Public Sector Organizational Failure: A study of collective denial in the UK National Health Service

Abstract

This study examines how organizational failure can result from collective denial. The rise of this phenomenon is examined using testimony from a Public Inquiry into the downfall of a UK hospital, where falling organizational standards led to unethical decision making and an unacceptable number of patient deaths. In this paper we show how collective denial, over time, became a process that resided within the fabric of organizational life. To explore the organizational processes associated with collective denial, and how and why it occurs, we identify a 'narrative of silence'. This narrative allows ever more serious failings to be justified as organizational members lose contact with reality and enter a downward spiral with no recovery. The paper suggests narratives of silence, and the resulting collective proliferation and normalization of denial, is greater in organizations characterized by leader-endorsed hubristic ideologies, resource pressures and the collective desire to maintain an outwardly good impression.

Keywords: Public sector, Organizational Failure, Denial, Collective Denial, Silence, Narrative, Hubris, UK NHS

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We are all familiar with organizational scandals where, with hindsight and reflection, it seems everyone was unknowingly trapped into catastrophic cycle of failure. These organizational phenomenon are interesting because the failure remains hidden; cloaked in professional socialization to recast misconduct into acceptable explanations (Dixon-Woods et al, 2011; Gabbioneta et al, 2019; Mannion et al 2019). The perpetual downward trajectory becomes so enculturated that those involved are surprised when the scandal engages national and international scrutiny (Hutchinson, 2016). Scandals involving inadequate health and social care have often exposed 'bad apples' among a profession assumed to be virtuous, trustworthy and caring (e.g. Harold Shipman, Richard Neale, Bristol Royal Infirmary – see Dixon-Woods et al, 2011) but few have exposed 'bad orchards' (see Mannion et al 2019) with institutional liability contributing to a system which fails to identify and correct widespread performance failings (Kazarian, 2019).

In this paper we argue that public sector organizational failure may best be understood from a perspective of 'collective denial': a concept referring to a shared process of coping with organizational failings, where almost everyone turns a blind eye, where professional misconduct is justified or ignored. Literature offers explanations about how moral boundaries can shift and professionals can change their sense of self, in order to reconcile acts of wrong-doing with who they are (Harrington, 2019; Kouchaki, 2014; Vadera & Pratt, 2013). We argue that in organizations with a high social imperative, this process can reside within the organization and its performance. Failure to identify and react to early signals of wrongdoing can allow organizational failure to remain hidden, and so become difficult to remedy (Anheier,

1999; Balch and Armstrong, 2010; Weick and Sutcliffe, 2003, 2015). Collective denial helps us to understand organizational failure perpetuated by many employees simultaneously, but we know little about how behavior develops and becomes normalized at an organizational level. In understanding the dynamic processes that led to shared denial we draw on a 'narrative of silence'. Here, narratives are useful in being the pivotal process, by which collective denial is upheld and sustained. Narratives are also useful motivational framework because they can control organizational expressions of concerns and produce organizational inertia (Naslund and Pemer, 2011; Dailey & Browning 2014). Particularly, our 'narrative of silence' offers useful explanations about how organizational members unify around silence about deteriorating standards of care, preventing corrective courses of action from being enacted (Stouten et al 2019; Morrison and Milliken, 2000), and allowing the collective denial of failure to embed and become crystallized.

Our theorizing of the collective denial of failure was inspired by an empirical case study set within the UK public sector, the downfall of Mid Staffordshire National Health Service (NHS) Hospital Trust (see Francis, 2013). This failure occurred during a period of constant change within the UK NHS, where organizations sought to gain Foundation Trust status by demonstrating their independence in financial and performance monitoring. Failures in healthcare face exceptional scrutiny and local transgressions can quickly attract national (or international) attention. Scandal narratives which diminish trust in the medical profession or depict nurses as uncaring capture the public and political interest (Hutchison, 2016; Mannion et al 2019). The public inquiry into the downfall (and later dismantling) of the Trust (Francis, 2013) largely fails to explore why the apparently common toxic culture (Pope, 2017) was never corrected, but escalated until implosion.

The UK NHS has been criticized for perpetuating a dysfunctional organizational culture where persistent problems of negative and intimidating behavior towards staff have become normalized and ignored (Pope, 2017; Mannion et al 2019). It is relevant that our analysis showed that many stakeholders working at the Trust during the period covered by the Francis Inquiry (2013) felt that the culture and working conditions were no better or worse than any other hospital. At no point did anyone from inside the organization successfully blow the whistle. The final dismantling was driven by external forces, as is commonly the case with public sector organizational failure (Jas and Skelcher, 2005).

Each case of failure is unique, and whilst numerous inquiries into health and social care misconduct have been undertaken (Dixon-Woods et al 2011; Mannion et al 2019), the Francis inquiry (2013) is unusual in that it focuses on organizational-level factors (the development of a bad orchard) rather than the individual-level failings (a bad apple). To understand organizational failure a deep and contextualized examination of a case study is a helpful way to explore the complex interconnections between actors and institutional conditions. Looking back, the question is whether the failure was an isolated case, or could happen again. Building on this notion we ask the following empirical questions. Why do actors seem unable or unwilling to stop the escalation of wrong-doing and denial? Why do actors become trapped into a narrative of silence? What leadership, professional and organizational practices contribute to the emergence and maintenance of collective denial?

Our study argues that some organizations are more prone to the phenomenon of collective denial than others. We make a contribution to public sector change failure literature by exploring the processes and mechanisms that underlie continued failure. We explore how the combined impact of enculturated professional and

organizational loyalties, and the inherently resource pressured nature of the work, made speaking out so difficult (see Cannon & Edmonson 2001; Schlosser & Zolin 2012).

Organizational failure in the Public Sector

Failure can be defined as deviation from expected and desired events resulting from the actions (or lack of action) of one or more organizational agents (Cannon and Edmonson, 2001). A failure can result from a single major event or a cumulative series of incidents. It can be difficult, in the moment, to identify the severity or level of failure; to know the point when failure becomes an inevitable outcome that will lead to the collapse of the entire organization (Anheier, 1999; Cannon and Edmonson, 2001). Work on organizational crisis examines how organizations respond to unpredictable events, arguing that organizations need to develop cognitive, behavioural, emotional and relational capabilities which increase their reliability and resilience, so reducing risk and improving responses to triggering events (Williams et al, 2017). This literature argues that unexpected errors or failings are in fact knowable if an organization is mindful to detecting weak signals (Weick and Sutcliffe, 2015).

Becoming more resilient to failure may have negative consequences. For example, organizational members may develop overly positive self-conceptions and emotionally disassociate by creating positive illusions but denying acknowledgement of failure (Westphal & Bonanno, 2007; Williams et al, 2017). In this sense, resilience could lead to missing signals of failure. Reviewing literature on crisis management and resilience, Williams et al (2017) argue that this darker side of resilience is virtually unexplained and in need of further research.

In the public sector, organizational failure is often more accurately seen as sustained poor performance or poor decision making (e.g. Jas and Skelcher, 2005; Meier and Bohte, 2003) as opposed to measurement against financial parameters and profitability. There are less-well established metrics for poor performance (Walshe et al, 2004) and the high persistence of low performance is more common than outright collapse. Jas and Skelcher (2005) argue that public sector organizations experience performance cycles and fluctuations but commonly engage in self-initiated turnaround if the organization possesses sufficient leadership capability. According to their model of decline and turnaround in public organizations, Jas and Skelcher (2005) posit that if self-initiated turnaround fails, external pressure will eventually generate leadership capability. This can take the form of leadership succession or external measures being imposed on the organization from regulatory bodies. In literature on high reliability organizations, Weick and Sutcliffe (2015) argue a mindful approach that emphasizes a sensitivity to operations, resists simplification of processes, and results in breakdowns and errors being more obvious at earlier stages. However, reaching this position can take considerable time and resources (Williams et al, 2017). Public sector organizations are highly susceptible to political change, policy clashes and conflicting objectives, which create constant flux, problems of performance measurement, and resource allocation (Meier and Bohte, 2003). Failure may be triggered by changing public needs, combined with increasing demand for services and increasing diversity in function and task (Andrews et al, 2006; Meier and Bohte, 2003; Walshe et al., 2004). In a context of such change, resource pressure and complexity, achieving high reliability and sensitivity to failure, is challenging.

High profile failures in healthcare and instances of professional misconduct attract scrutiny and lead to policy changes (Gabbioneta et al, 2019; Hutchison, 2016;

Mannion et al 2019), but beyond this, we argue it is important to understand the contextual origins and dynamics of failure because they are costly in terms of the material and human resources needed to put things right. Beyond resource costs is the human cost. Public sector poor performance can have significant impact on the welfare of citizens and so failure to correct knowingly poor performing organizations could be considered morally questionable.

Leadership, professionalism and organizational denial

The idea of a toxic or hubristic leader, as a catalyst for failure is a growing theme in contemporary debates (McManus, 2018; Picone et al, 2014; Stein, 2013; Tourish, 2014) positioning organizational leaders as a significant contextual factor when considering manifestations of denial about failure (see Piconne et al 2014). The relationship between organizational leaders and strong professional groups (Strong and Robinson, 1990; Harrison et al, 1992) also presents an interesting context to study collective denial. UK physician groups may resist leadership attempts to control them, or to take on institutional responsibility, due to macro level pressures (i.e. the protection of professional bodies) and micro level control (over clinical decision making, and the use of resources) (see Harrison et al, 1992; Strong and Robinson, 1990).

The power of professional groups within our case study overlaps with many of the outcomes of groupthink (Janis, 1982). Issues such as over-confidence and unnecessary risk-taking are clearly observable, but unlike groupthink our analysis is not limited to decision-makers in small groups. We see how the organization itself becomes an island underpinned with denial, not necessarily around a consensus view,

but a shared way of behaving and interpreting the environment. Ours is not primarily a story of group cohesion, but of collective agency. A combination of this agency and collective silence binds leaders and followers in such a way that everyone becomes complicit. Over an expanded time-span the fates of the organizational leadership and professionals become intertwined (Dunn and Eble, 2015; Vadera and Pratt, 2013).

Healthcare organizational failures such as the case of the Bristol Royal Infirmary scandal of 1998, where 35 children died due to the clinical incompetence of two cardiac surgeons (Mannion et al 2019, Weick & Sutcliffe 2003) highlight how strong individual leadership combined with structural hierarchies promoted an insular ‘club culture’, leading to the coercion of silence (Manion et al 2019). Whilst there is debate about how much choice is constrained in such situations where few regulated behaviors were permissible (Ashforth and Anand, 2003; Mannion et al 2019; Weick & Sutcliffe 2003); the implication that organizational actors just blindly adhere to keeping another’s secrets remains somewhat unconvincing (c.f. Gemmill and Oakley, 1992). More pluralistic approaches to leadership (De Rue and Ashford, 2010; Tourish, 2014; Uhl-bien and Opsina, 2012) give members or ‘followers’ agency and purpose, allowing the leadership to be co-constructed through collective relational processes, with members actively deciding whether to be influenced or not (see De Rue and Ashford, 2010; Tourish, 2014; Uhl-bien and Opsina, 2012). Here, a leader’s influence is positioned as a construct of collective agency; a willingness to defer and grant another power, rather than a response to oppression or helplessness (c.f. Gemmill and Oakley, 1992; Tourish, 2014).

Public sector professions are viewed as upholding moral and ethical values derived from acting in the interest of the public and gatekeepers in the face of bureaucratic pressures (Currie et al, 2019; Gabbioneta et al, 2019; Kouchaki 2014).

From this standpoint, professional misconduct is bound in poor performance in the public sector. When an organization's actions infringe the moral conduct of professionalism, individuals may feel pressured to deviate from the normative standards and ethics of their profession (Muzio et al, 2016).

Recent streams of literature have viewed silence about misconduct as a process, often supported by the same organizational systems and structures that have been put in place for the task of right-doing (see Palmer 2013). People engage in, and are susceptible to, wrong-doing because the boundaries between right and wrong can be narrow and confusing, can subtly shift, and are often influenced by social relationships that require the cooperation of others (see Palmer 2013; Muzio et al 2016). Understanding misconduct as a socially constructed phenomenon is useful to capture changes in relation to how individual professionals perform their work; changes in institutional arrangements; and professional boundaries (Palmer and Maher 2006). These changes can cloud professional judgement, create blind-spots, and lead to collective myopia regarding misconduct (Muzio et al., 2016). Behaviours can become embedded (through normalisation and socialisation) in professional and cultural norms, and in doing so sustain corrupt behaviour; allowing employees to retain a wrong course of action through legitimising processes (see Ashforth & Anand 2003; Balch & Armstrong 2010). Currie et al (2019) propose that further research is needed to explore sociological aspects of professional misconduct, for example how power differentials between professional groups prevent lower status individuals from speaking up. In this paper, we argue that if the leader's response to failure allows misconduct to be silenced and denial to be normalized then the organization will, over time, lose its ability to self-correct.

Literature examining healthcare scandals has tended to highlight individual perpetrators, or 'bad apples' (e.g. Harold Shipman, a general practitioner who murdered 236 patients; Clifford Ayling, who assaulted 12 women; or Richard Van Velzen, who removed children's organs without consent – see Dixon-Woods et al (2011) for an overview. Dixon-Woods et al (2011) argues that scandals of professional misconduct have reduced public trust, with a need for enhancement via new regulation and formal processes. Hutchison (2016) highlights the role that scandals have played in shaping health service reform over the last 75 years, and warns that the social construction of scandals by media and public inquiries become a political tool to apportion blame. Our case study is not about a few groups of 'bad apples', or even 'bad cellars' but relates to whole 'bad orchard' (Mannion et al 2019). In considering collective denial as a response to organizational failure over time, we need to consider organizational culture. Very few studies have investigated the organizational influences on professional misconduct, the only notable exception being Weick and Sutcliffe's (2003) account of wrongdoing at Bristol Royal Infirmary. Like other inquiries, this account focused primarily on the role of two surgeons but they also explained how groups of clinicians slowly became trapped into a cycle of wrongdoing from which they could not disengage. They argue that the impact of intimidating leadership is exacerbated by a process of sharing legitimating behaviors (Shephard et al, 2011; Weick and Sutcliffe, 2003), however, issues around silence and denial remain relatively unexplored. The failure to examine organizational dysfunction and address the prevalence of bullying and incivility (e.g. Carter et al, 2013) has led Pope (2017:577) to claim that the NHS is 'institutionally deaf', with widespread learned helplessness, which prevents staff from speaking out. We

examine the collective denial of wrongdoing, considering this 'deafness' by examining the development and maintenance of narratives of silence.

A narrative of silence

In this paper we refer to 'narratives of silence' rather than a culture or climate of silence (see Morrison & Milliken 2000; Knoll et al 2016). The choice of the term narrative reflects our view that, unlike culture or climate, only certain aspects of the work environment are silenced. Silence is not all-encompassing. Many different types of narrative threads or organizational stories may co-exist, each of which influences silence, voices and subsequent behaviors in a specific way, by instilling meaning and sensemaking (Naslund & Pemer 2012; McDonald et al 2006). The multiplicity of narratives within any given situation or organization allow for different accounts to emerge (McDonald et al 2006). Narratives can lead to a range of stories and serve as a tool for achieving control. One repetitive and dominant message can override all others, serving to mirror the 'truth' of those in powerful positions (Dailey & Browning 2014).

So, over time certain organizational narratives emerge and become dominant, providing a guide about how to think and behave (Dailey and Browning 2014; Naslund and Pemer, 2011). As such narratives span out across organizational contexts, they reframe established patterns, providing a new path for members to follow (Brown et al, 2012). Managers often aid this process by repeating and reinforcing the narrative, as a means of controlling behavior and to build confidence (Dunn and Eble, 2015; Bies 2009). For example, in our case study staff could, and did, safely give voice to issues of good management and successes – it was the voicing of concerns around poor care that were flattened.

A common message is that any dissent that threatens the publicly shared organizational image is not allowed (see Dailey and Browning 2014). Under such conditions, alternative messages and courses of action are inhibited. The organization can only operate in a direction congruent with the dominant message (Geiger and Antonacopoulou, 2009; Naslund and Pemer, 2011). In this way, organizational narratives of silence may be functional and purposeful, in being strategically used to enhance the organization's interests by allowing time for self-reflection and improvements free from critical gaze (Bies 2009; Van Dyne et al 2003). Yet at some point this strategic function may be overridden by more dangerous motives. Employees may use silence to signal their willingness to support organizational strategies and actions, but their reasons for creating a façade of silence are complex; and relate to a myriad of motives and consequences (Schlosser & Zolin 2012).

Dunn and Eble (2015) argue that corporate discourses from a position of power can unfairly marginalize or silence alternative narratives of experience. Silence, from this theoretical standpoint can be found in organizations' narrative practices as a contributing factor to sustained failure (see Naslund and Pemer, 2011) which we explore in the data below.

From a micro organizational lens, work on motives for silence and voice (Van Dyne et al 2003), and whistleblowing literature, provide understanding about the conditions that make it difficult for individuals to speak out. Attempts to personally voice concerns are likely to be punished (with termination, a loss of status or working conditions), especially if they are perceived by top management as threatening or challenging to the organization's authority (see Miceli et al, 2008). The ability to speak against mistakes is additionally constrained by the risk of being ousted or isolated in terms of being seen as an untrustworthy 'backstabber' or 'squealer'

(Mesmer-Magnus and Viswesvaran, 2005). What is less well articulated is the connection between these positions; how macro level organizational narratives around remaining silent intersect with individual risks of retribution and isolation (Schlosser & Zolin 2012; Knoll et al 2016).

Our case of collective denial of failure helps explain this connection, how individual behaviors and collective processes intersect, spread and solidify, becoming embedded across different organizational practices and contexts. This emergent state forms a collective narrative that acts as a reference point for regulating behavior (Ashforth and Anand, 2003), with an uncontestable spiral of silence developing where no-one speaks out about poor care.

Methods

Our case study

> *The patient was expecting a short stay…she was re-admitted to Stafford Hospital where she received very poor care. No one communicated with her or the family and she was left on a bedpan for hours without a bowl of water to wash her hands. The family often found traces of faeces under her fingernails and on her hands and she was not given a bath or shower whilst at the hospital. The patient died shortly afterwards.*
> Source: Independent case notes review, Francis (2010: vol 2. p.13).

In the UK, the NHS is a large public-service institution charged with providing healthcare. Our study analyzes a single exemplar case of Mid-Staffordshire Hospital Trust, a high-profile example of organizational failure. Scandals in the NHS are not new (Dixon-woods et al 2011), nor are public inquiries (Mannion et al 2019). Our chosen case study is exceptional in not being about the lack of governance around a small groups of clinicians (Cannon & Edmonson 2001) or individual 'bad apple' staff (Dixon-woods et al 2011), but instead encompasses the endemic tolerance of poor care across an entire organization (not a bad apple but a bad orchard

(Mannion et al 2019)). Investigations into the Trust revealed widespread appalling patient care that effected thousands of patients over a prolonged period (Francis, 2010). Patients needing pain relief were ignored, others were left unwashed for up to a month, food and drink were left out of reach, patient calls for help to use the toilet were ignored, with the result that they were left shamed, afraid and soiled (Francis, 2010). This lack of care continued for several years, despite the presence of external quality measures (Coombes, 2013). Since this failure was exposed, many wider debates around patient safety, (e.g. Jarman, 2013) organizational culture (e.g. Davies & Mannion, 2013; Tingle, 2015) and health leadership (Armit & Oldham, 2015; Bruce, 2013) have been triggered. With failure being so exceptional in this case, it was important to examine it holistically, with a keen interest on the specific circumstances of this organization, at that moment in time, within a wider system. Unlike other studies (e.g. Dixon-woods et al, 2011; Hutchison, 2016) which have compared multiple instances of wrongdoing by individuals, we focus on one single organizational case study where we can examine multiple actor's behaviour within the same context. Here we aim to balance the broad contextual issues from the specific context of the case, extracting some general lessons to understand the phenomenon of collective denial.

We began by sourcing data directly from testimony presented in the 2013 Public Inquiry (Francis, 2013). The inquiry took oral evidence from 164 witnesses over 139 days between November 2010 and December 2011, and received 87 witness statements and 39 provisional statements. The inquiry focuses on organizational level issues to explain how events occurred and provides 1,783 pages of testimony.

Following this, we systematically searched for accompanying and supporting documents that would also provide context and supplement our analysis. There was a

report by the Healthcare Commission (HCC) in 2009 (HCC, 2009) into events at the Stafford hospital between 2005 and 2009, which showed a catalogue of failings and a higher than expected number of deaths. Robert Francis QC launched his first initial inquiry in 2010 (Francis, 2010). Both of these reports, and other commentary from various professional and regulatory bodies from this time, provide context, and some illustrative quotations where helpful.

Despite the depth of these accounts it is recognised that no single case, however detailed, is without limitations. We did not have direct access to respondents; even the inquiry staff gathering data were one step removed. We use data from witnesses commenting on past events, and retrospectively analysing their own actions, who may seek to justify their own positions, and lessen their involvement. We acknowledge this as a significant limitation.

As Brown (2000) and Mannion et al (2019) both point out, public inquiries are not neutral representations of truth, but political devices used to give the illusion of control by offering acceptable allocations of responsibility and blame. Robert Francis QC who led the inquiry, offers 290 proposals (see Coombes, 2013) many of which depict an agenda different to ours. In using the Inquiry we accept some voices will be more privileged than others (see Brown, 2000), and acknowledge the conclusions presented are biased by the choices made. Throughout the research process we reviewed reports from other similar cases (including Bristol Royal Infirmary Heart Scandal (2001); and The Case of Baby ‘P’ (2008)) in order to check the feasibility of our interpretation. We believe that these limitations reflect a worthwhile trade-off against the detail offered, allowing us to access the experiences and decision-making of those who engaged in controversial actions, which they would be unlikely to willingly discuss via any other means.

Analysis

The data analysis was conducted with distinct first-order and second-order phases (see Gioia et al, 2012). The first phase involved gaining a familiarity and understanding of the inquiry and the context. Following an initial review of the literature, we conducted an in-depth reading of the 2010 and 2013 Francis Inquiries, and wrote 364 memos of various processes and structures (organizational, interpersonal and intrapersonal). Memos were informally written observations about the witness testimonies, offering initial reflections on potential relationships and between emotional and attitudinal responses exhibited in the informant's recollection of events.

The next stage involved an interactive use of reflective notes (summaries of our memos and thoughts of what occurred) written down by three researchers and discussed in a series of group meetings. For example, we discussed how major actors interacted with each other and what this revealed about their agency. We then collated earlier memos and reflective notes by exploring individual interpretations and dynamic, intertwined movements through an analysis of key themes (see Gioia et al, 2012).

Additionally, character profiles of 16 focal actors were developed, to contextualize the actions of key individuals, and understand the interconnected relationship between individual and collective actions. These included the Chief Executive and external institutions such as the Strategic Health Authority. We developed an event timeline (see Figure 1) with internal and external events and key policy changes and markers of failure which the organization was reacting to (also see Francis, 2013 p.49 for a timeline of key warning events).

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INSERT FIGURE 1 ABOUT HERE
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We see a number of events where failure was apparent, but which failed to motivate external stakeholders into corrective action. The lack of reaction to these events appears to reinforce the denial of any problems. These activities allowed us to develop a picture of what happened at the hospital over time, providing context against which we could analyze how poor care escalated and was normalized.

Up to now the analytic work had been largely a-theoretical and inductive. As we entered the second order phase, we purposefully identified codes relating to explanations of, and justifications for, instances of events and actions, to which broader categories were assigned. We wanted to understand the reactions to the various failure events highlighted in the timeline and gain theoretical insight into why actors seemed unable or unwilling to prevent the escalation of poor care, and what leadership and organizational practices contributed. Drawing on literature and theory that explains how wider theoretical categories were formed (Gioia et al, 2012), see table 2 below for the final coding outcome, and figure 2 for our final theoretical model, developed after further consideration of the results below.

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A case of collective denial of failure

For ease of reading we present our findings in three phases. These phases are not neatly bounded by our timeline of external events, but represent how multiple organizational processes dynamically unfolded over time. The first phase outlines the contextual conditions that allowed collective denial of failure to arise. The second phase, we call the 'emperor's new clothes.' This shows the constitution, confluence and maintenance of narratives of silence; around poor care and the need to remain

silent about slipping professional standards and misconduct. The final phase covers the later stages of the organizations' implosion.

The rise

In considering contextual factors that precluded and triggered events, three strong themes emerge: 1) political expectations expressed in performance targets, in particular the rhetoric around achieving Foundation Trust (FT) status created an imperative need for growth and change. FT status means that a hospital trust has satisfied a range of rigorous, financial criteria which allowed for self-governing, with less interference from Government; 2) a strengthening of professional and organizational identities; and 3) an untested but trusted leadership team.

The first theme, the need for Foundation status, has been widely discussed as a significant factor, with the Inquiry and other analysis supporting this (see Davies and Mannion, 2013; McGauran, 2002). In isolation the prioritization of this health policy is not especially useful; many other UK hospitals at that time were exposed to the same policy and financial pressures. At Mid Staffordshire the desire to achieve Foundation status, combined with previous concerns about the organization's performance and management, paved the way for an injection of new (but inexperienced) leadership, and a drive for transformation. No-one external to the organization was tasked with taking responsibility to ensure that the CEO and his team were capable of doing the job. It was assumed externally that the leadership could deliver policy priorities whilst maintaining quality and constraining costs.

> *I think we trusted that if there was a reasonable action plan, if they say – so long as we checked that they had understood, that then we trusted that they would do it.* p.77 (Peer Review Director of the Strategic Health Authority)

The inquiry criticizes the hiring of an inexperienced executive team which posed a significant risk:

> *Each executive was holding office for the first time – this was almost an entirely inexperienced team. Responsibility for the fact that many of them were too inexperienced must lie with Martin Yeates (the CEO) as he had recruited most of them* (Managing Director of the governing organization responsible for the hospital at this time p.149)

Despite the leader and his team lacking experience, the CEO appears to have had an intimidating approach. Whether this brash confidence was part of the CEO's deeper identity or language he adopted to give the impression of confidence is hard to determine, but excessive self-confidence was exhibited. Throughout the inquiry we get a picture of an arrogant leader who uses his forceful personality to silence critics, but also one who used his persuasiveness to draw in those around him:

> *…strong, forceful character'* but could also give the appearance of "*being open and willing to listen, and very ready to give assurances that concerns would be addressed. He was clearly a persuasive individual who convinced experienced and senior health service officials of his ability.* p.149

It is the strengthening of relationships between a cast of supporting characters that we argue is important for the development of denial throughout the organization; including the Board Chair and the Finance Director, but, more notably, the Director of Nursing and Medical Director who represent leadership within the medical and nursing professions. The unification of these professional and organizational leaders is symbolic of the shifting positions which we observe later:

> *She had her view and her view was often the only view that could be seen as being correct… I know that other people that did try and challenge her were quite often sort of berated down and dismissed very quickly* (Deputy Director of Nursing, describing the Director of Nursing; p160)

> *The thrust of the response from the senior management team, <u>including the Medical Director at the time</u>…, was that things would be better once [the organization] achieved Foundation Trust status. Nobody from senior management seemed bothered about what was happening on the floors at the time. Everyone was concerned about becoming a Foundation Trust.* (Consultant Physician p.201)

Together they appeared to overestimate their own capabilities and disregard the views of others. This personal capacity to ignore or downplay the seriousness of events suggests denial is used as an effective defense against personal culpability and any tarnishing of self-image which might result. They created a strong group identity which brought them together in pursuit of the same goals. Although two of these senior leaders subsequently left the organization, later appointed members of the senior management team appeared to quickly conform to the norms of this leadership group. One of these new managers

> *…described an "endemic culture" of bullying at the Trust…. She felt that all the executive team where in "a downward spiral of bullying and the inexperienced [CEO, COO and Director of Nursing] was creating a situation of a complete lack of leadership.* (Senior Manager appointed 2007; p160)

The new Director of Nursing justified her lack of action against professional misconduct by citing procedural obstacles that prevented her from speaking out. A new Medical Director significantly normalized conditions – believing that they were standard across other hospitals, citing inexperience and being overwhelmed as justifications for not acting. Regardless, we see how their normalization played a key role in preventing any corrective action.

In summary, the data illustrates how hegemonic power and unity between multiple actors at a senior level, including professional role models and leaders, was used to launder problems away, with this leader-endorsed narrative proliferated throughout, and largely unhindered by external control or resistance from professional groups.

The emperor's new clothes – escalating two narratives of silence

In considering how denial of failure can become normalized at a systemic, collective, level two key processes emerged; 1) the normalization of poor practice embedded throughout the organization, and 2) the silencing of dissenters led staff to become actively complicit in the need to maintain an outward facing good impression.

What we saw at Mid Staffordshire is how poor care standards were rationalized as 'normal'.

> *This happens everywhere and we were just the unlucky ones who got caught… "We're just like any other trust"…* (Executive Director of the Board p.182)

Throughout the inquiry the inadequacy of external regulators in addressing the failure is constantly exposed; characterized by an accommodating stance resulting in a poor ability to control, monitor and govern. External bodies charged with monitoring performance were far removed from front-line care and trusted in governance procedures and the reassurances the organization gave. For example, in 2004, the Healthcare Commission revised the star rating of the hospital from three to zero, following a failure to meet elective surgery targets. A 'Stars Recovery Plan' was produced by the organization in response, but this plan was never followed up or implemented. In 2006 and 2007 the Healthcare Commission declared the organization was 'doing OK', despite poor mortality rates and no physical inspection being carried out. In February 2008 the organization was awarded FT status, further providing external validation and support for the organizations' actions. This unquestioning attitude is constantly apparent in testimony from external bodies, and exacerbated by the hands-off attitude of the board. Concern for preserving and managing the external image of the organization, and the external support given, helped to normalize the poor standards which were developing, and further reinforce that nothing was wrong.

In parallel to this normalization process, we see the leadership shifting blame or concealing problems in reaction to any criticism. Within the 2010 Francis Inquiry there is evidence that the organization dismissed high mortality figures as coding errors, despite clear signals otherwise. As noted above, new senior management team members were quickly discouraged from 'rocking the boat'. Collective silence about the facts combined with the leadership team's self-confident attitude made the narrative about declining care standards easy to downplay. By preventing discussion about issues of poor care, this narrative became silenced.

Within the organization, professionals were under pressure to protect themselves by laundering or concealing problems:

> *There was the pressure to massage the figures because if you as the nurse in charge in that particular shift had had an excessive amount of breaches, you were then held responsible and had to explain it. And I understand that a lot of pressure was placed upon sisters in charge, particularly, and they felt responsible and sort of were made accountable, which was why they wanted to avoid that happening by obviously lying.* (Nurse in Accident & Emergency p.108)

We observed a shift towards the fulfilment of organization goals and away from professional codes of conduct. Here the maintenance of a narrative to remain silent about slipping professional standards and misconduct became apparent. This changed the meaning of being a 'good professional' by degrading the importance of professional standards and ignoring the seriousness of what is happening in terms of quality of care.

> *I think nobody likes to feel that they're not doing a good job. So that was one thing. The second thing is that we had our data analysed…one of the other data manipulators in the field, who suggested to us that we did not have a mortality problem. And I think that gave us inappropriate and false reassurance … So I fully accept that we should have been looking at quality of care, but I think we were misled….and, I think, the unwillingness to think that we were doing a bad job.* (Clinical Governance Lead for the Trust p.179)

The acts of professional wrongdoing (e.g. nurses not checking on patients regularly, ignoring call bells, failing to provide enough pain medication, health and safety breaches) (see Francis, 2010) required individual agency. No single instance in itself represents the catastrophic failure of care that was eventually uncovered at Mid Staffordshire; this comes from the collective and persistent nature of these actions. Normally, one might expect that individual instances of this nature would be dealt with through disciplinary procedures. In this case, top-down processes of denial were cascaded downwards, with individual instances of wrong-doing overlooked which (a) contributed to the normalization of these standards and (b) knowing that these actions were commonplace made it harder to meter out punishment e.g. ‘we all make mistakes from time to time’.

A common sense of co-complicity was enacted every time a staff member saw a breach but said and did nothing. Here silence is compliance, the decision to remain silent and not to offer critical feedback is a manifestation of agency; most likely based on a justified calculation of self-interest, and constrained choice.

> *Not a culture of openness and transparency throughout the [Trust]. Incidences of poor care were not formally fed through the system and they were not supplied to commissioners or regulators…this degree of silence in the face of catastrophic failing of care is unprecedented and remains surprising* (Primary Care Trust - Oral Submission p.47)

Witnessing misconduct by others challenged the professional moral compass - demands that were likely exacerbated by the projected expectations of wider society. Such societal expectations of moral ‘goodness’ mean physicians are strongly enculturated against speaking out against each other and their profession, for fear of bringing their profession into disrepute (Dixon-Woods et al 2011; McDonald et al 2006)):

> *It’s been a big burden to hold... I must appreciate I am also a doctor and in the eyes of the public I’ll always be a doctor, one would hope. But it’s*

> *been very difficult. I have been advised…by many different senior doctors, healthcare professionals that I need to be careful…we're all conscious of our vulnerability as healthcare professionals.* (Junior physician p.242)

Those who tried to give feedback were ignored or punished. Staff quickly found out any attempt to intervene or voice concerns was not rewarded, and could lead to isolation.

> *…it was a very unusual culture and closed – a closed workforce they didn't readily discuss any issues and it took a significant amount of time to gain trust of the workforce* (Director of Nursing p.169)

Strong in-group/out-group dynamics were evident throughout. Staff not buying in to the dominant organizational agenda of silence are clearly depicted (within the Inquiry evidence) as transgressors. We observed a culture of bullying, whereby professionals who were not 'on board' with the core organizational narrative around ignoring unethical behavior, were threatened with isolation or dismissal. For example, it is reported that senior nurses (sisters) in the accident and emergency department promoted a culture where people who challenged them were alienated. No one wants to be isolated or ousted from their professional group in their place of work, so the threat of isolation strengthened compliance (see Palmer 2013; Kreiner et al 2006).

> *[Concerns of malpractice] I did raise this with sisters [X] and [Y], however their response was extremely aggressive, basically telling me that they were in charge and accusing me and anyone else who agreed with me of not being team players* (Staff Nurse p.108)

This uncontestable, and seemingly closed, way of being mirrors the tale of the Emperor's New Clothes (Andersen et al, 1949). In the tale a vain Emperor parades the streets pretending he is wearing the finest cloth, which cannot be seen by people who are either unfit for office or particularly stupid. No-one wants to speak out about reality (the naked emperor), instead everyone is normalized into pretending that the Emperor is clothed - for fear of being thought stupid. Like the tale, no-one can speak out, with a spiral of silence developing, because people feel increasing pressure to

conceal their concerns. The denial that anything is wrong or concerning serves to create self-doubt about one's own perceptions. Even if initially evidence of wrong-doing or poor care seems clear, if no-one else claims to see this, or to be concerned then self-doubt about one's own perceptions will creep in. So, this silent compliance did not just happen, in the data there is agency but it is constrained by self-preservation, self-doubt and the professional training and socialization in which healthcare staff are enculturated (see Spyridonidis et al, 2015).

Irreversibility

This final period reveals how collective denial and organizational failure become so embedded that internal correction became impossible. Once complicit in ignoring poor quality (by this stage it is estimated one thousand patients had needlessly died) how do you retract? The individual is vulnerable to exposure, and there are group pressures to keep silent and/or perform the same transgression again. The reality of working in the NHS is that new scandals constantly emerge, and many staff would find little support from their leaders, regulators or even trade unions if they chose to speak out (Mannion et al 2019).

For staff not wishing to risk their own job security and expose themselves to abuse or isolation there were few options: (a) to leave (b) to collude, and voice that everything was fine so, and so become an active part of the denial, or (c) to repress any misgivings, and/ or stay silent. Both the inquiry itself (see Francis, 2013, p.66), and other corroborating reports (e.g. Frances 2010; HCC 2009) show that in certain areas staff turnover at the Trust was extremely high, but rather than sounding warning bells this helped to further silence concerns, as staff who were most unhappy were now no longer providing a dissenting voice.

Some staff did attempt another option, and attempt to speak out and resist the collective narrative that all was well. Whether those who chose to resist and speak out were ever a significant counter force is unclear from the Inquiry data. What is clearer is that resistance was dangerous. There is strong evidence in the Inquiry that those staff who spoke up were psychologically isolated and bullied. Poor handling of failure and the conflict it arouses can lead to a hostile working environment, in which people are ridiculed and bullied (Cannon and Edmonson, 2001; Mannion et al 2019). Over time there was an evident spread of bullying and even violence as actors emulated leader behavior by becoming coercive and abusive. The atmosphere of fear and isolation was pervasive and speaks to an organization where the rules that govern civil behavior were ignored.

In one tragic case a junior nurse committed suicide after an episode of bullying. The suicide occurred after she made a complaint, but little or no follow-up action was taken (p.1510-11). Staff appeared to be above the rules, with individuals punished for speaking out.

> *People saying they know where I live, and basically threats to my physical safety* (Staff Nurse p.236)
>
> *Investigators received varying reports from staff about [staff behavior] but they agreed that feedback when incident reports were filed was rare* (Francis concludes p.65)

Whilst, bullying in the pressured environment of healthcare is not uncommon (Carter et al, 2013; Pope, 2017) we saw clear disturbing evidence of escalation across all levels.

> *On arrival at Stafford I found the Emergency Department to be an absolute disaster. Its culture was unlike any other I had worked in despite being in the NHS for 25 years. There was a culture of bullying and harassment towards staff, especially the nursing staff.* (Specialist Registrar in emergency medicine p.121)

We saw evidence of organizational members becoming emotionally distanced from the organization. There is a reluctance to raise concerns because there was no mechanism for upward feedback.

> *…what we were saying in the meetings would not have made the slightest difference to them* (Union representative p.206)

We saw accounts of apathy and powerlessness.

> *…the fear factor kept me from speaking out, plus the thought that no-one wanted to know* (Staff Nurse p.235)

Together, these examples represent various means of organizational members exiting (whether physically, or emotionally). These choices represent the point where individuals stopped trying.

In such stressful situations of failure, a coping strategy for those who remain is to repress or shift one's moral referents (Shephard et al, 2011), with staff appearing to further commit to the narrative of silence. Breaches of care once thought of as unacceptable became justified. In this self-justification, it is not the loss of moral reason, but instead the grounds of reason drift, allowing intentional harm to be downplayed.

> *They [the staff] didn't realise how far off acceptable standards things had slipped to, and I don't think that any of them would have let that happen if that had happened overnight. I think they would have been up in arms* (Specialist Registrar in emergency medicine on newly arriving at the Trust and observing levels patient care p.178)

Over time, active participation in uncivil or unethical behaviours is more widely tolerated. Professionals became encapsulated within a frame of reference and way of behaving that would have been unacceptable to outsiders (Balch & Armstrong 2010). But within the organization, what was seen as professionally acceptable became entangled with what was organizationally acceptable:

> *I regarded myself as a professional who was attempting to understand if it was just me that felt that this was an unacceptable state of affairs, and whether or not other people were saying "No, actually, this is – this is okay and you can do this, this and this, and this will help to change the direction.* (Junior Physician p.238)

Decreasing the salience of one's professional identity allows misconduct to be more easily rationalised, decreasing the severity of harm; put simply, people changed who they were, so they could more easily normalise what they did (Ashforth & Anand 2003). Below, the professional in charge of patient safety explains her failure to act over an indication of care-quality breach. This suggests professional identification was firmly aligned to the organization (and protecting its reputation – viewed as their 'responsibilities') rather than their role as a gatekeeper of professional standards (Hutchison, 2016).

> *We did have some discussion at this point about whether we should [refer] to a professional body [regarding the clinical safety issue]... my recollection is we thought about that. You know, what were our responsibilities at this time? So, ... we could have done more...* (Internal Peer Review Director - investigating a safety breach p.80)

Staff complicit in misconduct coped by denying and concealing what was happening, changing the importance of events and changing who they were (weakening their allegiance to their profession and its standards). We see a shift away from the traditional codes of conduct and the meaning and importance they held, illustrated through the disregard of national benchmarking standards. For physicians, their desire to craft themselves in a favourable light meant reinterpreting the rules regarding what was good or bad practice. By laundering professional standards, the threat to their professional identity was resolved.

> *There's an abnormal culture which was both within the consultant staff and in other staff, whereby it…frequently seemed to me that we had to produce a Stafford version of the NICE guidance [the UK national standard of clinical care] as opposed to taking it as written by NICE … I think that in retrospect there – there was an unwillingness to accept nationally agreed guidance at face value…* (Physician p.173)

The negative behaviors outlined could be placed on a continuum of ineffective to incompetent. Whilst never good, it is difficult to establish wicked intent. At each period many staff were driven by a shared desire to create an organization that delivered high quality care, but reality became confused. This shared desire pushed actors with different interests and identities together; they got onboard and stayed onboard. With this drift, the continuum became embedded in the fabric of organizational practices, processes and structures. The ramifications were that poor standards were now an accepted part of organizational life. The normalization of poor care and poor working conditions, and the blindness to misconduct were endemic and resistant to any form of self-correction.

Discussion

In our examination of organizational failure at Mid Staffordshire Trust we draw on the idea of narratives of silence. In our study two such narrative threads clearly emerged as dominant, the need to remain silent around poor care and the need to remain silence about slipping professional standards and misconduct. Physician narratives about not reporting violations or errors regarding another physician's work is not new (see McDonald et al 2006). What is usual is the emergence of narrative confluence around both these narratives, with both physicians and managers by implication, reaching consensus.

Our contribution, is to show that under certain organizational conditions widespread narrative confluence can create the phenomenon of 'collective denial'. We define collective denial as having defining characteristics that distinguish it from other process, control or domination concepts. Firstly, it is a phenomenon that occurs in situations where multiple actors collectively engage and comply to quash

dissenting voices, thus its appearance and rise cannot be solely attributed to a singular individual such as the leader. In taking this approach we move away from the majority of work that extrapolates single 'bad apple' individuals, or small groups to a wider lens. Second, the phenomenon involves cumulative episodes of multilevel, dynamic failure that unfold and escalate over time – rather than any singular event or bad decision. Third, the phenomenon creates a cocoon of systemic and collective unreality; with narratives that serve to silence reality and control and prevent the enormity of failure from being openly discussed, widening the scope for ever more serious failings to occur.

Narratives of silence highlight how unfolding processes and their consequences, lead to a sense of unity. Many organizations require staff to become allied agents of the collective, committed to working in service of the organizations' strategic goals (see King et al, 2010). Employees are driven to behave in ways that are congruent with the organizations' needs and motivated to enact their work in a manner consistent with these needs, rather than their own values (Vadera and Pratt, 2013). However, in our case this led towards a position where their own sense of right, or a moral compass shifted (McManus, 2018; Shepherd and Cardon, 2009). Members give up their own mindfulness (see Ashforth and Anand, 2003; Shepherd and Cardon, 2009) and their professional identity (McDonald et al 2006) for the good of the organization, perhaps safe in the knowledge that the professional and organizational leadership will sanction this behavior (Gabbioneta et al, 2019; Gemmill and Oakley, 1992; Balch and Armstrong, 2010).

As the phenomenon escalates, levels of misconduct and the risk of being uncovered heighten, with multiple participants trapped in a set course of action, with no possibility of correction. This means that emerging failure is especially

problematic and difficult to resolve without intervention from outside. Silence can be driven by many motivations. It may simply be an act of organizational protection at its genesis (Bies, 2009) but over time it can change to a position of entrapment (Weick & Sutcliffe, 2003). People become unable to speak out, issues become 'undiscussables' because now everyone is complicit in poor care or hiding misconduct, and the consequences of speaking out are too grave in terms of the organization's reputation or personally being isolated or bullied (Ryan & Oestreich, 1991; Van Dyne et al 2003; Milliken et al 2003).

Under such conditions learning becomes impossible (Schlosser & Zolin, 2012). Seminal work by Argyris (1977) suggests voice is essential for organizational learning. Without voice, the feedback and 'double loop' learning, which requires questioning, modification and multiple perspectives, will be nullified. To learn you need decision-quality, enhanced by many divergent voices, practices and goals (Morrison & Milliken, 2000). The silencing of voice means that early warning signs are missed (Weick and Sutcliffe, 2015), organizational reasoning becomes fundamentally crystallized, allowing actors to become trapped and ever more serious failures to be ignored and justified (Morrrison & Milliken 2000; Schlosser & Zolin 2012).

Summarizing these contributions we present a model of the dynamics of collective denial resulting in organizational failure (see figure 2). This process explains how multiple actors engage in a 'narrative of silence' and seem unable or unwilling to stop the escalation of wrongdoing. This process involves normalization of decisions and actions that culminate to take people away from reality.

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INSERT FIGURE 2 ABOUT HERE

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The concept of collective denial helps explain why some organizations might be more prone to organizational failure by describing key contextual triggers that allow collective denial of failure to emerge. We asked what leadership and organizational practices contributed to emergence and maintenance of denial and found that combined impact of assumptions about leadership capability, enculturated professional identities and organizational loyalty create an environment where a narrative of silence can develop.

Within the public sector and healthcare in particular, enculturated professional identities and organizational loyalties make speaking out against the leader and fellow staff difficult (Pope, 2017; Spyridonidis et al, 2015). What is interesting is the power of our narratives across both clinical and managerial staff. Other research has shown that the narratives of these two groups is highly divided (Strong and Robinson, 1990; McDonald et al 2006). This surprising and highly relevant merging of narrative confluence, is perhaps, fueled by the recent rise of many hybrid-clinical staff, who act as both managers and supervisors which means that professional boundaries become blurred (Gabbioneta et al, 2019; Spyridonidis et al, 2015).

Engagement in the falsehood (that all was well) can be turned into something pernicious, as employees can believe that their silence is saving the organization (and the good work going on within in it) from scrutiny and downfall (Schlosser & Zolin 2012). Our research, therefore, builds on work which illustrates how strong professional codes can provide the raw material that leads to organizational misconduct and wider organizational failures (see Vadera and Pratt, 2013). In doing so, we highlight how strong professional codes of conduct and ideas of professional loyalty, embedded in the identity of professionals, such as physicians, may override other salient needs (in our case good care to patients).

Our research supports the argument that public sector failure is often encapsulated by cumulative poor decision-making and consistent under-performance which goes unchecked (Meier and Bohte, 2003; Walshe et al, 2004; Mannion et al 2019). We observed that any rescue from failure may be difficult where resources are stretched or unavailable, making speaking out against decisions more difficult, and where external controls are ineffective and time horizons long enough to allow a set course of action to solidify. Developing an organization which is mindful and able to prevent failures takes considerable time and cost (Weick and Sitcliffe, 2015; Williamsn et al, 2017). The incremental decline of organizational conditions is significant (see Schlosser & Zolin 2012). Ryan and Oestreich (1991) illustrate how a cycle of mistrust can develop as supervisors and employees engage in self-protective behaviors in response to negative assumptions about each other.

We observed a similar cyclical pattern but represent this as a spiral (downward) in our model, illustrating the ever increasing and encapsulating nature of collective denial. Events that slowly unravel can catch people out, with staff overlooking minor mistakes which then pave the way for a tolerance for more serious breaches (see Ashforth and Anand, 2003). Our theoretical model (see figure 2) shows how the processes of developing a narrative of silence became irreversible. Collective denial resides within the fabric of the organization, making the shared denial more challenging, dangerous and difficult to address than simply by changing the leader (see Ashforth and Anand, 2003; Balch and Armstrong, 2010). Our data shows how the fate of the leadership and members became increasingly enmeshed; almost everyone becomes complicit, with something to lose if the new shared reality is threatened. A shared commitment binds people so tightly that even those with choice, power and mobility are without voice (Balch and Armstrong, 2010; Weick and

Sutcliffe, 2003). In our case, violation of the principals of quality care, and abusive working conditions, became for many, an accepted part of healthcare work (Balch and Armstrong, 2010; Pope, 2017).

Practical Implications

Since writing this paper other healthcare scandals have emerged, suggesting that collective denial is not an exceptional occurrence (https://www.independent.co.uk/news/health/shrewsbury-maternity-scandal/ accessed 13.2.2020). The context and practices outlined in our case and others in themselves contain nothing extraordinary, it is the toxic mix of these factors that creates the devastation that ensues, and warrants furthers research. As discussed, the unique combination of policy pressures and professional culture, may mean that healthcare organizations are particularly susceptible to this phenomenon. In terms of being able to detect early warning signs, and prevent such failures, the picture is complex. Once collective denial resides within the fabric of the organization, our data suggest it will be dangerous and difficult to address. New staff coming into an organization, although more acutely and newly aware of the issues, are unlikely to have the confidence or power to speak out. Currently, internal and external governance processes appear limited in terms of addressing areas of concern, as they emerge.

To prevent such future failures our work suggests there needs to be safeguards which allow for self-reflection and correction from an early stage. Here, powerful internal cynics, or troubleshooters, who are assigned the task of highlighting areas of potential decline, and policy misalignment may be useful. We also need to reposition employees and give them sufficient power to ensure their concerns are acted upon with positivity and gratitude (see Tourish 2014 p. 88). We need employees with the

power to have courage to dismantle and actively argue against simplistic ‘success’ paradigms, bringing in diverse and challenging worldviews. How these notions could become embedded within the current system is beyond the scope of this paper, but what our paper offers is a framework through which possible solutions (which we intend to explore in the future) might be evaluated.

References

Andersen, H.C., Burton, V. and Houghton Mifflin Company (1949) *The emperor's new clothes*. Boston: Houghton Mifflin Co.

Andrews, R., Boyne, G., and Enticott, G. (2006). Performance failure in the public sector. *Public Management Review*, 8(2), 273-296

Anheier, H.K. (1999) *When Things Go Wrong: Organizational Failures and Breakdowns*. Thousand Oaks, Calif.: SAGE Publications.

Argyris, C. (1977) Double Loop Learning in Organizations, *Harvard Business Review* 55 (5), 115-124.

Armit, K., & Oldham, M. (2015). The Ethics of Managing and Leading Health Services: a view from the United Kingdom. *Asia Pacific Journal of Health Management,* 10(3), SI18-SI21.

Ashforth, B. E. and Anand, V. (2003) The Normalization of Corruption in Organizations. *Research in Organizational Behavior*, 25(1), 1-52.

Balch, D. R. and Armstrong, R. W. (2010) Ethical Marginality: The Icarus Syndrome and Banality of Wrongdoing. *Journal of Business Ethics,* 92 (2): 291–303.

Bies, R. J. (2009). Sounds of silence: Identifying new motives. In J. Greenberg & M. Edwards (Eds.), *Voice and silence in organizations* (pp. 175–202). Bingley, England: Emerald.

Brown, A. D. (2000) Making sense of inquiry sensemaking. *Journal of Management Studies,* 37(1): 45–75.

Brown, A. D., Ainsworth, S. and Grant, D. (2012) The rhetoric of institutional change. *Organization Studies*, 33, 297-321.

Bruce, J. (2013). Learning from Tragedy. (cover story). *Board Leadership*, 2013(129), 1–6.

Cannon, M. D. and Edmondson, A. C. (2001) Confronting failure: antecedents and consequences of shared beliefs about failure in organizational work groups. *Journal of Organizational Behavior* 22(2): 161–177.

Carter, M. Thompson, N. and Crampton, P. (2013) Workplace bullying in the UK NHS: a questionnaire and interview study on prevalence, impact and barriers to reporting. *BMJ Open* 3:e002628.

Coombes, R. (2013) Francis interview: what doctors must learn from my report. *British Medical Journal*, 346: f878

Currie, G. Faulconbridge, JR. Gabbioneta, C. Muzio D. Richmond, J. (2019). Professional Misconduct in Healthcare: Setting Out a Research Agenda for Work Sociology. *Work, Employment and Society*, 33(1): 149-161

Dailey, S. L. and Browning, L. (2014) Retelling stories in organizations: Understanding the functions of narrative repetition. *Academy of Management Review*, 39(1), 22–43.

Davies, H. and Mannion, R. (2013) Will prescriptions for cultural change improve the NHS? *British Medical Journal,* 346: f1305.

De Rue, D. S. and Ashford, S. J. (2010) Who will lead and who will follow? A social process of leadership identity construction in organizations. *Academy of Management Review*, 35(4), 627–647

Dixon-woods M, Yeung K and Bosk CL (2011) Why is U.K. medicine no longer a self-regulating profession? The role of scandals involving "bad apple" doctors. *Social Science and Medicine* (10): 1452-9.

Dunn, C. & Eble, M. (2015) Giving voice to the silenced: Using critical discourse analysis to inform crisis communication theory. *Journal of Business Ethics*, 132:717-735

Francis, F. (2010). Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust: January 2005 -March 2009 nationalarchives.gov.uk

Francis, F. (2013) The Mid Staffordshire NHS Foundation Trust Public Inquiry. nationalarchives.gov.uk

Gabbioneta, C., Faulconbridge, J. R., Currie, G., Dinovitzer, R., & Muzio, D. (2019). Inserting professionals and professional organizations in studies of wrongdoing: The nature, antecedents and consequences of professional misconduct. *Human Relations*, *72*(11), 1707-1715 https://doi.org/10.1177/0018726718809400

Geiger, D. and Antonacopoulou, D. (2009). Narratives and Organizational Dynamics: Exploring Blind Spots and Organizational Inertia. *Journal of Applied Behavioral Science*, 45(3): 411-436.

Gemmill, G. and Oakley, J. (1992) Leadership: An alienating social myth? *Human Relations*, 45(2) 113-129.

Gioia, D. A., Corley, K. G. and Hamilton, A. L. (2012) Seeking Qualitative Rigor in Inductive Research: Notes on the Gioia Methodology, *Organizational Research Methods,* 16 (1)15-31.

Harrington, B. (2019). Turning vice into virtue: Institutional work and professional misconduct. *Human Relations*, *72*(9), 1464–1496. https://doi.org/10.1177/0018726718793930

Harrison, S., Hunter, D. J., Marnoch, G., & Pollitt, C. (1992). *Just managing: power and culture in the National Health Service.* Macmillan International Higher Education.

Healthcare Commission (HCC) (2009) *Investigation into Mid Staffordshire NHS Foundation Trust.* nationalarchives.gov.uk

Hutchison, J. S. (2016). Scandals in health-care: their impact on health policy and nursing. *Nursing Inquiry*, 23(1), 32–41.

Janis, I. L. (1982) *Groupthink: Psychological Studies of Policy Decisions and Fiascos*. Boston: Houghton Mifflin.

Jarman, B. (2013). Quality of care and patient safety in the UK: the way forward after Mid Staffordshire. *Lancet*, 382(9892), 573–575.

Jas, P., and Skelcher, C. (2005). Performance Decline and Turnaround in Public Organizations: A Theoretical and Empirical Analysis. *British Journal of Management*, 16(3), 195-210.

King, G.A. and Rothstein, M.G., (2010). Resilience and leadership: The self-management of failure. *In Self-management and leadership development*. Edward Elgar Publishing.

Knoll, M., Wegge, J., Unterrainer, C., Silva S & Jonsson T. (2016) Is our knowledge on voice and silence in organizations growing? Building bridges and

(re)discovering opportunities. *German Journal of Research in Human Resource Management* 30(3–4): 161–194.

Kreiner GE, Hollensbe EC and Sheep ML (2006) Where is the "me" among the "we"? Identity work and the search for optimal balance. *Academy of Management Journal* 49 (5) 1031-105.

Kouchaki M (2014) Professionalism and moral behavior. *Business & Society* 54 (3) 376 – 385.

Mannion, R, Davies, H, Powell, M.A., & Blenkinsopp. (2019). Healthcare scandals and the failings of doctors: Do official inquiries hold the profession to account*? Journal of Health Organization and Management*, 33 (2), 221-240.

McDonald R, Waring J and Harisson S (2006) Rules, safety and the narrativisation of identity: a hospital operating theatre case study. *Sociology of Health & Illness* 28 (2) 178–202.

McGauran, A. (2002) Foundation Hospitals: freeing the best or dividing the NHS. *British Medical Journal* 324(7349):1298.

McManus, J. (2018) Hubris and unethical decision making: The tragedy of the uncommon. *Journal of Business Ethics*. 149:169-185

Meier, K., & Bohte, J. (2003). Not with a bang: but a whimper. *Administration and Society,* 35(1), 104-121

Mesmer-Magnus, J. R. and Viswesvaran, C. (2005) Whistleblowing in organizations: An examination of correlates of whistleblowing intentions, actions, and retaliation, *Journal of Business Ethics* 62(3), 277-297.

Miceli, MP , Near J P and Dworkin TM (2008). *Whistle-blowing in Organizations*. New York: Routledge

Milliken, F. J., Morrison, E.W. & Hewlin P. F. (2003). An Exploratory Study of Employee Silence: Issues that Employees Don’t Communicate Upward and Why, *Journal of Management Studies*, 40(6), 1453-1476.

Morrison, E. W. & Milliken, F. J. (2000) Organizational Silence: A barrier to change and development in a pluralistic world. *Academy of Management Review*, 25(4): 706-725

Muzio D, Faulconbridge J, Gabbioneta C and Greenwood R (2016) Bad Apples, Bad Barrels and Bad Cellars: A 'Boundaries' Perspective on Professional Misconduct. In Palmer D, Greenwood R and Smith-Crowe K (eds) *Organizational Wrongdoing*. Cambridge, UK: Cambridge University Press: 141–175.

Näslund, L, and Pemer, F. (2012) The appropriated language: Dominant stories as a source of organizational inertia. *Human Relations,* 65(1): 89–110.

Palmer D and Maher MW (2006) Developing the process model of collective corruption. *Journal of Management Inquiry* 15 (4) 363 – 370.

Palmer D (2013) *Normal Organizational Wrongdoing: A Critical Analysis of Theories of Misconduct in and by Organizations.* Oxford: Oxford University Press.

Picone, P. M., Daginao, G. B., Mina, A. (2014) The origin of failure: A multidisciplinary appraisal of the hubris hypothesis and proposed research agenda. *Academy of Management Perspectives* 28(4): 447-468.

Pope, R. (2017). The NHS: Sticking fingers in its ears, humming loudly. *Journal of Business Ethics*. 145:577-598

Ryan, K.D. and Oestreich, D.K/ (1991) *Driving Fear out of the workplace: How to overcome the invisible barriers to quality, productivity and innovation*. San Francisco, CAUS: Jossey-Bass.

Schlosser, F. & Zolin, R. (2012). Hearing voice and silence during stressful economic times. *Employee Relations* 34 (5), 555-573

Shepherd, D. A. and Cardon, M. S. (2009) Negative Emotional Reactions to Project Failure and the Self-Compassion to Learn from the Experience. *Journal of Management Studies* 46(6): 923–949.

Shepherd, D. A., Patzelt, H. and Wolfe, M. (2011) Moving Forward from Project Failure: Negative Emotions, Affective Commitment, and Learning from the Experience. *Academy of Management Journal* 54(6): 1229–1259.

Shrewsbury maternity scandal: NHS used report to create 'false narrative' on maternity services. (2019). https://www.independent.co.uk/news/health/shrewsbury-maternity-scandal/shrewsbury-maternity-nhs-babies-deaths-care-a9231486.html Accessed 20.2.2020

Spyridonidis, D., Hendy, J. and Barlow, J. (2015) Managing Hybrid Professional Identities. *Public Administration* 93 (2): 395–411.

Stein, M. (2013) When does narcissistic leadership become problematic? Dick Fuld at Lehman Brothers. *Journal of Management Inquiry* 22(3): 282-293.

Stouten, J., Tripp, TM., Bies, R. J. & De Cremer D. (2019). When Something Is Not Right: The Value of Silence. Academy of Management Perspectives (33)3: 323-333.

Strong, P., & Robinson, J. (1990). *The NHS under new management.* Open University Press.

Tang, Y., Li, J., & Yang, H. (2015) What I see, what I do: How executive hubris affects firm innovation. *Journal of Management,* 41(6):1698-1723

Tingle, J. (2015) Applying the lessons of the Francis Inquiries: Culture Change, part two. *British Journal Of Nursing*; Vol. 24 (7), pp. 416-7.

Tourish, D. (2014) Leadership, more or less? A processual, communication perspective on the role of agency in leadership theory. *Leadership,* 10 (1): 79-98.

Uhl-Bien, M. and Ospina, S. M. (2012) *Advancing Relational Leadership Research: A dialogue among Perspectives*. Charlotte: Information Age Publishers.

Vadera, A. K. and Pratt, M. G. (2013) Love, Hate, Ambivalence, or Indifference? A Conceptual Examination of Workplace Crimes and Organizational Identification. *Organization Science* 24(1):172-188.

Van Dyne, L., Soon, Ang. & Botero I.C. (2003). Conceptualizing Employee Silence and Employee Voice as Multi-dimensional Constructs, *Journal of Management Studies,* 40(6):1359-1392.

Walshe, K., Harvey, G., Hyde, P., and Pandit, N. (2004). Organizational failure and turnaround: Lessons for public services from the for-profit sector. *Public Money & Management*, 24(4), 201-208

Weick, K. E. and Sutcliffe, K. M. (2003). Hospitals as cultures of entrapment. *California Management Review*, 45(2), 73-84.

Weick, K.E. and Sutcliffe, K.M. (2015). *Managing the unexpected: Sustained performance in a complex world*. San Francisco: Jossey-Bass.

Westphal, M., & Bonanno, G. A. (2007). Posttraumatic growth and resilience to trauma: Different sides of the same coin or different coins? *Applied Psychology*, 56(3), 417-427.

Williams, T.A., Gruber, D.A., Sutcliffe, K.M., Shepherd, D.A. and Zhao, E.Y. (2017). 'Organizational Response to Adversity: Fusing Crisis Management and Resilience Research Streams'. *Academy of Management Annals*, 11, 733-769.

Table 1 – Data Structure

1st Order Concepts	2nd Order Theme	Aggregate Dimension
• Poor previous performance • Pressure from above and within – to do better	Imperative need for growth and change	The Rise
• Overly concerned with internal approval rather than external standards • Pressure to provide united front in tackling strategy	Strengthening of professional and organizational identities	
• Inexperienced managers unable to question/raise concerns • Promise of success • External trust that leadership team can self regulate	Unchecked confidence	
• Prioritising compliance with external targets • Dismissive of difficulties – we are the same as others • Defensive, angry and unresponsive to critique – ignore feedback	Management of external image (internally)	Normalization
• External/internal trust in procedures • External validation and support • External empathy – it's a tough job	External trust and support	
• Threat of job security • Failure to punish transgressions – staff above the rules • Bullying and violence – middle to bottom	Aggressive enforcement of regime	
• Concealment of problems to outsiders – miscommunication and gaming the numbers • Deny problems (the statistics are wrong) • Lack of transparency across all areas	Obfuscation and fabrication of reality	Silencing
• Profound loss of voice • Fear of being ousted from the in-group • Feedback is a betrayal of loyalty	Culture of compliance	
• High staff turnover • Exhaustion – no energy to resist • Whistleblowers ousted and a staff suicide	Loss of correcting voices	Irreversibility
• Increasing powerlessness and passivity of front-line staff • Increasing apathy • Loss of empathy – indifference to patients concerns/suffering	Emotional distancing	
• Justifying degradation in care • Denial of wrongdoing • General malaise	Shift in moral/social referents	

Figure 1 – Timeline of events at Mid Staffordshire NHS Trust 2000-2009

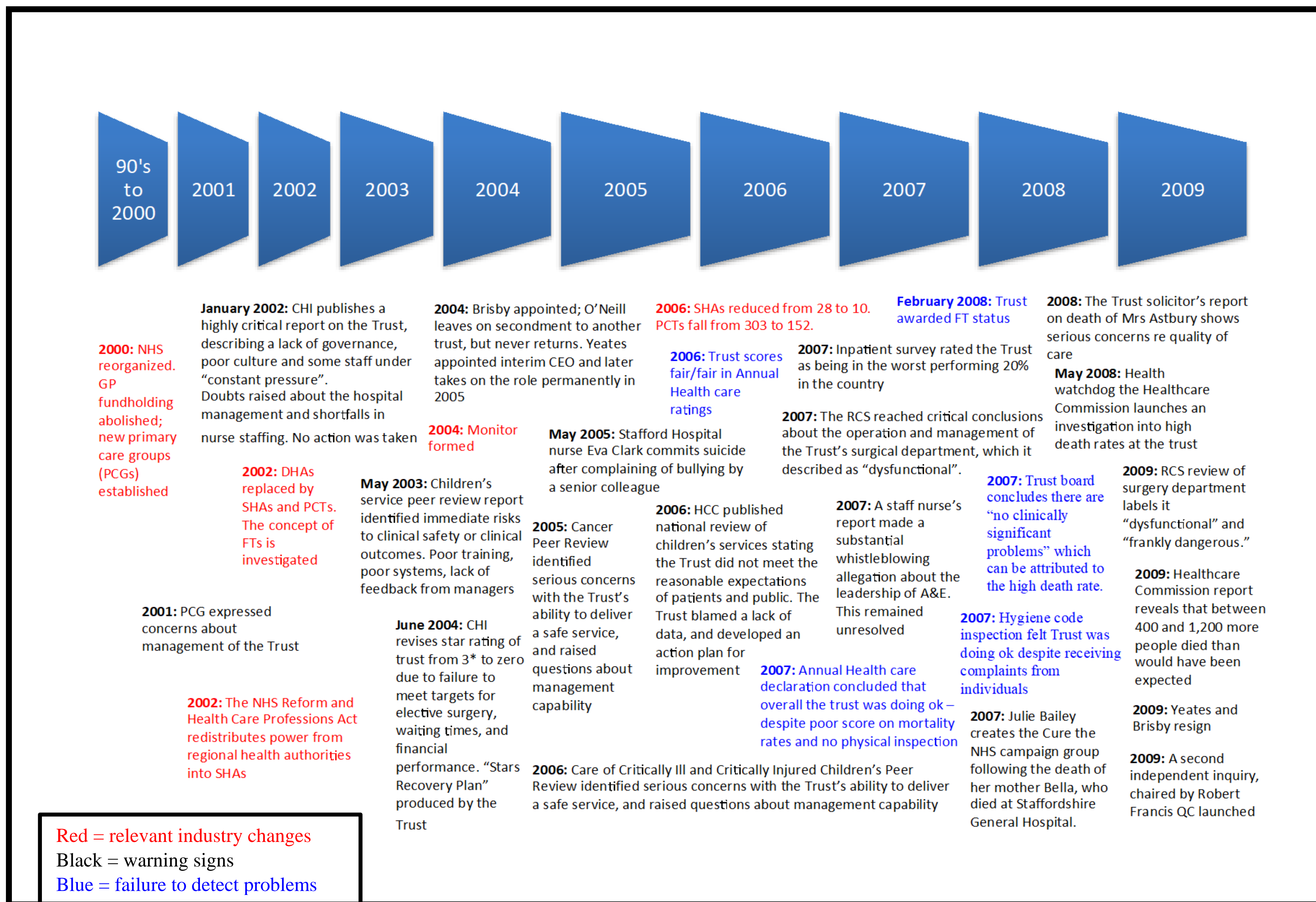

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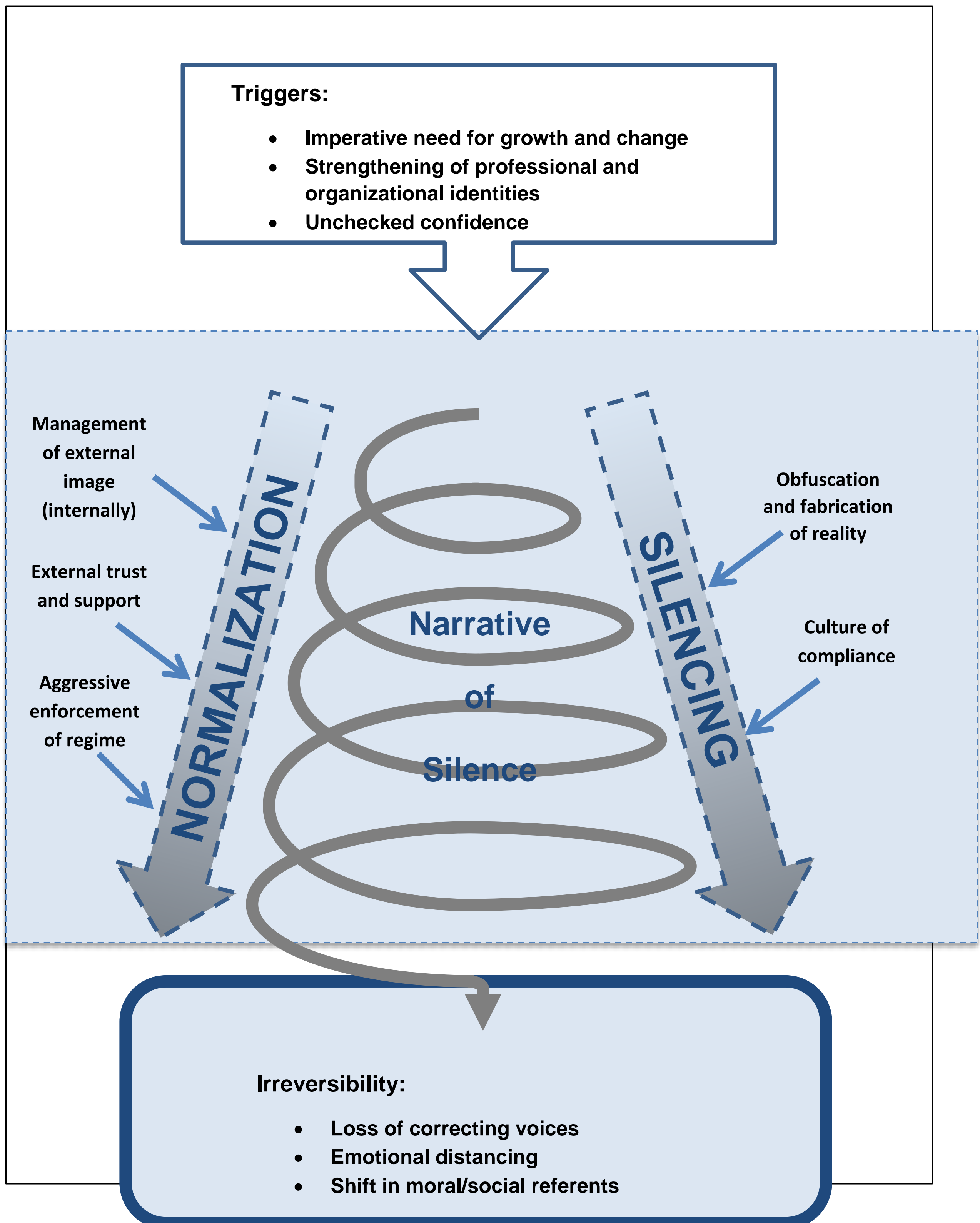
Figure 2 – The Dynamics of Collective Denial



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