Response to commentaries on 'Organisational failure: rethinking whistleblowing for tomorrow's doctors'

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Word count: 789

We thank the commentators for their thoughtful engagement with our paper.[1] In different ways, they make the same substantial point: our suggested interventions are not enough to solve the problems of organisational failure. On this we wholeheartedly agree. Organisational failure in healthcare is complex and multifaceted, it cannot be solved by one intervention in medical education. We did not intend to imply that our proposals alone would solve organisational failure, and this positioning misconstrues the aims of our paper. We had more modest ambitions, we wanted to shift the analytical emphasis away from the individual and explore the implications raised by our analysis for our piece of the jigsaw – medical education.

Having stepped away from such grand claims, the commentators make some valid points to which we would like to respond more specifically. Jesudason makes the distinction that Normalisation of Deviance (NoD) is well suited to understand institutional misfeasance but not malfeasance.[2] We are inclined to agree; NoD can do some things but not all. Likewise, our case study illustrates some aspects of organisational failure but not all (we return to this point below). Jesudason suggests students might consider whether institutional corruption is inevitably human or preventable with better governance, different forms of leadership, and forms of training that defuse rather than re-instantiate hierarchies. We are grateful to Jesudason for these thoughts, they illustrate the kind of inspired thinking we think is needed, thinking that avoids exhortations to individuals to do better.

Powell questions, 'To what extent can tomorrow's doctors prevent organisational failure by speaking up?'[3] As we have said, this framing overstates our aims and rather sets us up to fail. We believe no intervention, however good, will singlehandedly solve organisational failure. But acknowledging this does not invalidate our aim to understand more about the 'organisational' of organisational failure, and explore the implications this holds for whistleblowing and medical education. Powell suggests that most whistleblowing cases involve nurses and are dealt with by NHS managers, so perhaps focusing on medical students is misguided. This may be a fair point but it is not one that arises from our case study. The whistleblower was a consultant obstetrician and he directed his letter to two doctors with managerial responsibilities. We might have been bigger in our thinking, but we felt our discussion should be grounded in our analysis.

On the issue of culture's propensity to eat medical school curricula for breakfast, Powell questions whether NHS culture needs to change first. This is something of a moot point depending on your understanding of culture. Anthropologist, Clifford Geertz, insisted that culture is not a *power* to which events or behaviours can be causally attributed; it is a *context* within which they can be intelligibly described and understood.[4] Positioning culture as context helps us think about cultural change. Contexts continuously and incrementally evolve, reflecting changes in the immediate and institutional environments, as well as in the wider social and political environment (for a more developed discussion of this point see [5]). If we accept that culture is continuously evolving, reflecting movements internal and external to the NHS, then shifts in medical education are part of this change.

Newdick's commentary helpfully describes the political and governmental landscape that lay outside our paper.[6] While we mentioned the financial context and policy imperatives to attain Foundation Trust status, Newdick lifts our gaze from the organisation, to the responsibilities governments should bear for healthcare failures. This illustrates the point above about analytical lenses; no one perspective can see everything, and how we look at problems shapes how we respond to them. There are, however, two points on which we would urge caution. First, like Powell, Newdick alludes to the likeness of inquiries. While we agree there are thematic similarities, the danger is that by homogenising different instances of organisational failure we lose the opportunity to learn more specific lessons from them. To understand malfeasance, the Ian Patterson case is more illuminating

than Bristol Royal Infirmary. Likewise, the personal toll on staff resulting from protracted understaffing and bullying comes through the Liverpool Community Health Review more vividly than the Morecambe Bay Investigation. Second, is Newdick's onus on the moral integrity of NHS managers to resist the culture of concealment and go public. This is the recourse to individualist thinking we sought to avoid. Again, close analysis of specific cases can teach us why managers might not go public; the Morecambe Bay Investigation illustrated how clinicians and managers did not see themselves as tolerating patient suffering, as Newdick suggests (for a discussion of how this perception was sustained and eventually overturned, see [7]).

In summary, to tackle organisational failure action is needed on many fronts, but that we cannot do it all should not deter us from doing some.

1 Taylor DJ, Goodwin D. Organisational failure: rethinking whistleblowing for tomorrow's doctors. *J Med Ethics* 2022;**48**:672–7. doi:10.1136/jme-2022-108328

2 Jesudason E. Manufacturing safer medics. *J Med Ethics* 2022;**48**:680–1. doi:10.1136/jme-2022-108581

3 Powell M. To what extent can tomorrow's doctors prevent organisational failure by speaking up? *J Med Ethics* 2022;**48**:682–3. doi:10.1136/jme-2022-108580

4 Geertz C. *The Interpretation of Cultures*. Basic Books Inc 1973.

5 Goodwin D. NHS Inquiries and the Problem of Culture. *Polit Q* 2019;**90**:202–9.

6 Newdick C. Root causes of organisational failure: look up, not down. *J Med Ethics* 2022;**48**:678–9. doi:10.1136/jme-2022-108579

7 Goodwin D. Describing failures of healthcare: a study in the sociology of knowledge. *Qual Res* 2021;**21**. doi:10.1177/1468794120975986