

Organisational failure: rethinking whistleblowing for tomorrow's doctors

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ABSTRACT

The duty to protect patient welfare underpins undergraduate medical ethics and patient safety teaching. The current syllabus for patient safety emphasises the significance of organisational contribution to healthcare failures. However, the ongoing over-reliance on whistleblowing disproportionately emphasises individual contributions, alongside promoting a culture of blame and defensiveness amongst practitioners. Diane Vaughan's 'Normalisation of deviance' (NoD) provides a counterpoise to such individualism, describing how signals of potential danger are collectively misinterpreted and incorporated into the accepted margins of safe operation. NoD is an insidious process that often goes unnoticed, thus minimising the efficacy of whistleblowing as a defence against inevitable disaster.

In this paper, we illustrate what can be learnt by greater attention to the collective, organisational contributions to healthcare failings by applying NoD to The Morecambe Bay Investigation. By focusing on a cluster of five 'serious untoward incidents' occurring in 2008, we describe a cycle of NoD affecting Trust handling of events that allowed poor standards of care to persist for several years, before concluding with a poignant example of the limitations of whistleblowing, whereby the raising of concerns by a senior consultant failed to generate a response at Trust board level. We suggest that greater space in medical education is needed to develop a thorough understanding of the cultural and organisational processes that underpin healthcare failures, and that medical education would benefit from integrating the teaching of medical ethics and patient safety to resolve the tension between systems approaches to safety and the individualism of whistleblowing.

INTRODUCTION

The duty to protect patient welfare forms a key part of undergraduate medical education, underpinning both medical ethics and patient safety teaching. However, although guided by ‘Outcomes for Graduates’¹, UK medical schools retain significant autonomy over their curricula and the teaching of both medical ethics and patient safety can vary across medical schools in both content and quantity². This lack of uniformity across medical schools has drawn concern from various specialties and learned bodies, who have produced their own recommended curriculum in response²⁻⁹. Moreover, the lack of curricular coordination can cause problems for students where there is overlap between subject areas but the content being taught in one subject differs with that being taught in another. For example, curriculum guidance on patient safety indicates a key goal is to foster a systems approach to patient safety and avoid a culture of blame^{10 11}. Despite this clear move towards a systems approach, current literature relating to medical school ethics curricula continues to be dominated by a focus on individual action— both in recognising transgressions from good practice and the duty to speak out when this occurs¹²⁻¹⁶. This lack of coordination between patient safety and ethics teaching results in a continued focus on individual action that overshadows the social, cultural and organisational underpinnings of healthcare failures¹⁷ and fuels a perception that threats to patient safety result from the actions of a minority of incompetent practitioners. This perspective neglects the gradual drift in standards which sociological theories have shown to precede organisational failings^{18 19} and instead reinforces a culture of blame and defensiveness, in which students may view the raising of concerns as a threat to professional integrity.

To counter this heavy emphasis on the individual, some medical school curricula interventions have placed more focus on teaching a systems approach to patient safety²⁰⁻²⁴. However, many of these curricula reforms are short courses, delivered across either a single day²²⁻²⁴ or condensed period of time²⁰, with only one intervention spanning multiple years of medical training²¹. Given how deeply entrenched perceptions are about the causes of healthcare failures – tending to be thought of as the consequence of error or incompetence – and the fear of raising concerns this continues to generate^{13 25}, current curricula

interventions may not be sufficient to fully enable students to identify and appropriately respond to systemic threats to patient safety.

In this paper, we argue for better connection between medical ethics and patient safety curricula using *The Report of the Morecambe Bay Investigation*²⁶ as a case study. Case studies have been recognised as a valuable approach for demonstrating the clinical relevance of patient safety principles¹¹, as medical students have found it hard to relate to patient safety when presented as abstract academic concepts²⁷. Another key recommendation of recent patient safety curricula is to learn from other safety-critical industries²⁷. One theory which has shifted perceptions of organisational failure is Diane Vaughan's 'Normalisation of Deviance' (NoD)¹⁸. Borne from retrospective analysis of the Challenger spacecraft disaster, NoD describes how signals of potential danger are inappropriately misconstrued as representative of safe operation and thus formally incorporated into routine standards of practice. But despite widespread adoption within other safety-critical industries, applications of NoD to healthcare are relatively limited. In cases where the theory is discussed, these are often superficial, and fall back on focusing on the individual within a cultural context, forming poor case examples from which to base effective discussion and teaching of the organisation's role²⁸⁻³⁰. We apply NoD to the Morecambe Bay Investigation to demonstrate how the organisation is implicated in drifting standards, and how the organisational context affects responses to whistleblowing. By doing so we aim for a 'cross pollination' of ideas between patient safety and medical ethics curricula. We suggest that greater understanding amongst medical students about the social, cultural and organisational contributions to healthcare failures would provide a corrective to the heavy emphasis on the individual in whistleblowing discourses, soften the blame culture and pave the way for a more collective approach to raising concerns. We highlight how, even when there were whistleblowers, individual action was insufficient when pitted against cultural and organisational processes that outweighed the concerns raised. Our analysis of the Morecambe Bay Investigation sheds light on the question of why, when so much was going wrong, did managers and executives not appear to notice. This is a question that has continued salience and has been asked of more recent maternity failures such as those at Cwm Taf, Shrewsbury and Telford, East Kent and Nottingham³¹.

NORMALISATION OF DEVIANCE

NoD is a process that explains how people who work together can sustain an understanding of the situation as normal when faced with increasing evidence that something is going wrong³². Key to NoD are the organisational procedures through which signals of potential danger are rationalised as representing safe operation. It is characterised by a five-stage pattern of decision-making¹⁸:

- *Signal of potential danger*
- *Official act acknowledging escalated risk*
- *Review of the evidence*
- *Official act indicating the normalisation of deviance: accepting risk*
- *Continued operation*

Note the 'official acts'; these are formal organisational processes that acknowledge and endorse the level of risk current practice carries as acceptable, signalling that workers should continue to operate as normal despite a seemingly obvious increased risk of lapses in safety. This is important to recognise as, often when NoD is operationalised in healthcare studies, the focus tends to be on the individual within the culture, particularly how they gradually become accustomed to seeing breaches in safety standards to the point where they themselves adopt them^{29 30} or sometimes wrongly equating NoD with normalisation of wilful, routine rule-breaking²⁸. Where organisational influences and policy contexts are mentioned, they are not given the same level of attention as the individual. What falls out of view with this focus is the explicit endorsements that occur at the organisational level.

Below, we apply NoD to the *Report of the Morecambe Bay Investigation*²⁶ to describe the pattern of investigation and handling of 'Serious Untoward Incidents' (SUIs), demonstrating a cycle of incident mishandling that permitted further lapses in care. We discuss how signals of potential danger became misconstrued as they passed through the Trust, before finally highlighting a problem created by positioning whistleblowing as a primary defence against lapses in healthcare.

The Morecambe Bay Investigation examined the high rate of maternal and neonatal deaths over a period of 9 years within the small maternity unit of Furness General Hospital (FGH), one of the three hospitals comprising Morecambe Bay Hospitals Trust. We focus on the events of 2008, in which five SUIs occurred in the FGH maternity unit:

- (1) A baby was damaged due to perinatal hypoxia
- (2) A maternal death due to high blood pressure
- (3) A maternal and neonatal death due to an amniotic fluid embolism and hypoxia respectively
- (4) A stillbirth due to hypoxia during labour
- (5) A neonatal death due to sepsis, secondary to prolonged rupture of membranes and maternal illness

The prevailing view, held by clinical staff, hospital managers, and executives, was that these events were unconnected and did not signal systemic failures in care. This view was maintained by governance procedures which prevented the incidents from being considered together³³. The inquiry report of the Morecambe Bay Investigation established that systemic failings in care were in fact present and there were countless missed opportunities to identify deteriorating standards²⁶.

TRUST CULTURE PRIOR TO 2008

Vaughan identified culture, in the sense of how the policy context and production pressures intersects with institutionalised belief systems and organisational priorities, as a crucial factor underpinning NoD¹⁸. For the Morecambe Bay Trust, prior to 2008, organisational culture was shaped by three objectives dominating the board's agenda: attaining financial balance against a backdrop of a £6.36 million deficit^{26 34}, progression towards Foundation Trust status²⁶ and ensuring standards of clinical governance. Devoting resources to the latter often hampered progression of the other two goals; this was inherently expensive³⁵ and contributed little to the Foundation Trust application, which prioritised national targets such as MRSA reporting and cancer referrals²⁶. At this time, the policy imperative to pursue Foundation Trust status was strong³⁶ so that ultimately, the trust board was forced to

balance conflicting goals³⁷, necessitating economic evaluation of investments in clinical governance³⁸.

Prior to 2008, the perinatal mortality rate was lowⁱ, patient satisfaction was high and recent level 2 accreditation of maternity services by the Clinical Negligence Scheme for Trusts all suggested standards of care within the obstetric department were adequate²⁶. This stream of positive signals is likely to have contributed towards a genuine belief of safe operation within the maternity unit by staff and board members, and it forms the context in which the 2008 SUIs were investigated.

THE SUI'S OF 2008— NORMALISATION OF DEVIANCE IN ACTION

The five SUI's of 2008 resulted in death or serious harm to seven individuals. Clinical details differed on a case-by-case basis, contributing towards the failure to recognise them as a series of connected incidents. Accordingly, SUI handling differed between cases, with a mixture of internal and external investigations being used. Nevertheless, a core theme of failure to recognise signals of potential danger and normalisation of current standards of practice emerged at both departmental and trust board levels (table 1). During 2008, indications of potential danger were first generated when poor risk assessment and management resulted in hypoxia-induced damage to a baby. However, this incident failed to generate an official response which, we suggest, was a decision influenced by the prior departmental construction of risk and still low incident rate.

The subsequent three SUI's all produced similar signals of poor monitoring and management, and all were formally investigated at departmental level. These internal investigations all failed to highlight key deficiencies in multidisciplinary team-working. A coroner's report was used as an external investigation for the third SUI, which concluded the maternal death was 'unpredictable' and 'unavoidable'. Investigations were formally reviewed by the trust board, who accepted their conclusions and endorsed recommendations that subsequently failed to address key departmental issues. These acceptances of investigation findings provided several official endorsements of standards within the obstetric department, allowing key failings to go unnoticed and poor standards of

foetal monitoring, multidisciplinary teamworking and, ultimately, clinical management to persist.

An external investigation of the fifth SUI generated the clearest signal of departmental problems, prompting the chief executive to commission a further external investigation (The Flynn Report) despite conflicting organisational production pressures and a deeply entrenched construction of risk about the preference for 'normal birth'ⁱⁱ³⁹. The Flynn Report identified issues in interdisciplinary team-working, but also commended the overall maternity strategy for 2009–2012. An action plan was created by the Trust in response, which was shared with the North West Strategic Health Authority (NWSHA) and the Care Quality Commission (CQC). Despite the positive signals generated by the Flynn Report, there remained concern (by NWSHA) that although the incidents had been investigated individually, a gap in understanding remained about potential systemic factors connecting the SUIs and a further external investigation was recommended to examine all the incidents collectively. However, during the commissioning phase (of what became known as the Fielding Report), the chief executive requested these incidents were not re-examined, as it was believed they had been appropriately dealt with; instead the focus should be on governance structures needed to move forward. Accepting these terms of reference, the final report commented that the cluster of SUI's appeared 'coincidental rather than evidence of serious dysfunction'²⁶. This further normalised poor standards within the department and serves as powerful example of a factor underpinning NoD — structural secrecy.

Stage of Normalisation of Deviance	First SUI	Second SUI	Third SUI	Fourth SUI	Fifth SUI
Signal of potential danger	Poor risk assessment and management resulted in hypoxia-induced damage to a baby.	Poor monitoring resulted in maternal death due to high blood pressure.	Poor clinical decisions and monitoring resulted in maternal and neonatal death due to amniotic fluid embolism and hypoxia respectively.	Poor management and inadequate monitoring resulted in stillbirth.	Poor examination, monitoring and management resulted in neonatal death due to sepsis, secondary to prolonged rupture of membranes and maternal illness.
Official act acknowledging escalated risk	No evidence suggests this SUI was reported to the board.	Internal investigation identified flaws in record keeping, but not key failings in multidisciplinary team working.	Internal investigation missed key failings in multidisciplinary team working. A coroner's report concluding maternal death was unpredictable and unavoidable was used as an external investigation.	Internal investigation missed key failings in multidisciplinary care.	Internal investigation overly protective of staff, playing down issues of foetal monitoring. An external report was critical of care, particularly foetal monitoring.
Review of evidence	-	The board formally reviewed investigation findings.	The board formally reviewed investigation findings.	The board formally reviewed investigation findings.	The board formally reviewed investigation findings. The Chief Executive was unhappy with the disparity between investigations and reported his concerns to the local supervising midwifery officer and the NWSHA. A second external report, the Flynn Report, was commissioned.
Official act indicating normalisation of deviance: accepting risk	-	Board members were satisfied with the report. They delegated implementation of recommendations and reported the incident to the NWSHA.	Board handling followed a similar pattern to the second SUI.	Board handling followed a similar pattern to the second SUI.	The Flynn report identified issues in interdisciplinary team-working, but commended the overall maternity strategy for 2009–2012.
Continued operation	-	Key failings in care missed and poor standards persisted.	Poor standards of care persisted.	Poor standards of care persisted.	Concern remained by external governing bodies and a collective re-examination of all 2008 SUI's was recommended. The Fielding review was commissioned, but this focused on governance arrangements, not previous incidents, thus allowing a perception within the Trust that SUI's had been appropriately investigated and standards of care were acceptable.

Table 1. Handling of each serious untoward incident, highlighting the relevance of normalisation of deviance for each incident. NWSHA; North West Strategic Health Authority; SUI; serious untoward incident.

STRUCTURAL SECRECY

Vaughan defined structural secrecy as the way ‘patterns of information, organisational structure ... and regulatory relations systematically undermine the attempt to know and interpret situations in all organisations’¹⁸ (see figure 1 for an illustration of the complex internal and external governance systems existing for the Trust). The problem of structural secrecy grows with increasing organisational complexity and the phenomenon played a considerable role in the handling of SUIs at FGH. Signals were mixed; incidents differed in their outcomes, external reviews were positive about departmental performance despite identifying flaws in care, and for one of the SUIs, the coroner concluded maternal death was unpredictable and unavoidable. Signals were weak; no investigation suggested problems within the department required immediate attention, and, as the number of incidents grew, they were interpreted as coincidental rather than connected, in line with prevailing belief that there were no systemic failures of care²⁶. Structural secrecy thus consolidated Trust

members construction of risk and contributed to further structural secrecy; the decision not to re-examine SUI's in the Fielding report led to an unrecognised bifurcation in the Trust's and NWSHA's vision for the maternity unit. The former believed SUIs had been appropriately managed, while the latter still believed they required scrutiny²⁶. This discrepancy in perceived direction persisted for two years, only becoming clear when mounting scrutiny and external pressures (including a police investigation) unequivocally laid bare the problems within the department and ultimately broke the cycle of NoD.

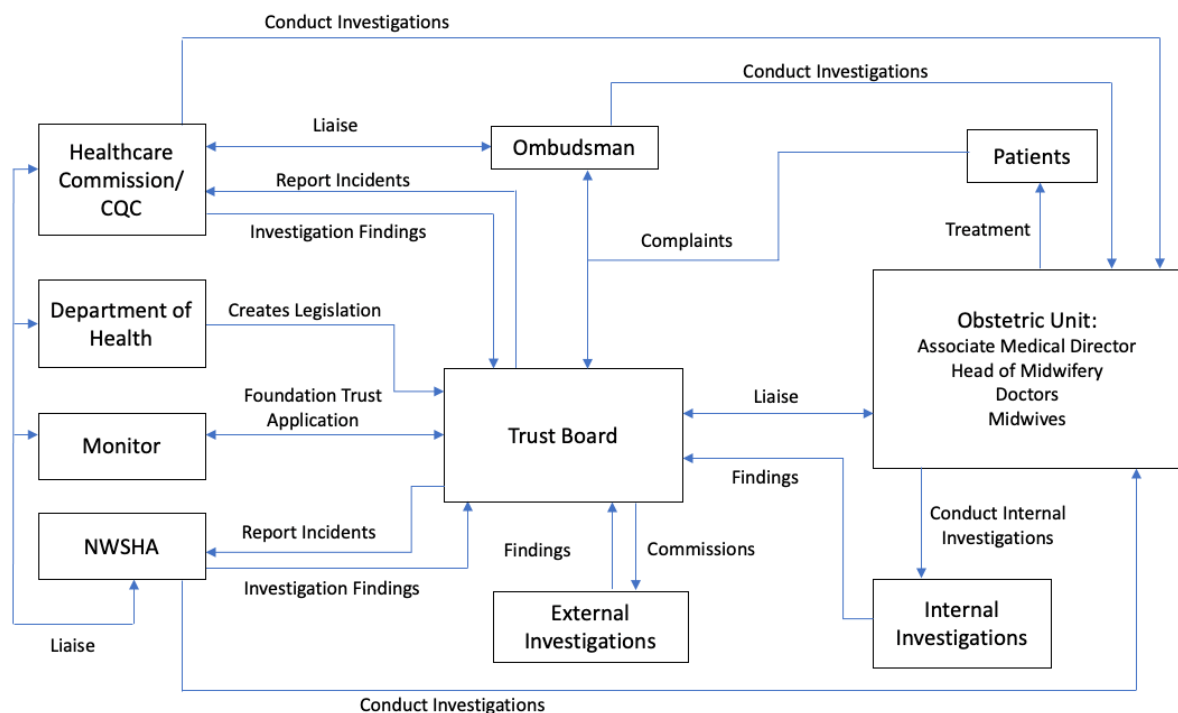


Figure 1: The complexity of control systems existing between the Trust and external bodies. CQC; Care Quality Commission, NWSHA; North West Strategic Health Authority.

WHISTLEBLOWING AND ITS ORGANISATIONAL CONTEXT

Following the fourth SUI, an obstetric consultant wrote to the chief executive and medical director, voicing concerns about standards of care. No evidence suggests these concerns were acknowledged, and the medical director reported no recollection of the letter²⁶. The exact reasons why this letter failed to generate a response remain unclear, but these concerns were raised only once, without follow-up, and went against a tide of positive

signals about departmental operation spanning several years. As Mannion and Davis identify, speaking up is only the first step in a long process of effecting organisational change⁴⁰. For managers, a whistleblowing letter is one sign amongst many other mixed or even positive signs, and this may lead to discrepancies between the envisaged and actual response. However, Mannion et al. identify the need for a more sophisticated understanding of both whistleblowing and organisational responses to it. They argue that whistleblowing has been portrayed too simplistically, as a choice to either speak up or stay quiet when the reality is a more complex process of verifying individual and collective understandings of risk, interactional ways of signalling concern, and multiple informal and formal routes of raising concerns⁴¹. Emphasis to date has been on creating an environment where staff feel safe to raise concerns^{13 25} but in many healthcare inquiries there were whistleblowers; the obstacle was not unwillingness of staff to speak out but managerial unwillingness to hear and take action⁴¹. Events at FGH were no exception. From our perspective, the obstetric consultant's letter represents a poignant example of whistleblowing's limitations and the need to understand more about the organisational context in which whistleblowing is received.

Our analysis of the Morecambe Bay Investigation shows how a single voice – even a voice with considerable expertise and standing in the field – is unlikely to be sufficient to counter a process of NoD, wherein the level of risk is understood to be acceptable and has received multiple official endorsements. The individualism of whistleblowing and its disconnectedness from social and organisational processes, gives rise to understandable frustrations with the process of speaking up¹³, unrealistic expectations of the prospect of change and, consequently in some cases, drastic measures to raise concerns^{42 43}.

CONCLUSION

Our analysis of *The Report of the Morecambe Bay Investigation* demonstrates a cycle of NoD, in which organisational processes of investigation endorsed the status quo, and the structural secrecy inherent in governance arrangements mixed positive and negative signals resulting in multiple, confusing flows of information. Ultimately, the cycle of NoD is argued to have delayed recognition of systemic issues within the maternity department of FGH,

allowing poor standards of care to persist years after the events of 2008. Pre-existing organisational pressures to both attain Foundation Trust status and repay a significant financial deficit are likely to have contributed to development of these issues, with similar themes of financial and production pressures being a feature of other high-profile failures of NHS care such as the Bristol heart⁴⁴ and Mid Staffordshire⁴⁵ scandals.

Unlike previous work²⁸⁻³⁰, our application of NoD places the organisational structures and culture at the centre of analysis, thus shifting emphasis away from the individual. Whilst cultural and organisational explanations of lapses in safety receive some recognition in medical school curricular guidance^{10 11}, understanding of these issues remains superficial beyond social science studies of healthcare quality and safety, with minimal clinical cases from which to facilitate teaching of sometimes alien concepts²⁷. We therefore argue that greater credence and space in medical education is needed for future doctors to develop a more thorough understanding of the cultural and organisational processes that underpin healthcare failures. Our analysis may therefore serve as a vehicle to deliver clinically focussed case-based teaching on NoD, improving student's abilities to effectively engage with the concept and assimilate it into their understanding of healthcare failures.

Furthermore, despite a move towards incorporating systems-based approaches to issues of patient safety¹¹, learning continues to be muted by the ongoing emphasis within healthcare on individual action – both in the causes of poor patient care and in whistleblowing as a key response^{13 25}. This continued focus on individual action thereby overshadows learning around systems approaches. Despite numerous initiatives aimed at eliminating a culture of blame within the NHS, still ideas about individual error or incompetence underlie perceptions of organisational failure. Even since the events documented here, the first author (a medical student working in FGH from 2017-2022) often witnessed persistence of a blame culture amongst both medical students and staff within the hospital. It is also unlikely FGH is an isolated exception, with both the very public case of Dr Hadiza Bawa-Garba⁴⁶ and recent parliamentary reports⁴⁷ suggesting that the message about organisational and cultural causes of failure continues to be overshadowed by a dominance of individualist thinking.

Additionally, our analysis demonstrates the limitations of current whistleblowing practices, which again is dominated by an overly individualistic framing that continues to generate fear amongst both medical students¹³ and junior doctors²⁵. To redress this continued emphasis on the individual, and enhance the cohesion between the teaching of medical ethics and patient safety, we propose that medical educators for ethics and patient safety collaborate on the topic of whistleblowing to develop a curriculum that positions whistleblowing in its cultural and organisational context. Such a curriculum might use case studies to explore and identify the individual, collective and organisational factors that have enabled whistleblowing to be successful in raising concerns, and where they have obstructed or dismissed the raising of concerns. Attention might also be addressed to improving students' understanding of how concerns are dealt with on an organisational-level, developing more collective processes for gathering intelligence and concerns about a clinical environment, and intervening in the organisational processes that dismiss those concerns. Further, as engagement with topics of patient safety is dependent upon students understanding the clinical relevance of the presented material²⁷, medical schools may wish to tailor discussion on these themes to the organisational and cultural situation their medical students operate within drawing on local, publicly available external reviews. Despite 'learning from failure' being one of the primary aims of independent reviews, investigations and inquiries, it seems they may be an underutilised resource in medical education. Such a curricular development in medical education, harmonising the ethics and patient safety teaching on whistleblowing, we hope would improve future doctors' ability to identify systemic threats to patient safety, soften the blame culture and encourage the development of more collective processes for raising concerns.

COMPETING INTERESTS

There are no competing interests for any author.

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ⁱ It is explained in *The Report of the Morecambe Bay Investigation* that as childbirth is physiologically normal in the great majority of cases, obvious markers of problems such as deaths remain rare even when quality is poor, hence, high-level figures such as the perinatal mortality rate failed to signal any problem. (P19)

ⁱⁱ For a discussion of how ‘normal birth’, as a dominant professional ideology, was implicated in events at FGH, see Goodwin, D (2018) Cultures of caring: Healthcare ‘scandals’, inquiries, and the remaking of accountabilities. *Social Studies of Science*, 48(1): 101-124.

