

Understanding the organisational context for adverse events in the health services: the role of cultural censorship

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Abstract

This paper responds to the current emphasis on organisational learning in the NHS as a means of improving healthcare systems and making hospitals safer places for patients. Conspiracies of silence have been identified as obstacles to organisational learning, covering error and hampering communication. In this paper we question the usefulness of the term and suggest that “cultural censorship”, a concept developed by the anthropologist Robin Sherriff, provides a much needed insight into cultures of silence within the NHS. Drawing on a number of illustrations, but in particular the Ritchie inquiry into the disgraced gynaecologist Rodney Ledward, we show how the defining characteristics of cultural censorship can help us to understand how adverse events get pushed underground, only to flourish in the underside of organisational life.

(Quality in Health Care 2001;10:257–262)

Keywords: cultural censorship; organisational culture; quality improvement; patient safety

Organisational culture, learning and change

The concept of “organisational culture” is now widely used by policy makers and researchers alike to explain adverse events and poor quality patient care more generally. There is also much talk about the importance of “positive organisational cultures”¹ in reducing risk of harm to patients and of the related need to promote a “culture of reporting”.² As argued in *An Organisation with a Memory*:

“Organisational culture is central to every stage of the learning process—from ensuring that incidents are identified and reported through to embedding the necessary changes deeply in practice.”³ (page ix)

Although its meaning is much debated,^{4–6} “organisational culture” usually refers to a set of shared understandings, values, and beliefs which implicitly inform behaviour, provide members with a sense of identity, and are symbolically embodied and expressed through ceremonies and rituals of various kinds as well as

in more mundane ways through policies, guidelines, and procedures.²

Especially since the 1980s, in both the private and public sectors, the idea of “organisational learning” (OL) has taken root.⁷ The influence of OL can be seen in *An Organisation with a Memory*³ which argues that the key to long term and comprehensive improvements in the quality of health care is to enable the NHS to learn from its mistakes by engaging in “active learning” so that lessons are embedded in practice—in effect, to undergo a cultural change and become a learning organisation. In the health services teamwork is seen as essential to this process, especially given the complexities of modern care.⁸ The challenge is to maximise the benefits of teamwork while dealing with the many inherent problems in teams, including the potential for interpersonal conflict—especially, but not only, between doctors and nurses.⁸

Key messages

- This paper responds to the current emphasis on organisational learning in the NHS as a means of improving healthcare systems and making hospitals safer places for patients.
- In understanding adverse events this paper challenges the view that conspiracies of silence and associated blame cultures are “to blame”. Instead, the anthropological concept of cultural censorship is presented and its value for an understanding of adverse events is demonstrated with reference to a range of literature including government inquiries, policy documents, and research studies.
- It is suggested that cultural censorship may be so deeply embedded in western healthcare systems that the introduction of mandatory reporting schemes may simply drive mishaps, mistakes and even malpractice underground to flourish in the underside of organisation life.
- The paper concludes with a discussion of the implications of the argument for policy and practice in the health services, including suggestions for action.

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Accepted 9 July 2001

Cultural censorship

In Britain, in the wake of a series of scandals in the NHS, attention has turned to the role of subcultures in adverse events and, particularly, to those team and group loyalties which breed “cultures of silence”.^{9–11} It now seems to be taken for granted, wrongly in our view, that *cultures of silence* are underpinned by *conspiracies of silence*.¹² We believe that the anthropological concept of *cultural censorship* presented below makes a much needed contribution to an understanding of the “underside” of organisational life.¹³

Cultural censorship is a concept developed by the social anthropologist Robin Sheriff to explain why the racism observed in Brazil, and which was generally known to exist both by middle class Brazilians and shanty town dwellers, was not spoken of publicly.¹⁴ Drawing on this experience, Sheriff argues that cultural censorship is a socially shared silence which plays a critical yet often invisible role in “shaping not only private experience but also the politically charged social relationships that make up public life” (page 114).¹⁴

Before describing how cultural censorship can help us to understand cultures of silence in the NHS, it is helpful to distinguish it from other forms of communal silence. Under conventional hegemony, dominant views are naturalised so that they become common sense and are taken entirely for granted within the community. In this setting, people lack the ideological means to give voice to dissent. Cultural censorship, by contrast, does not prevent people from saying and thinking what is outside the limit of the rational and credible in dominant ideology.¹⁴ In Sheriff’s study the mainly Black shanty town population is aware of, and under certain circumstances willing to talk about, the discourses that deny the existence of racism in Brazil. Health workers in the present study are similarly placed in their response to the kinds of language that uphold medical power and obscure error. What is commonly known from gossip in “a variety of quarters”, “corridor chat”, and patients’ complications is simultaneously hidden from view (page 52).¹² As Sherriff notes: “One of the central features of cultural silence is that it tends to be, in rather paradoxical terms, simultaneously recognized and concealed” (page 115).¹⁴

The silence produced by cultural censorship should not be read as an acceptance of dominant ways of thinking, but neither are people coerced into being silent; indeed, there may even be laws, procedures, or reporting schemes to protect people and encourage them to speak out. Unlike conspiracies of silence there is no collective plan, agreement, or plot under cultural censorship. Workers have different motivations for remaining silent in a given situation and they are normally divided over what counts as an adverse event. Typically, consensus only emerges retrospectively following an external inquiry. Constrained by lack of consensus and motivated by a variety of political and psychological interests, people choose to forget what they know and withdraw into

silence—but they do so collectively on the basis of tacit communal understandings.

Another distinguishing feature of cultural censorship is its specificity. Even for theorists who accept that silence need not be conspiratorial or coercive, the silence they describe tends to pervade all aspects of life as in, for instance, the diffuse kinds of silencing experienced by women under patriarchy.^{15–16} Cultural censorship, by contrast, relates to highly specific issues like the political significance of racism in Brazil. Such specificity allows us to focus on the experiential complexities of a given situation—in this case, the silence surrounding particular adverse events in the health services.

For our central case study we have chosen to use the inquiry into the gynaecologist Rodney Ledward, known as the Ritchie report,¹² because (a) the Ledward case is a prime example of an adverse event that is both known and concealed—exactly the kind we are interested in here, (b) the relative extremity of the case makes the issues we wish to address highly visible, and (c) it documents the existence of cultural censorship over nearly two decades from when Ledward’s errors were perceived as “normal complications” to when he was struck off the Medical Register. We will follow with a brief survey of reports, inquiries, and associated research literature that further illustrate the points we wish to make. We do so to make the argument that cultural censorship exists in less extreme settings and to suggest that it may be an endemic problem of western healthcare systems. In the final section we suggest ways of overcoming the problems of cultural censorship with a view to making hospitals safer places for both patients and health professionals.

The Ritchie Report and cultures of silence

The Ritchie Inquiry was concerned with “quality and practice within the National Health Service arising from the actions of Rodney Ledward” (page 5), the incompetent and disgraced gynaecologist who was struck off the Medical Register on 30 September 1998 for malpractice.¹² Until then Ledward was the epitome of success, leading a team that prized his speed as a surgeon. He was admired as a fine clinical teacher and an innovator and showed a keen interest in audit, producing reports which, Ritchie emphasised, were “models for their time”. He also had friends in high places among senior consultants, grateful patients, and the devotion of his two secretaries. Some junior doctors in particular were strong supporters of Ledward, writing to Ritchie in glowing terms about his contribution to their career success, his humanity, and his commitment to teaching and to the care of his patients.¹²

In interpreting such evidence, Ritchie recognises that junior doctors were “reluctant to criticise their seniors because it might jeopardise their careers, as they [are] so dependent on their senior colleagues for references” (pages 15–16).¹² But Ritchie does not draw out the implications of the junior doctors’ involvement

in Ledward's malpractice. Dependent on his patronage, junior doctors were drawn into what Ritchie refers to as a "macho culture" which, we would add, also involved the forming of bonds through individual and collective "transgressions".¹³ Junior doctors undertook surgical procedures on Ledward's behalf unattended and without sufficient expertise¹²; they examined patients unattended and covered up for him (as he covered up for them). It was not simply that Ledward dominated his juniors; both he and they had an interest in maintaining the status quo.

Like the junior doctors, nurses also became drawn into bonds of transgression but, unlike them, this came from trying to *protect* both themselves and their patients to compensate for the shortfall in Ledward's practice. The Ritchie report shows that several nurses were aware of the extent of his malpractice, some over many years, but had problems resolving the situation. Throughout the report it is apparent that nurses' attempts to deal with the problems created by Ledward were riven by uncertainty and ambiguity about their role, their status, and their duty to patients. As is characteristic of cultural censorship, nurses worked in an environment where the problems were generally known and yet not acknowledged. They were in the position of knowing and yet not knowing. For example, Ritchie heard from one ward sister who had worked on the gynaecology ward as a staff nurse since 1985 and who, over time, gradually became aware of the problems Ledward's surgery caused for patients. However, she lacked confidence in her own judgement and, as she explained to the inquiry, was unwilling to question a "consultant's ability" so, instead of reporting what she knew, she devised strategies for dealing with the situation by making sure the most competent and experienced nurses were put on Ledward's sessions (pages 117–118).¹² This ward sister's account illustrates how her belated attempts to minimise the damage only served to implicate her in Ledward's malpractice, making her feel more guilty rather than less because she had, unintentionally, covered up for him.

Ritchie believes that the only action open to nurses was to report their concerns to the nurse manager. However, throughout most of the 1990s, when Ledward was at the height of his malpractice, there was an RCN hotline for whistle blowers which was widely promoted through the national media and professional journals. Furthermore, under the UKCC's code of professional conduct, nurses were (and are) required to "act always in such a manner as to promote and safeguard the interests and well being of patients . . ."¹⁷ What emerges from the Ritchie report, however, is that the nurses' situation was both highly politicised and fraught with psychosocial tensions, including feelings of humiliation, guilt, and shame by association, so the only form of resolution open to them was to lessen their own suffering by withdrawing into silence. Speaking out would only make it worse.

It was not only junior doctors and nurses who became implicated in some way in Ledward's malpractice or who encountered problems of resolution, but also consultants and managers. For example, a junior consultant complained to the Chairman of the Division about the inequality of workload, drawing attention to Ledward's management style, and was simply told to "get on with it" (page 109)¹² while one senior consultant who confronted Ledward directly was told by him that he was "extremely foolish to do so". This consultant subsequently withdrew and "did not pursue the matter further" (pages 110–111).¹² At a very senior consultant level, the extent of shared concern was both expressed and concealed by euphemism: Ledward was referred to as a "bad penny" and his practice described as "not frightfully good" (page 111).¹² Despite their evident concerns, consultants did not seek resolution by reporting Ledward to an existing committee (set up specifically to deal with professional concerns about wrongdoing) known as the "three wise men" (page 113).¹² At the inquiry one consultant anaesthetist expressed the belief that organisationally there was "little anyone could do" (page 112).¹²

Managers were also reluctant to speak out. Ritchie heard that one district manager knew that consultants were concerned about Ledward's behaviour, including his surgery, but he did nothing.¹² Another senior manager admitted to being afraid of Ledward, and it seems that one senior nurse manager opted for containment and conciliation instead of voicing her concerns: she visited a gynaecology patient at home and acted as a buffer between angry women and Ledward. Like many of the nurses, those GPs who did have concerns about Ledward did not think it was their place to complain about a consultant and so they withdrew into silence.¹²

Discussion

This discussion of the Ritchie report highlights a central paradox of cultural censorship—namely, that knowledge (in this case, knowledge of malpractice in the NHS) can be both recognised and concealed. Perceptions of Ledward's "errors" depended less on his power and influence as a consultant than on institutionalised bonds of "rule breaking" within his clinical team, which served the very different yet compatible interests of himself and his juniors. These bonds were unintentionally reinforced by nurses' attempts to protect both themselves and their patients from further suffering, which had the effect of covering up for Ledward. In other words, it was not as Ritchie and others believe a "conspiracy of silence" which protected Ledward¹²; there was no conspiracy, but a case of cultural censorship in the NHS. Indeed, the evidence presented in the Ritchie report shows that there was no consensus on which to base a conspiracy. Opinions about the poor quality or otherwise of Ledward's practice were divided and consensus only emerged *retrospectively*.

It was noted above that cultural censorship may be an endemic problem of western health-care systems and not peculiar to the Ledward case; its characteristics have been identified in a range of other studies. This discussion focuses on four defining characteristics: problems of consensus, bonds of transgression, lack of resolution, and the paradox of things being both recognised and concealed.

Consensus

Lack of consensus that an adverse event had occurred was one of the strongest themes to emerge from the Ritchie report. The inquiry was told that it was difficult to do anything about Ledward because “almost every case they came across was a complication that could be explained” (page 111).¹² A similar theme is echoed in a number of research papers. A study of doctors’ responses to complaints found that, in the face of the anxiety generated and the perceived challenge to their expertise, doctors maintained a sense of control by redefining untoward events as “non-mistakes” that were part of the expected and accepted risks of medical practice.¹⁸ Doctors attempted to protect themselves by externalising the untoward event, including blaming the patients and their relatives for complaining in the first place, even to the extent of labelling them as “vicious” and “psychiatric”. Another study found that inequalities in power between nurse executives and physicians turned quality processes into a battleground, undermining the basis for consensus.¹⁹ A further paper highlighted the divergent ways in which nurses responded to wrongdoing and the variables which impacted on their perceptions of whether or not an adverse event had occurred.²⁰ Here nurses were of two kinds—those who reported every error or wrongdoing and those who reported none. Low staffing levels made it impossible for nurses to comply with quality standards and so wrongdoings emerged in the grey area between policy and practice. Similarly, the investigation into the North Lakeland Trust reported that nurses were divided in their perceptions over what counted as bad practice and remained so during and even after the inquiry.¹⁰

Like nurses, health service managers also have to deal with the gap between policy and practice, although in a different way. Managers are responsible for the implementation of policy, but their powers of enforcement are limited compared with the medical profession’s power to regulate itself and to construct errors as non-errors. This situation is further complicated by the absence of a shared language between managers and doctors which makes it difficult for them to arrive at a consensus about how to monitor and evaluate medical practice.²¹ The findings of these various studies illustrate that (a) lack of consensus is not exclusive to the Ledward case but pervades professional practice at all levels, and (b) a range of factors (political, professional, psychological, and organisational) impact on an individual’s perception of, and responses to, an

adverse event. In defining an event as “adverse”, context seems to be as important as content, if not more so.

Bonds of transgression

Another important aspect of cultural censorship is the collective tendency of some groups to engage in “bonds of transgression”.¹³ Here social solidarity is forged through infringements of recognised good practice, and groups operate according to a kind of inverted policy. In the Ledward case, inexperienced physicians undertook surgical procedures without supervision and it was tacitly understood that individuals would “cover” for each other’s transgressive acts.¹³ Many similar examples can be found in reports and inquiries scattered throughout the literature on organisational wrongdoing. The investigation into the North Lakeland Trust reported abuse of elderly patients and found that “a culture developed within the Trust that was described by stakeholders to the Commission for Health Improvement (CHI) as closed, inward looking and insular and which allowed ‘unprofessional, counter-therapeutic and degrading—even cruel—practices’ to take place” (page 12).¹⁰ Under this regime the whistle blowers (student nurses who were not part of the culture) suffered retaliation and were “intimidated and pilloried by other staff within the Trust . . .” (page 15).¹⁰ In situations such as this, staff who become uncomfortable about wrongdoing within their organisation are afraid to speak out and may even become implicated in such acts. In their paper on nurses’ responses to organisational wrongdoing, Orbe and King found that some nurses felt coerced into supporting wrongdoing.²⁰ One nurse felt unable to report that her nurse manager used her position to further the career of her lover; another turned a deaf ear to sexist language. “No [I haven’t] reported this” wrote the nurse in question, “I am a coward” (page 52).²⁰

Resolution

In cultural censorship there is a lack of resolution. People cannot ameliorate their suffering, find a way to redress their complaints and grievances, and are consequently unable to maintain a grasp on their personal, professional, and organisational lives and relationships. Resolution is central to our argument because it is this very lack of resolution—the individual’s recognition that attempting to resolve the situation will only make it worse—which sustains the conditions for cultural censorship. Reinforcing our analysis of the Ritchie report and, as other literature suggests, it is not only the fear of social isolation and retaliation but the fear of implication in another’s wrong doing which serves to maintain silence in the work place.^{10 20 22} As the examples above suggest, it is not only the less powerful groups within an organisation who may suffer in this way; GPs, consultants, and senior and middle managers may also encounter problems of resolution.^{18 21 22}

Paradox

For an understanding of organisational culture to move forward, it is essential that we appreciate a characteristic feature of cultural censorship—that adverse events can be widely known about yet simultaneously concealed. One NHS manager commented, “in my directorate it is recognised that things are concealed”. Bonds of transgression are the basis for this paradox, whether one is a willing party in transgression or drawn in through other motives. Workers in this position develop an “underground” language that refers euphemistically to the unofficial/forbidden event. In surgery, unqualified doctors who undertake unsupervised procedures are familiarly known to “have a go”. “See one, do one” is another euphemism for the common (but officially disowned) expectation that doctors need only see a clinical procedure once in order to perform it without supervision.

Conclusion

In the light of Roger Higgs’ remark that “helping people to break their silence, or to find their voice, hitherto unheard or unacknowledged, is one of our major moral imperatives” (page 247),²³ we now draw out the implications of our analysis for policy and practice in the health services. We suggest that cultural censorship is so deeply embedded in the system that policy makers and managers would be ill advised to put their faith in reporting schemes as a central plank in the shift to an open culture, although they have their place. The examples of cultural censorship presented above suggest, however, that reporting schemes are not neutral or value free, and that—as social scientists have been telling us for a very long time—such a belief is an illusion which only masks the interests such systems embody.²⁴ There are many identified barriers to reporting.^{25 26} Mandatory reporting schemes may create widespread anxiety amongst health professionals about their possible misuse, including fear of being subject to vindictive actions.²² As seems to be the case in one hospital,²⁷ under these conditions cultural censorship may become institutionalised despite the existence—or even because of—reporting schemes.

Our analysis also suggests that blame cultures are not necessarily “to blame” for cultures of silence; the process of reporting errors (or not) is far more paradoxical and ambiguous than that. As Sheriff found in Brazil and as we found in our own research, cultures may seem open but may really be closed.²⁸ Policy makers, managers, and professionals need to understand from the outset that resolution for individuals may mean remaining silent: the major challenge then is how to make it safe for people to come forward and speak out. Providing support to “whistle blowers” through, for example, “hot lines” may be helpful but should not be seen as solutions in themselves because cultural censorship and all it implies—bonds of transgression, knowing and concealing, lack of resolution for whistle blowers—is inherent in the way doctors and nurses are trained and work together. We know,

for example, that nurses have “to rely on the informal ‘underground’ aspects of their role to influence medical decision-making and to establish a supportive base from which to carry out their work of caring and healing” (page 21).²⁹ Rule breaking and the tacit understanding of its inevitability is part and parcel of organisational life in the NHS and, indeed, is often viewed as necessary to the smooth functioning of teamwork.³⁰

In this context, health service organisations need more supportive and transparent means of enabling people to speak out safely long before they are driven to whistle blow, as others also recognise.^{25 26} Here we can learn from the history of the NHS that what may be needed is someone within the organisation who has a degree of independence—is both an insider intimately acquainted with the organisation and an outsider with independent status.³¹ What is critical to resolution is the deployment of individuals who both understand the informal culture and are comfortable operating in the formal one, who stand between the two at the interface and have no vested interest in the outcome.

Our view is that reporting schemes need to operate alongside independent support systems of the kind we suggest, otherwise the danger is that the more effective—and therefore the more intrusive—professionals perceive reporting schemes to be, then the more likely it is that mishaps, mistakes and even malpractice will be pushed further underground and may flourish in the “underside” of organisational culture.¹³

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