exactly who had gotten in his record or how they'd gotten into it and gotten that information.

By explaining the policies governing patients' confidential health information, Candace was informing the patient about the access associated with the patient role in the teaching hospital and helping to reinforce this particular aspect of the patient role to someone who was new to it.

However, in some instances, the patient advocate did not know why an event had unfolded the way that it had and so worked to find out. This was the case with Sherry, the patient advocate who received the call from Mr. Boland. When she first talked to him, Sherry started by offering to send him a form that would allow him to file a formal complaint with Risk Management. However, she then talked about it with her colleagues and learned that the EMTs were not trained to provide the kind of medical care Mr. Boland had needed, so they had been following the appropriate rules. At that point, Sherry called Mr. Boland back and explained that he had been cared for according to proper procedures. As a result, this novel experience, which had caused a breach in the patient's trust in the competence of the hospital, could be accounted for as part of the normal hospital processes and procedures.

Process Breaches

The same institutionalized role expectations were violated in process breaches as in novelty breaches; that is, patients and their family members took for granted that *the hospital was trying to help them and that by coming to the hospital they would be well cared for.* What differed was the patient advocates' understanding of the breach. Specifically, sometimes patients and family members did in fact experience problems in which they were harmed, treated poorly, or inconvenienced. These experiences violated their expectations that the hospital was trying to help them because they were in fact prevented from accessing care. Process breaches occurred when patients and families experienced problems or mishaps in hospital processes, such as poor handoffs between departments. Process breaches represented 13.5% of all breaches at teaching hospitals and 9% of breaches at VA hospitals.

In one example of a process breach, Sarah, a patient advocate at Heartland Teaching Hospital, recounted a case in which a transporter[4] brought a patient from one department to another and found that there was no one available to receive the patient. The transporter called his supervisor, who instructed him to leave the patient so that he could stay on schedule and pick up the next patient. As it turned out, the transporter delivered the patient to the wrong destination. The patient waited on the gurney, unable to move because of her medical condition, for 45 minutes until someone noticed and helped her. Later, the patient, who was very upset about being left alone in such a vulnerable state, met with a patient advocate because her trust that the hospital system would care for her effectively had been violated.

Repairing Process Breaches. Unlike in novelty breaches, in which the patient advocate knew or determined that the patient or family members' experience was in fact a normal hospital process, in process breaches, the patient advocate agreed that there was a problem. For patient advocates, these breaches became the proverbial "canaries in the coal mine," symptomatic of the potential for a pattern of similar breaches. Critical to patient advocates' ability to repair these breaches was explaining the problem in contrast to institutionalized expectations about roles so that the process could be changed.

For example, after hearing the patient's story about being left unattended on a gurney, Sarah explained what had happened to the dispatch manager, who did not need to be convinced that the patient role had been breached. The Dispatch Department then created more specific rules regarding how to transport patients, a form of rule specification (Blau 1963): transporters must call the main dispatch, not their supervisors, if they have any doubts about what they should do with patients. They also provided training for transporters to convey this new rule. The result of greater rule specification was that transporters' patterns of interaction shifted permanently. As this example shows, changes in rule implementation sometimes required the redesign of a process and dedication of resources.

What became important in repairing process breaches, then, was how patient advocates explained the problem in terms of existing rules to make changes to the hospital's procedures and policies. Because of the different constellation of roles, how they explained rules differed. For example, Sam, a patient advocate at Heartland Teaching Hospital, worked for several months on a problem presented by a patient—namely, that the hospital staff had been unwilling to schedule her next cardiology appointment because her insurance would only guarantee referrals for six months, although she needed an appointment in a year. What eventually enabled Sam to convince other staff to make the appointment, thereby repairing the breach, was that he wrote an email highlighting that by not making the appointment they were not following the doctor's order, as he explained:

> The clerical staff is so ingrained that this is the way we're going to do it that they weren't willing to budge until I had to send an email saying, you know, "The physician wants this patient to be seen in a year, and according to the guidelines we have set up, she's not going to be. So we need to follow the physician's orders and fix the clerical part later, but she needs an appointment." So finally, she got [the appointment]. And the doctor sent her a letter saying, "Thank you for persevering. We've changed this place."

As this suggests, what enabled the patient advocate to instigate change in a process was reminding others of the authority of the doctor in the teaching hospital. Although

the breach did enable a process to be changed, how it was repaired simultaneously reinforced the dominant position of the doctor.

At VA hospitals, patient advocates repaired process breaches by explaining rules in a different way. For example, Anna had handled a number of problems regarding patients' inability to get refills for prescription drugs on time, which caused patients to go through withdrawal. When the patient advocate brought this to the attention of the management team, she justified the need for a change in the process by describing it in terms of a breach of the patient role: the patients going into withdrawal was a "real problem" and "just awful" and was clearly not providing good care to the veterans. This explanation helped to motivate a repair of the breach within the hospital, by providing more staff for and greater monitoring of the process of medication.

Looking at both novelty and process breaches, we can see that operational breaches violated patients or their families' expectations that they would be well cared for while in the hospital. This amplified intensely the sense of vulnerability that they already felt as patients who needed medical treatment or as family members who were trusting the hospital to take care of their relatives.

Patient advocates repaired operational breaches by explaining rules. They explained rules to people who had less knowledge of the rules or who had different knowledge of or opinions about how rules could or should apply to a particular situation. Being able to explain rules provided a justification for why an event or experience had occurred in a particular way (Perrow 1986). In the case of novelty breaches, patient advocates explained rules to the patients or family members who experienced the breach, attempting to change how they viewed the breach, while also maintaining the hospital's policies and procedures and reinforcing that the hospital had appropriately cared for the patient in this specific incident. In process breaches, patient advocates explained the problems in terms of rules to people who could make organizational changes. By instigating organizational changes, patient advocates were also maintaining the taken-for-granted expectation that patients would be well cared for.

One notable difference between the two hospital contexts was within the category of novelty breaches: 23.5% of breaches at teaching hospitals were novelty breaches compared with just 5% at VA hospitals. As was the case for patient threat breaches, to understand this difference, it is important to account for the exposure of the patients and family members to the hospital system. At teaching hospitals, patients and their families were often new to the hospital. Unlike patients and families at VA hospitals, they rarely had experience in the patient or family role, nor did they have networks of patients who could help to socialize them into understanding what "normal" looked like at the hospital. Viewed in this way, we can see that the patient advocates' explaining of rules in response to novelty breaches was a way of helping patients and families understand their positions in the complex organization of the teaching hospital. Patient advocates were providing patients and their families with an infusion of capital that would enable them to act more consistently with the dispositions expected of people occupying their roles. A second difference occurred in the process breaches, in which the patient advocates were attempting to get medical or administrative staff to make changes to the organization. They explained rules in ways that reinforced the dominant roles in the hospital: the authority of doctors in the teaching hospital and the prominence of the patient in the VA hospitals.

Institutional Breaches

Whereas interpersonal breaches emerged out of specific social interactions and operational breaches arose out of organizational processes, institutional breaches occurred when a taken-for-granted belief about the purpose of the hospital was violated. My analyses revealed a single kind of institutional breach: a *resource breach*, or a violation of an expectation that patients would be able to access medical or nonmedical resources that they needed for their care and well-being in the hospital. At the VA hospitals, there was a widely shared expectation that patients should be able to access needed resources because the patients were veterans. Therefore, by repairing the breach and providing for veterans, patient advocates were helping to maintain the honor and value accorded to veterans in the VA hospitals. In contrast, at teaching hospitals, the patient and the patient advocate expected that the hospital should provide needed resources, but other staff members did not always share this expectation and were therefore unwilling to cooperate in the repair of the breach. Resource breaches occurred primarily at VA hospitals, comprising more than half (55%) of the VA breaches. Resource breaches constituted 17.5% of teaching hospital breaches but involved a number of failed attempts at breach repair. Patient advocates drew on all four rule use patterns to repair these breaches. It is noteworthy that this is the only kind of breach that entailed switching between sets of rules.

Resource Breaches

Resource breaches occurred when *patients were not able to access medical or nonmedical resources that they needed for their care and well-being.* In these breaches, patients had come to the hospital to receive medical care, but they were unable to obtain the medical and nonmedical resources they felt they required. Patient advocates' ability to repair resource breaches varied depending on the type of hospital in which they occurred.

At the VA hospitals, where the hospitals existed to provide care for veterans, *there was a widely shared, taken-for-granted belief that veterans had served the United States through their military service and that the VA should honor them by providing them with medical care.* This was exemplified in a story that Dave, a patient advocate and himself a veteran, shared with me. Dave was asked to help a veteran who had been a prisoner of war (POW) for three years in Korea. The veteran was unable to feel his feet because of damage that occurred while he was a POW, and he had had several car accidents as a result. He had tried to get some help from the VA but was getting increasingly irate (to the point of complaining to the hospital's director) because the doctors and nurses had been unable to help him get a van that he could drive with hand controls. The patient advocate explained his predicament:

> If he had lost his feet, the VA would've have taken care of it right away, but the law is written up, if you can walk, you don't need hand controls. Well, the problem is, yes, he could walk for short distances, which is to say, "Yes, he can walk," but no, he really couldn't drive. So he fell through that crack in the system.

Dave felt a sense of moral duty to respond to this breach: "This guy did three years in hell, you know, I mean, if we can't acknowledge that, and take care of his problems, then . . . then we fail a moral test as a people. I like being a part of the system that . . . that makes sure we live up to those debts." Dave's feeling that his work was part of a system of honoring veterans who had served is critical to understanding the effort patient advocates went through to repair resource breaches.

Another VA patient advocate described why problems involving access to resources were so prevalent: "Because veterans are serviced according to eligibility [for VA-provided services and resources], a lot of time there are things that they need . . . but we're not able to provide because they don't meet eligibility criteria." "Eligibility criteria" were rules that determined what conditions veterans had to meet to receive particular forms of healthcare from the VA. These rules were established through negotiations between the U.S. Congress, the VA, and veterans' groups (e.g., veteran service organizations). Yet patient advocates, as well as the other staff in the VA hospitals, felt that the rules were unjust and that too many veterans were not getting the services they deserved. In other words, the lack of resources for patients violated patient advocates' belief that the VA should honor veterans for their service.

Patient advocates in teaching hospitals also encountered resource breaches, though comparatively few of them (17.5% of all teaching hospital breaches). For example, a patient who had two back surgeries did not feel ready to go back to work when his paperwork said that he should. The doctor refused to sign the paperwork, and the patient, Mr. Jones, was so upset that he said to Melissa, the patient advocate,

> I've never been in the situation where I feel hostile enough to do some type of damage that I would have to suffer the repercussions of later on. I thought about my kids and about my wife. I was going to go up to the floor and I was going to try to talk to the doctor and if they didn't let me talk to the doctor this time, I don't know what I would have done, but I definitely probably would have been escorted out of here for some reason.

Repairing Resource Breaches. Resource breaches were unique in that patient advocates used all four rule use patterns to respond to these problems. It is noteworthy that it is the only type of breach in which patient advocates switched between sets of rules. When confronted with a patient who was unable to access a resource necessary for his or her healthcare, VA patient advocates actively solicited, collected, and learned about the rules of organizations outside of the VA so that they could switch to these organizations, if necessary. One patient advocate explained,

> We have patients that come to us and say that they aren't eligible [according the VA eligibility rules]. "I need to be seen by the dentist and this happened in the service." I think maybe we should treat them, but he or she doesn't meet the criteria but nevertheless they still need the treatment. I had that happen so much [that] I went into the community and I researched and found out through our social workers and other community agencies that treat people based on their income or may even supply free service. I got the numbers, what the cost was, their times and stuff, so when I have a veteran that comes in that needs dental care, I provide them with that referral list for the community. I don't send them away with nothing.

Repairing resource breaches required substantial effort. Patient advocates in the VA had to seek out rules that would help them maintain the belief that veterans should be honored for their service. This sometimes meant going beyond the rules provided by the VA, as in the case above, or making sustained effort over time to find new ways to interpret or recombine rules. It was just such a sustained effort over time that was required of Dave in helping the POW. He spent months trying to get the VA to pay for a van that could be driven by hand controls, sending emails and calling various regional offices to find a different set of formal policies and rules that would help to provide the POW with the van he needed and the training to learn how to use the van's hand controls.

But patient advocates could not always repair resource breaches on their own. They required the cooperation of others. VA patient advocates bent formal organizational policies, or asked other people to do so, when the VA failed to provide veterans with needed resources. Kayla described how she responded after an irate veteran called

her, furious that he had been trying to get his medication for a month, saying, "Why won't this VA help him? What kind of place is this? And I'm calling my president. That's how the conversation started [laughter]." After investigating what had happened, Kayla explained how she repaired the breach:

> What normally would happen is that it would take the pharmacy 7 to 10 days for this medication to come. Well, [because of lack of medication] this veteran's already been without sleep 7 days, so 7 to 10 days is totally unacceptable. That's not really going to help him. Yes, you did technically take care of what he initially asked you for, but anyone with half a brain could see there's more that needs to be done here. So I contacted the supervisor in the pharmacy. And normally, we don't do this, but she agreed under the circumstances. They mailed the medication out directly from our pharmacy, Federal Express, overnight.

By explaining how the rule about shipping the medication from a central location would negatively impact the patient, this patient advocate was able to convince the head of the pharmacy to make an exception to a rule to provide medical resources for the patient. Patient advocates in VA hospitals found receptive audiences in fellow staff members because they too shared the taken-for-granted belief that the veterans deserved resources as a symbol of honor for their military service.

The repair of resource breaches at teaching hospitals involved the same set of rule use patterns, yet patient advocates there were less successful in obtaining cooperation from others within the hospital. In Melissa's work with Mr. Jones, for example, she did not attempt to get the doctor to sign the paperwork that would provide him with more time off from work, and he ended up losing his job. However, Melissa knew about a local insurance provider that would provide insurance to Mr. Jones, so she switched to a different set of criteria, thereby helping him get the paperwork necessary for this free insurance.

At teaching hospitals, patient advocates' attempts to repair resources breaches often resulted in failure. These failures occurred because they were unable to convince other staff members to help them resolve a breach. For example, Kristin tried to help the mother of special-needs twins get mercury-free flu shots while they were visiting the teaching hospital for other appointments, going so far as to call the head of pharmacy to get the shots and get a doctor to write an order for the shots. However, neither Kristin nor Sam, who had joined in to try to help with this case, could convince any nurses to actually administer the shots because (they said) they did not have full medical information about the children. After meeting with the nurses in person, Kristin and Sam were left having to call the mother and explain that they were unable to help her. Although the two patient advocates had made considerable efforts to provide the mercury-free shots, the other staff's unwillingness to help reveals that this belief about providing resources for patients was not widely shared nor a dominant belief.

Institutional breaches disrupted patients', their families', and staff members' expectations about the position of the patient in the hospital. Resource breaches at VA hospitals constituted an institutional breach, throwing into question the central place of the veteran patient for the entire institution of the VA and military culture more broadly. Importantly, the expectation that the field will provide resources to the position of patient was widely shared among the people who populated the VA hospital. They had all earned the credential of military service, or were closely connected to people who had, so they had relatively similar dispositions toward these expectations. Therefore, when these breaches occurred, they were personally affected and experienced the problem as a breach (e.g., this was most clear in the case of the patient advocate who said, "… if we can't acknowledge that [the veteran did three years in hell], and take care of his problems, then … then we fail a moral test as a people. I like being a part of the system that … that makes sure we live up to those debts"). Because of the importance of veterans in the VA system, patient advocates relied on the full set of rule use patterns to try to repair the resource breach, putting in extraordinary effort to find ways to fill in resources even if they were not from within the VA itself. Switching between multiple rules provided patient advocates with discretion: when they were unable to achieve their desired resolution through one set of rules, they selected another rule set that they hoped would have a more advantageous effect. Patient advocates' fluency with rules allowed them to imagine how a problem would be viewed according to multiple rules. VA patient advocates' repair work helped to maintain the taken-for-granted belief about veterans.

In contrast, at teaching hospitals, providing resources to patients was not a widely shared taken-for-granted belief, and thus patient advocates had a more difficult time repairing them. When they were able to switch between sets of rules, to rules outside of the teaching hospital, they had some success in their repair. But when they had to rely on fellow staff members, their attempted breach repairs were eventually blocked by people more concerned about preserving the primacy of the doctor position.

Discussion

Scholars have begun to challenge the assumption that institutions are self-reproducing (Scott 2008), arguing that the work of maintaining institutions requires some degree of agency (Lawrence and Suddaby 2006). When and how the work of maintaining institutions occurs, and who is best positioned to accomplish it, requires greater specification. As the research reported here shows, institutionalized beliefs require maintenance in the face of

breaches, or violations of taken-for-granted beliefs about roles. When breaches occur, the individuals experiencing the breach do not know how to go on, threatening the continuity of action because institutionalized beliefs about roles have been violated. These breaches must be repaired, which, in this research, required patient advocates' skillful use of rules. What causes breaches and how they are repaired varies in different organizational and institutional contexts. This research, summarized in Table 3, suggests that to gain insight into the work of maintaining institutions, a valuable focus is breaches, how they are repaired, and who is engaged in the process of repairing them.

Breaches are a form of disruption to institutions. Typically, in the study of institutions and institutional work, "disruptions" are defined as deliberate attacks on institutions (Lawrence and Suddaby 2006). Patient advocates' work of repairing breaches invites scholars to view disruptions in more nuanced ways. Given recent interest in understanding institutional change, disruptions have primarily been studied as opportunities to create institutional change, or as opportunities to turn "institutional wrinkles into significant tears in the institutional fabric" (Reay et al. 2006, p. 994). But this research suggests that disruptions can also arise out of smaller-scale, less intentional disturbances of the institutional order. Rather than deliberate attacks on a specific institutional order, these disruptions emerged at least in part out of hospitals' attempts to standardize the complex human services work of caring for patients, which as Leidner (1993) and Heimer and Stevens (1997) showed, is much harder than in other kinds of work. Thus, this research suggests that these smaller-scale, everyday disruptions can be sites in which problems are smoothed out, or to elaborate the metaphor by Reay et al. (2006), where institutional wrinkles are ironed out through the institutional work of pressure specialists' skillful use of rules.

If breaches (and their repair) extend our view about the conditions under which maintaining institutions is necessary, the work of patient advocates provides greater specificity about who is best equipped to engage in the work of maintaining institutions. When patients, family, and staff experienced breaches, they reacted strongly, but they themselves were not able to repair the breaches. It was up to the patient advocates to repair them. Patient advocates benefited from their institutional and cultural embeddedness, or their knowledge of how shared understandings and meanings shape activities, structures, and processes (Dacin et al. 1999). Specifically, patient advocates' embeddedness provided them with knowledge about rules, knowledge about how to learn about rules when they ran across a novel problem, and knowledge about how to selectively and creatively apply rules to specific situations. Patient advocates skillfully tailored their interpretation of rules in their conversations with others and convinced others to act on these interpretations. As such, this research helps us see that in organizations densely packed with rules, embeddedness in an organization can provide individuals with knowledge that can help them use rules as tools (Silbey and Bittner 1982)—in this case, to repair breaches.

Investigating the work of patient advocates provides greater specification about the agency involved in maintaining institutions. Scholars have suggested that when actors face contradictions (Seo and Creed 2002) or problematic situations (Emirbayer and Mische 1998), they are more likely to exhibit agency. I extend this previous research by focusing attention on situations in which there are breaches of institutionalized beliefs about roles, sudden problems that require repair for action to continue. These breaches prompted patient advocates to carefully reconstruct institutionalized beliefs about roles or to engage in expectation maintenance (Emirbayer and Mische 1998).

The analyses suggest that patient advocates' repair of breaches required different forms and amounts of agency, depending on both the extent to which organizations provided "ready-made" accounts and the extent to which institutionalized beliefs were shared. Thus this research helps to refine how we conceptualize agency, building on calls to understand agency not as an "analytically constant" variable but one in which there is variation in the form of agency depending on the situational context (Emirbayer and Mische 1998, p. 1004; Battilana and D'Aunno 2009). First, patient advocates engaged in four rule use practices—explaining rules, coaching others about rules, documenting according to rules, and switching between rules—to repair breaches. One can see variation in the extent of agency required based on the extent to which the organization provided rules that could be used to repair the breaches or that patient advocates had to tailor a response to a specific breach. For example, in documenting according to rules, patient advocates selectively drew on hospital-provided policies and procedures to repair breaches. Because these rules already existed, they functioned as ready-made accounts (Garfinkel 1967, Zucker 1991). Documenting according to rules required the least amount of agency, in that it required patient advocates to know about and draw on rules, but not to create them (as they did in switching between rules). Nor did they have to convince other people to cooperate (as they did with explaining rules).

Explaining rules required patient advocates to explain how a rule applied to a specific situation. They used that explanation to convince someone to repair the breach, whether that meant helping a family member come to terms with how a patient had died (as in novelty breaches) or convincing a management team to allocate resources to change an organizational process (as in process breaches). When explaining rules, patient advocates tailored their accounts to reflect the

Table 3 Breaches of Institutionalized Role Expectations and Their Repair by Patient Advocates

Cause of breach	What was breached	Prevalence in each hospital type (%)		Repair of breach with rule use patterns				Effect of patient advocates' breach repair work
		Teaching	VA	Explaining	Coaching	Documenting	Switching	
Interpersonal breaches								
Staff treatment Staff members' behavior toward patients and/or families	Teaching: Patients' and/or families' expectations about the competence of the medical staff VA: Patients' and/or families' expectations that veterans deserve respect by staff	13	13	√–	√–	√		Teaching: *Restored* patients' and/or families' expectations about the competence of medical staff VA: *Restored* patients' and/or families' expectations that veterans would be respected by staff
Patient threat Patients or their families' behavior toward staff	Teaching and VA: Staff's expectations that patients should be compliant, willing recipients of hospital staff's care	17.5	7	√–	√	√		Teaching and VA: *Restored* staff's expectations that patients would be compliant, willing recipients of staff's care
Medical decision making Conflicting expectations about who could make medical decisions	Teaching and VA: Anyone's expectations that they should be able to make medical decisions	15	11	√	√	√–		Teaching and VA: *Clarified* expectations regarding who could make medical decisions
	SUBTOTAL	*45.5*	*31*					
Operational breaches								
Novelty breach Patients and/or families harmed, treated poorly, or inconvenienced in unfamiliar situation	Teaching and VA: Patients' and/or families' expectations that they would be well cared for at the hospital	23.5	5	√				Teaching and VA: *Changed patients' and/or families' expectations* of what good care entailed in a specific situation
Process breach Patients and/or their families harmed, treated poorly, or inconvenienced	Teaching and VA: Patients' and/or families' expectations that they would be well cared for at the hospital	13.5	9	√				Teaching and VA: *Changed formal organizational rules* to maintain organizational system that would provide good care for patients and/or families
	SUBTOTAL	*37*	*14*					

Table 3 (cont'd)

Cause of breach	What was breached	Prevalence in each hospital type (%)		Repair of breach with rule use patterns				Effect of patient advocates' breach repair work
		Teaching	VA	Explaining	Coaching	Documenting	Switching	
Institutional breach								
Resource breach								
Patients unable to access medical or nonmedical resources they needed for their care and well-being	Teaching: Patients' and patient advocates' expectations that hospitals should provide patients with the resources needed for their medical care	17.5	55	√–	√	√	√	Teaching: *Restored, and some* failure *to restore,* patients' and patient advocates' expectations that hospitals should provide patients with the resources needed for their medical care VA: *Restored* everyone's expectation that veterans should be honored for their service by providing them with medical care
	VA: Everyone's expectation that veterans should be honored for their service by providing them with medical care							
	SUBTOTAL	*17.5*	*55*					
	TOTAL	*100* ($n = 52$)	*100* ($n = 56$)					

Notes. A checkmark (√) indicates strong presence of a rule use pattern, a check-minus (√–) indicates inconsistent use, and a blank cell indicates no use. See the text for examples.

dominant role among the constellation of roles as a way of making their recommended repair of the breach acceptable. Similarly, coaching required patient advocates to share their knowledge of rules with others. But coaching involved not only explaining rules but also instructing patients, family members, or staff about how they could or should make use of organizational rules (Lipsky 1980). Coaching about rules involved trying to influence others' actions. Some coaching recipients were willing apprentices, whereas others rebuffed these attempts. Through coaching, patient advocates facilitated the agency of others.

Switching between sets of rules required the greatest degree of agency. To repair the resource breaches, patient advocates had to seek out and enact rules from other organizations that would enable them to maintain the institutionalized belief about the patient role as deserving of medical care. The hospitals did not provide these sets of rules, so patient advocates had to seek out rules that would enable them to secure resources for the patients.

Second, this research suggests that the ability to repair a breach depends in part on the extent to which an institutionalized belief about a role is taken for granted. This was evident through the different ways that patient advocates repaired resource breaches in teaching versus VA hospitals. Because the central importance of the patient position was widely shared in VA hospitals, patient advocates and other staff members themselves experienced a lack of resources for veteran patients as breaches: they felt a sense of moral outrage (as in the example of Dave trying to get the former POW a car he could drive with his hands), which motivated them to use all the rule use patterns to try to repair the breaches. Not only did VA patient advocates personally experience resource breaches, but they were also able to convince other staff members to cooperate in breach repair, because these other staff members took for granted the centrality of the patient position and thus were motivated to help repair resource breaches. In contrast, in teaching hospitals there was not wide agreement about the centrality of the patient position, and, as a result, although patient advocates still tried to repair resource breaches, they could not rely on other staff members to help. Indeed, sometimes when they tried to convince other staff members to help, they failed to repair breaches, resulting in frustration for the patient advocates as well as for patients and families.

One might wonder what was central to teaching hospitals, if not the patient. This research suggests that the position of the doctors and the medical care they could provide was most dominant, resulting in a constellation of roles in which the doctors' authority to provide medical care was prioritized over and above the patients' resource needs. This may provide

insight into why orchestrating change to a more patient-centered orientation is so difficult in healthcare (Kellogg 2011). Although many hospitals are attempting to make changes that will result in more patient-centered care, unless the institutionalized beliefs that influence taken-for-granted expectations about roles and relationships between roles are taken into account, they are unlikely to be successful.

This finding also confirms and builds on recent street-level bureaucrat scholarship, which has argued that there may be important organizational differences in the extent to which street-level bureaucrats have agency (Vinzant and Crothers 1998, p. 37). The research reported here suggests that it is not necessarily the organization, per se, but institutionalized beliefs about roles that influences that extent to which these workers be able to use discretion in handling cases. These institutionalized roles, and the identities and dispositions that are associated with them, provide one important source of motivation for patient advocates' persistence in working through problems and convincing others to cooperate (Maynard-Moody and Musheno 2003).

Fligstein's (2001) discussion of social skill, which he defines as the ability to motivate others to act, has been a foundational article for many contemporary discussions of individual-level agency situated in organizations and institutions. One aspect of social skill is "the ability to skillfully use rules and resources" (Fligstein 2001, p. 107). My findings suggest some specific ways in which individuals use rules to elicit cooperation from others. Rules within organizations (e.g., organizational protocols) and outside of organizations (e.g., state laws) allow action to take place because they provide a set of expectations and a form of legitimacy to act in a particular way (Feldman and Levy 1994). Patient advocates' agency lies in their ability to select and enact (Emirbayer and Mische 1998) existing rules in ways that help them to do their job of handling emergent problems. I refine these ideas by specifying four rule use patterns in which pressure specialists interact with rules: explaining rules, coaching others about rules, documenting according to rules, and switching between sets of rules. As discussed above, these four rule use patterns reflect variation in the form and degree of agency.

Understanding the work of patient advocates helps broaden our understanding of the institutional work that goes into maintaining institutions. Specifically, this research refines Lawrence and Suddaby's (2006) and Zucker's (1991) claims that one way in which maintaining institutions occurs is through roles that have authority for maintaining institutions. Whereas most examples are of "authorizing agents," or agencies and other organizations that permit certain actors to enter an institution or field (e.g., the discussion by Leblebici et al. 1991 of regulatory agencies in the radio industry), this study of patient advocates showed that *individuals* occupying less visible roles dedicated to reactive problem solving also play an important role in maintaining institutions. Specifically, pressure specialists shape how rules are used and how constellations of roles are experienced. Whereas patient advocates' repair of breaches of institutionalized beliefs about roles are one such example, researchers may find it fruitful to study the variety of roles that organizations rely on to handle recurrent disruptions.

Battilana and D'Aunno (2009, p. 41) noted that most studies of institutional work have taken place at a field or organizational level of analysis, an oversight that is important to correct to understand how individuals can affect institutions. Yet even when individuals are studied, they are typically high powered, with control over resources or some aspect of the field (e.g., institutional entrepreneurs; see DiMaggio 1988). But in this case, it is lower-power actors who are embedded in the organization, yet not closely tied to any one department, who are able to restore, clarify, and change patients', families', and staff's institutionalized beliefs about their own and others' roles.

Given the patient advocates' high level of embeddedness and low levels of power over the field, coupled with authority to cut across departmental lines, it is perhaps not surprising that the patient advocates' work resembles another study of highly embedded, low-power actors. The institutional work involved in repairing institutional breaches resembles the kind of work identified by Martí and Mair (2009) in their studies of social entrepreneurship (see also Canales 2012). They found that the activities involved in alleviating poverty included "enhancing institutions," which enabled the poor to benefit from various institutions from which they had been excluded. It involved the work done by "smaller actors to complement, broaden and enhance those institutions" (Martí and Mair 2009, p. 105) that the poor were excluded from, such as education and health organizations. In a similar manner, patient advocates used rules in a variety of ways to find means for veterans to access the resources they needed from an organization that, from these actors' perspectives, was not providing veterans with the care they deserved. Unlike institutional entrepreneurs, these actors did not challenge the rules directly, nor did they attempt to create a competing set of rules that might better serve veterans. As frontline workers, they used their embeddedness in the VA—their knowledge of how shared understanding and meanings shaped rules, resources, people, and organizations—to work around a limited and, in their minds, flawed system. As such, the research reported here joins with other research that argues that frontline workers' embeddedness can be a resource for agency (Reay et al. 2006). As Martí and Mair (2009) suggested, enhancing institutions resembles Lawrence and Suddaby's (2006) definition of "enabling work," in that it involves facilitating, supplementing, and supporting institutions. Lawrence

and Suddaby (2006) suggested that roles can be designated for this work. This research suggests that pressure specialist may be one such role.

The comparative research design sensitizes us to several factors regarding future studies of breaches and their repair. Most notably, what is considered a breach varies across contexts because the institutions shaping taken-for-granted understandings differ. Looked at as a group, the patterns of breaches at each hospital type help elucidate the institutional structures that underlie everyday life. Furthermore, the relationships among roles affected whether and how breaches were repaired. When there was widely held agreement about what constituted a breach, patient advocates and other staff were motivated to repair them and were more successful in their repair work. For example, the VA patient advocates were particularly motivated to repair resource breaches, in large part because they shared the dispositions formed through military service (e.g., the importance of honoring veterans), and they put in persistent and creative effort to ensure that resources were assembled to maintain this institutionalized role. This suggests more broadly that the extent to which roles (or other forms of social life) are institutionalized can influence how motivated people will be to repair them when breaches occur. Future research on the work of maintaining institutions should consider these aspects of the phenomenon.

In the research reported here, Bourdieu's theorizing about the distribution of capital among positions in a field helped to reveal the differential arrangements among the roles common to both settings. For researchers interested in studying roles, especially in comparative contexts, this may be a particularly useful way to understand how the relations between roles inform breaches and their repair. But this research also furthers the project of bringing Bourdieu into organizational analysis (Emirbayer and Johnson 2008) in two ways. Whereas Bourdieu theorized that it was class conditions that form peoples' taken-for-granted understandings, these findings support Vaughan's (2002) assertion that organizational settings, too, are formative in establishing taken-for-granted understandings of roles. Furthermore, my research shows that, applied to an organizational context, the role constellations informed expectations regarding the role in relation to other roles (interpersonal breaches), in relation to the organization (operational breaches), and in relation to the larger institution (institutional breaches).

Implications for Practitioners

This research has several implications for practitioners and "consumers" of healthcare. The Veterans Health Administration, as a health system in which the government operates healthcare facilities and employs healthcare professionals, is as close as we get to "socialized medicine," a sometimes pejorative political term during a time when healthcare reform is one of the most important public policy issues in the United States. Yet in recent years, journalistic accounts have shown that the Veterans' Health Administration provides more patient-centered care than many of its counterparts (Longman 2007). This research provides one explanation about why that might be the case. Specifically, I suggest that the patient role is central in the constellation of roles that comprise the VA hospitals, which helps to create an institutionalized patient-centered focus. And this resulted in patient advocates, and other staff, going to extraordinary effort to help veterans. In contrast, the patient role is not the most important role in teaching hospitals; rather, the doctors and other providers of medical care were prioritized when breaches occurred. As a result, the majority of the patient advocates' repair work involved familiarizing patients, families, and staff about how to execute the expectations accompanying their roles.

Second, some prior research has found that front-line workers who encounter organizational problems in their everyday work do not engage in activities that will change the organization. Instead, they focus on making a quick, one-time solution (Tucker et al. 2002). The kind of action that one can expect from a pressure specialist depends on the organization in which the pressure specialist is embedded. When the people who make organizational rules and policies are local, meaning that the pressure specialist can access them to discuss problems (as in the process breaches), the pressure specialist is better able to instigate organizational changes that would help to maintain the constellation of positions. In contrast, when pressure specialists are unable to directly access the creators of the rules, as evidenced by the VA's eligibility rules, pressure specialists are less likely to be involved in changing the rules and instead work around them. For those who are interested in seeing pressure specialists be able to play a greater role in institutional change, it would be beneficial to consider whether there are opportunities for the pressure specialists to have access to those who oversee policy and its implementation. This could occur by structuring opportunities for pressure specialists to attend regular hospital management meetings, a practice that did occur at some hospitals I studied, or to make pressure specialists part of committees that develop policy.

Limitations

The rule use patterns used to repair breaches across these two settings provide proof that these observations may be generalized. However, I focused on pressure specialists, who are allocated the time and resources to learn about rules and interact with a wide variety of people, and in a setting—hospitals—that is particularly rule saturated. This allowed patient advocates to act entrepreneurially in their use of rules. When organizational members confront breaches yet are not granted

the time and resources to learn about rules, their use of rules may look quite different. Organizational members may rely on the rules with which they are most familiar. Professionals, for example, may rely on rules associated with their professional training (Meyerson 1994). Alternatively, organizational members might use a different set of tools altogether to repair breaches. Future research should examine how individuals use rules, or other forms of legitimacy to which they have access, to repair breaches. This research will help develop our understanding of individual rule use beyond existing literature, which focuses on powerful actors' creation of rules (Lawrence and Suddaby 2006).

This study focused on how patient advocates viewed, experienced, and responded to breaches. It did not offer insight into the patients', families', or hospitals' perspectives, and thus we cannot be sure how these other actors view the short- or long-term success of the rule-based repair work. Future research could examine how these parties participated in and viewed the organization after experiencing an interpersonal, operational, or institutional breach. Furthermore, given the multitude of organizations, insurance providers, and caregivers that patients and families must deal with when navigating the U.S. healthcare system, it may be important to understand how patients and families acquire the skills to navigate through and access resources in healthcare systems. In the United States, citizens, policy makers, and organizational actors are looking outside of our national borders to see how other countries provide and deliver healthcare. It may be insightful to understand what kinds of breaches occur and how they are handled in other nations' healthcare systems as a way to understand the problems and benefits of a variety of delivery models.

Conclusion

Institutions are by definition enduring, but as this research reminds us, they are not taken for granted all the time, nor by everyone. By engaging the theory of ethnomethodology, it becomes possible to identify breaches as critical moments in which the taken-for-granted status of institutions is called into question. Furthermore, ethnomethodology helps to identify the methods used by individuals and, perhaps in other settings, groups and organizations, to repair those breaches. This research has revealed the skill and agency necessary for institutions to be maintained. Researchers interested in better understanding the dynamics of institutions, both the constraints they impose and the opportunities for agency and change within and around them, might attend to such consequential moments in organizational life.

Acknowledgments

The author thanks Jane Dutton, Karen Golden-Biddle, Cedric de Leon, Siobhan O'Mahony, Stine Grodal, Hille Bruns, Moira Killoran, Paul Carlile, Elana Feldman, senior editor Martha Feldman, and three anonymous reviewers for their helpful comments on this article. The author is also grateful to Lloyd Sandelands, Karen Staller, Rick Bagozzi, Julia Adams, and Bill Kahn for earlier input on the project. This paper also benefited from the constructive feedback of audiences at Boston University, Providence College, the Massachusetts Institute of Technology, the University of Southern California, and Harvard University. A previous version of this paper was presented at the 2010 Academy of Management Meeting in Montreal. This research was supported by a grant from Blue Cross Blue Shield of Michigan and the University of Michigan's Public and Nonprofit Center. The author appreciates the time and consideration extended by her informants in the patient advocate community.

Endnotes

[1]There were two exceptions. One participant declined to be recorded, and my recording device malfunctioned in another interview. When I did not record the interviews, I took extensive written notes, which I immediately transcribed after the interview.

[2]All names are pseudonyms.

[3]There were occasional situations in which patient advocates interacted with patients who were there involuntarily (e.g., patients in psychiatric wards) or patients who were incarcerated. However, these were rare, and there were different expectations governing these roles.

[4]Hospitals employ people specifically to transport patients from one department to another. Their job title is "transporter." At Heartland Teaching Hospital, transporters worked in the Dispatch Department, which coordinates the movement of patients who need assistance throughout the hospital.

References

Agha Z, Lofgren RP, VanRuiswyk JV, Layde PM (2000) Are patients at Veterans Affairs medical centers sicker? A comparative analysis of health status and medical resource use. *Arch. Intern. Medicine* 160(21):3252–3257.

Barley SR (1986) Technology as an occasion for structuring: Evidence from observations of CT scanners and the social order of radiology departments. *Admin. Sci. Quart.* 31(1):78–108.

Barley SR, Tolbert PS (1997) Institutionalization and structuration: Studying the links between institutions and actions. *Organ. Stud.* 18(1):93–117.

Battilana J (2011) The enabling role of social position in diverging from the institutional status quo: Evidence from the UK national health service. *Organ. Sci.* 22(4):817–834.

Battilana J, D'Aunno T (2009) Institutional work and the paradox of embedded agency. Lawrence T, Suddaby R, Leca B, eds. *Institutional Work: Actors and Agency in Institutional Studies of Organizations* (Cambridge University Press, Cambridge, UK), 31–58.

Bilmes L (2007) Soldiers returning from Iraq and Afghanistan: The long-term costs of providing veterans medical care and disability benefits. Working Paper Series RWP07–001, Kennedy School of Government, Cambridge, MA.

Blau PM (1963) *The Dynamics of Bureaucracy: A Study of Interpersonal Relations in Two Government Agencies* (University of Chicago Press, Chicago).

Bourdieu P (1986) The forms of capital. Richardson J, ed. *Handbook of Theory and Research for the Sociology of Education* (Greenwood, New York), 241–258.

Bourdieu P (1989) Social space and symbolic power. *Soc. Theory* 7(1):14–25.

Bourdieu P (1990) *The Logic of Practice* (Harvard University Press, Cambridge, MA).

Canales R (2012) The stranger as friend: Loan officers and positive deviance in microfinance. Golden-Biddle K, Dutton JE, eds. *Using a Positive Lens to Explore Social Change and Organizations: Building a Theoretical and Research Foundation* (Routledge, New York), 431–462.

Cicourel AV (1968) *The Social Organization of Juvenile Justice* (John Wiley & Sons, New York).

Dacin MT, Tracey MP (2010) Formal dining at Cambridge colleges: Linking ritual performance and institutional maintenance. *Acad. Management J.* 53(6):1393–1418.

Dacin MT, Ventresca MJ, Beal BD (1999) The embeddedness of organizations: Dialogue and directions. *J. Management* 25(3):317–356.

Department of Veterans Affairs (2007) Facts about the Department of Veterans Affairs. Media Relations, Office of Public Affairs, Department of Veterans Affairs, Washington, DC.

DiMaggio PJ (1988) Interest and agency in institutional theory. Zucker LG, ed. *Institutional Patterns and Organizations: Culture and Environment* (Ballinger, Cambridge, MA), 3–22.

DiMaggio PJ, Powell WW (1991) Introduction. Powell WW, DiMaggio PJ, eds. *The New Institutionalism In Organizational Analysis* (University of Chicago Press, Chicago), 1–38.

Dobbin F (2001) Why the economy reflects the polity: Early rail policy in Britain, France, and the United States. Granovetter M, Swedberg R, eds. *The Sociology of Economic Life*, 2nd ed. (Westview Press, Boulder, CO), 401–424.

Douglas JD, ed. (1971) *Understanding Everyday Life* (Routledge and Kegan Paul, London).

Eisenstadt SN (1980) Cultural orientations, institutional entrepreneurs, and social change: Comparative analysis of traditional civilizations. *Amer. J. Sociol.* 85(4):840–869.

Emirbayer M, Johnson V (2008) Bourdieu and organizational analysis. *Theory Soc.* 37(January):1–44.

Emirbayer M, Mische A (1998) What is agency? *Amer. J. Sociol.* 103(4):962–1023.

Fairhurst E (1983) Organizational rules and the accomplishment of nursing work on geriatric wards. *J. Management Stud.* 20(3):315–332.

Feldman MS (1995) *Strategies for Interpreting Qualitative Data* (Sage, Thousand Oaks, CA).

Feldman MS, Levy AJ (1994) Effects of legal context on decision making under ambiguity. Sitkin SB, Bies RJ, eds. *The Legalistic Organization* (Sage, Thousand Oaks, CA), 109–134.

Fineman S (1998) Street-level bureaucrats and the social construction of environmental control. *Organ. Stud.* 19(6):953–974.

Fligstein N (2001) Social skill and the theory of fields. *Sociol. Theory* 19(2):105–125.

Garfinkel H (1964) Studies of the routine grounds of everyday activities. *Soc. Problems* 11(3):225–250.

Garfinkel H (1967) *Studies in Ethnomethodology* (Prentice-Hall, Englewood Cliffs, NJ).

Garud R, Jain S, Kumarswamy A (2002) Institutional entrepreneurship in the sponsorship of common technological standards: The case of Sun Microsystems and Java. *Acad. Management J.* 45(1):196–214.

Gephart RP Jr (1978) Status degradation and organizational succession: An ethnomethodological approach. *Admin. Sci. Quart.* 23(4):553–581.

Glaser BG, Strauss AL (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Aldine de Gruyter, New York).

Greenwood R, Suddaby R, Hinings CR (2002) Theorizing change: The role of professional associations in the transformation of institutionalized fields. *Acad. Management J.* 45(1):58–80.

Hassard J (1990) Ethnomethodology and organizational research: An introduction. Hassard J, Pym D, eds. *The Theory and Philosophy of Organizations: Critical Issues and New Perspectives* (Routledge, London), 97–108.

Heimer CA, Stevens ML (1997) Caring for the organization: Social workers as frontline risk managers in neonatal intensive care units. *Work Occupation* 24(2):133–163.

Heritage J (1984) *Garfinkel and Ethnomethodology* (Polity Press, Cambridge, UK).

Hirsch P, Lounsbury M (1997) Ending the family quarrel: Towards a reconciliation of "old" and "new" institutionalism. *Amer. Behav. Scientist* 40(4):406–418.

Hogan NS (1980) *Humanizing Health Care: Task of the Patient Representative* (Medical Economics Company, Oradell, NJ).

Hosticka CJ (1979) We don't care about what happened, we only care about what is going to happen: Lawyer-client negotiations of reality. *Soc. Problems* 26(5):599–610.

Hughes EC (1936) The ecological aspect of institutions. *Amer. Sociol. Rev.* 1(2):180–189.

Institute of Medicine (2006) Posttraumatic stress disorder: Diagnosis and assessment. Report, Subcommittee on Posttraumatic Stress Disorder of the Committee on Gulf War and Health: Physiological, Psychologic, and Psychosocial Effects of Deployment-Related Stress, National Academies, Washington, DC.

Jepperson RL (1991) Institutions, institutional effects, and institutionalism. Powell WW, DiMaggio PJ, eds. *The New Institutionalism in Organizational Analysis* (University of Chicago Press, Chicago), 143–163.

Kahn WA (2005) *Holding Fast: The Struggle to Create Resilient Caregiving Organizations* (Brunner-Routledge, New York).

Kellogg KC (2011) *Challenging Operations: Medical Reform and Resistance in Surgery* (University of Chicago, Chicago).

Kunda G (1986) Ideology as a system of meaning. *Internat. Stud. Management Organ.* 16(1):54–79.

Lawrence TB (2004) Rituals and resistance: Membership dynamics in professional fields. *Human Relations* 57(2):115–143.

Lawrence TB, Suddaby R (2006) Institutions and institutional work. Clegg SR, Hardy C, Lawrence TB, Nord WR, eds. *Handbook of Organization Studies*, 2nd ed. (Sage, London), 215–254.

Leblebici H, Salancik GR, Copay A, King T (1991) Institutional change and the transformation of interorganizational fields: An organizational history of the U.S. radio broadcasting industry. *Admin. Sci. Quart.* 36(3):333–363.

Leidner R (1993) *Fast Food, Fast Talk: Service Work and the Routinization of Everyday Life* (University of California Press, Berkeley).

Lipsky M (1980) *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services* (Russell Sage Foundation, New York).

Lofland J, Snow D, Anderson L, Lofland LH (2006) *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis*, 4th ed. (Wadsworth, Toronto).

Longman P (2007) *Best Care Anywhere: Why VA Health Care Is Better Than Yours* (PoliPointPress, Sausalito, CA).

Mailick MD (1982) Patient representative programs: A social work perspective. *Soc. Work Health Care* 7(4):39–51.

Mailick MD, Rehr H (1981) *In the Patient's Interest: Access to Hospital Care* (Prodist, New York).

Manning PK (1977) Rules in organizational context: Narcotics law enforcement in two settings. *Sociol. Quart.* 18(1):44–61.

Martí I, Mair J (2009) Bringing change to the lives of the poor: Entrepreneurship outside traditional boundaries. Lawrence TB, Suddaby R, Leca B, eds. *Institutional Work: Actors and Agency in Institutional Studies of Organizations* (Cambridge University Press, Cambridge, UK), 92–119.

Maynard-Moody S, Musheno M (2003) *Cops, Teachers, Counselors: Stories from the Front Lines of Public Service* (University of Michigan Press, Ann Arbor).

McDonald S (2005) Studying actions in context: A qualitative shadowing method for organizational research. *Qualitative Res.* 5(4):455–473.

Meyer AD (1982) Adapting to environmental jolts. *Admin. Sci. Quart.* 27(4):515–537.

Meyerson D (1994) Interpretation of stress in institutions: The cultural production of ambiguity and burnout. *Admin. Sci. Quart.* 39:628–653.

Nielsen VL (2007) Differential treatment and communicative interactions: Why the character of social interaction is important. *Law Policy* 29(2):257–283.

Oakes LS, Townley B, Cooper DJ (1998) Business planning as pedagogy: Language and control in a changing institutional field. *Admin. Sci. Quart.* 43(2):257–292.

Orbuch TL (1997) People's accounts count: The sociology of accounts. *Annual Rev. Sociol.* 23:455–478.

Padgett DK (1998) *Qualitative Methods in Social Work Research: Challenges and Rewards* (Sage, Thousand Oaks, CA).

Perrow C (1986) *Complex Organizations: A Critical Essay*, 3rd ed. (McGraw-Hill, New York).

Pratt MG, Rockmann KW, Kaufmann JB (2006) Constructing professional identity: The role of work and identity learning cycles in the customization of identity among medical residents. *Acad. Management J.* 49(2):235–262.

Reay T, Golden-Biddle K, Germann K (2006) Legitimizing a new role: Small wins and microprocesses of change. *Acad. Management J.* 49(5):977–998.

Sartin JS (2000) Gulf War illnesses: Causes and controversies. *Mayo Clin. Proc.* 75(8):811–819.

Schutz A (1962) *Collected Papers*, Vol. 1 (Martinus Nijhoff, The Hague, The Netherlands).

Scott WR (2008) *Institutions and Organizations*, 3rd ed. (Sage, Thousand Oaks, CA).

Scott WR, Ruef M, Mendel PJ, Caronna CA (2000) *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care* (University of Chicago Press, Chicago).

Seo MG, Creed WED (2002) Institutional contradictions, praxis, and institutional change: A dialectical perspective. *Acad. Management Rev.* 27(2):222–247.

Silbey S, Bittner E (1982) The availability of law. *Law Policy Quart.* 4(4):399–434.

Skolnick JH (1994) *Justice Without Trial* (Macmillan, New York).

Spradley JP (1979) *The Ethnographic Interview* (Holt, Rinehart and Winston, New York).

Sudnow D (1965) Normal crimes: Sociological features of the penal code in a public defender office. *Soc. Problems* 12(3):255–276.

Thomas JC, Johnson V (1991) The urban public hospital as street-level bureaucracy: The employee perspective. *Public Personnel Management* 20(3):271–284.

Tucker AL, Edmondson AC, Spear S (2002) When problem solving prevents organizational learning. *J. Organ. Change Management* 15(2):122–137.

Van Maanen J (1973) Observations on the making of policeman. *Human Organ.* 32(4):407–418.

Van Maanen J, Schein E (1979) Toward of theory of organizational socialization. Cummings LL, Staw BM, eds. *Research in Organizational Behavior*, Vol. 1 (JAI Press, Greenwich, CT), 209–264.

Vaughan D (2002) Signals and interpretive work. Cerulo KA, ed. *Culture in Mind* (Routledge, New York), 28–54.

Vinzant JC, Crothers L (1998) *Street-Level Leadership: Discretion and Legitimacy in Front-line Public Service* (Georgetown University Press, Washington, DC).

Werner A, Malterud K (2003) It is hard work behaving as a credible patient: Encounters between women with chronic pain and their doctors. *Social Sci. Medicine* 57(8):1409–1419.

Wessely S (2001) Ten years on: What do we know about the Gulf War syndrome? *Clin. Medicine* 1(1):28–37.

Wooten ME, Branch EH (2012) Defining appropriate labor: Race, gender, and idealization of black women in domestic service. *Race, Gender Class* 19(3–4):292–308.

Zilber TB (2002) Institutionalization as an interplay between actions, meanings, and actors: The case of a rape crisis center in Israel. *Acad. Management J.* 45(1):234–254.

Zilber TB (2009) Institutional maintenance as narrative acts. Lawrence TB, Suddaby R, Leca B, eds. *Institutional Work: Actors and Agency in Institutional Studies of Organizations* (Cambridge University Press, Cambridge, UK), 205–235.

Zimmerman DH (1970) The practicalities of rule use. Douglas JD, ed. *Understanding Everyday Life* (Aldine Publishing Company, Chicago), 221–238.

Zucker LG (1988) Where do institutional patterns come from? Organizations as actors in social systems. Zucker LG, ed. *Institutional Patterns and Organizations* (Ballinger, Cambridge, MA), 23–52.

Zucker LG (1991) The role of institutionalization in cultural persistence. Powell WW, DiMaggio PJ, eds. *The New Institutionalism in Organizational Analysis* (University of Chicago, Chicago), 83–107.

Emily D. Heaphy is an assistant professor of organizational behavior at Boston University's School of Management. She received her Ph.D. in management and organizations from the University of Michigan. Her research interests include situated embedded agency, high-quality connections and relationships, and the role of the body in work.