Cultures of caring: healthcare 'scandals', inquiries, and the remaking of accountabilities

Abstract:

In the UK, a series of high-profile healthcare 'scandals' and subsequent inquiries repeatedly point to the pivotal role culture plays in producing and sustaining healthcare failures. Most notably, the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) which documents the failings at the Trust said to have contributed to the deaths of hundreds of patients between 2005 and 2009, was overwhelmingly a comment on the culture that existed at the hospital. More recently, the Report of the Morecambe Bay Investigation (2015), which documents the failings in maternity care at Furness General Hospital, provides a stark illustration of how uncompromising working relationships between different professional groups, unwillingness to question taken-for-granted practices, and zealous pursuit of professional ideology can combine to produce an organisational culture so dysfunctional as to culminate in the deaths of eleven babies and one mother.

Increasingly the government's response of choice to such 'scandals', inquiries are an emerging sociotechnology of accountability that signal a shift in how personal accountabilities of healthcare professionals are being configured. Moreover, in focusing on problematic organisational cultures, these inquiries acknowledge, make visible, and seek to distribute a collective responsibility for healthcare failures.

In this article, I examine how one particular inquiry – The Report of the Morecambe Bay Investigation (2015) – seeks to make culture visible and accountable. I question what it means to make culture accountable and show how the inquiry report enacts new and old forms of

accountability: conventional forms that position actors as individuals, where actions or decisions have distinct boundaries that can be isolated from the ongoing flow of care; and transformative forms that bring into play a remote geographical location, the role of professional ideology, as well as a collective cultural responsibility.

Keywords: Accountability, inquiries, culture, professional regulation

‘Inquiries into crimes and misdemeanours are becoming a way of life in Britain’s NHS’, says then editor of the British Medical Journal, Richard Smith in 2000. This observation was made during a period characterised as a ‘crisis in quality’ (Bevan, 2008) as a number of high profile healthcare ‘scandals’ were being investigated by inquiry including: paediatric heart surgery at Bristol Royal Infirmary (2001), the incompetent practice of gynaecologist Rodney Ledward (2000), the murderous conduct of General Practitioner Harold Shipman (2002-5), as well as post-mortem organ retention practices at Alder Hey (2001). Since then, this trend towards commissioning inquiries following healthcare failures has continued, with the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013), and the Morecambe Bay Investigation (2015) following in quick succession. Increasingly, it seems, the inquiry is the response of choice to healthcare failures.

Inquiries can vary from small internal investigations to statutory public inquiries commissioned by parliament. However, Walshe and Higgins (2002: 895) have noted a trend towards them taking the form of an ‘independent external investigation with full inquisitorial powers’. The purpose of an inquiry, they suggest, is to retrospectively examine events to establish what occurred and what lessons should be learnt, however, in healthcare their scope is increasingly concerned with the clinical performance of healthcare professionals.

Inquiries are often triggered by seriously troubling events: flagrant lapses in care or abuses of position. However, having these circumstances recognised as such can require sustained media attention and well organised lobbying by patient groups (Walshe and Higgins, 2002). Nevertheless, this does not explain why an inquiry should increasingly be considered the optimal tool for investigation and regulation. It has been suggested, in circumstances of public discontent, that inquiries serve a political agenda, conveying a sense of decisive action (Greer and McLaughlin, 2016; Walshe and Higgins, 2002; Smith, 2000) but perhaps it also suggests dissatisfaction with traditional forms of regulation for healthcare professionals.

Indeed, Walshe and Benson (2005) suggest that public faith in professional regulation is lower than ever before, something they attribute to the criticism of regulatory arrangements arising from Bristol and Shipman inquiries. Brown (2011) also notes how the series of failures mentioned above cast doubt on the medical profession's ability to regulate itself effectively. Professional regulation is often criticised for being protective of its members (Ehrich, 2006), even by doctors themselves; in light of Dame Janet Smith's review of professional revalidation following the conviction of Harold Shipman, Dr Roger Neighbour, then President of Royal College of General Practitioners, commented 'The GMC's proposals, prior to Dame Janet, much as we might wish them to have been adequate, were more appropriate to a golf club's membership committee' (2005: 241). Consequently, Waring et al (2010) argue that an era of managerial control has emerged in which NHS[i] institutions have encroached upon the authority of the medical profession to regulate itself. They identify three distinct causes of these regulatory changes; i) a restructuring of public services which resulted in market-like incentives and increased use of targets and measurement; ii) changing public attitudes towards expertise and risk exemplified by the state's management of clinical judgement in the form of protocols and guidelines; and (iii) public awareness of the profession's inability to prevent or respond to instances of medical misconduct as indicated above. Waring and colleagues suggest that this 'new' regulatory framework is characterised by an aim to demonstrate transparency of procedures, and independence from the profession and the state; aims to which inquiries also aspire.

Furthermore, societal tolerance for the 'behind closed doors' (Rosenthal, 1995) tenor of much professional regulation has been diminishing. Moran (2000:5) describes a transformation that occurred in UK society between 1950-2000, involving 'the destruction of deference' and 'a shift from a population of grateful subjects to a population of demand citizens'. Dixon-Woods et al (2011:145) support this societal repositioning by pointing towards the 'remarkable increase in the ability of the lay public to have its demands taken seriously' once transgressions were publicised through campaigning groups. In line with these shifting relations between, patients, doctors and regulatory

frameworks, Smith (2000) called for inquiries to be held in public to reduce suspicions of bias, corruption and incompetence, and Walshe and Higgins (2002) note the growing societal and legal expectation of openness. This move toward inquiries signals a shift in how professional accountabilities are being configured; it is a more public form of accountability, with greater external scrutiny and less reliance on professional self-regulation.

In addition to changing public expectations, understanding of the nature of the problem also appears to have evolved over the last decade or so, in that there has been particular emphasis on the role 'culture' has played in healthcare failures. This is most clearly exemplified by events at Mid Staffordshire NHS Trust[ii]. Here, blame is laid on 'an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities' (2013: 3). It is a sweeping indictment of everyone from healthcare assistants, nurses and doctors, to managers and executive members of the Board of Governors. The inquiry (2013:13) found that

> The culture at the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff; there was an atmosphere of fear of adverse repercussions, a high priority was placed on the achievement of targets, the consultant body largely dissociated itself from management, there was low morale amongst staff, there was a lack of openness and an acceptance of poor standards.

Mid Staffordshire was not the first time the culture of a hospital had been found wanting. The inquiry into paediatric heart surgery at Bristol Royal Infirmary characterised the hospital as having a 'club culture' with too much power in the hands of too few individuals (2001: 2). Moreover, the inquiry found the hospital's culture was such 'as to make open discussion and review more difficult. … Those who tried to raise concerns found it hard to have their voice heard.' (2001: 5)

In grappling with how 'culture' informs actions and responsibilities, inquiries are further reshaping accountabilities. Thus far, professional regulation has struggled to accommodate a relational form of agency. Instead, as Goodwin (2014: 57) has argued, frameworks of accountability are

> …premised on a model of practice that emphasises independence of thought and autonomy of actions, it posits decisions as discrete moments of an individual's cognition, and punctuates practice with moments wherein diffuse accountabilities crystallise on particular actors at particular times. … Conceptualising practice in this way strengthens the connection between action and outcome and reflects an overly deterministic impression of clinical decision-making.

Goodwin demonstrates the dependencies involved in collaborative work, how one relies on both the judgements and actions of others in shaping the context for one's own thoughts and actions and how such entanglements are erased from view in codes of professional conduct. Singleton (2012: 431) makes a related point about the erasure of contexts in accountability systems used to trace cattle movement. She argues,

> If the practices of being called to account are enacted as unsituated, … then they may be irresponsible. By irresponsible, here I mean insensitive to and dismissive of embedded, embodied, and collective practices. It is in these ways that the CTS [Cattle Tracing System] is irresponsible even though it calls farmers to account. It individualises farmers and cattle, it displaces, colonises, and replaces practices of responsibility.

In light of these criticisms of conventional modes of accountability, and with respect to the growing emphasis placed on 'culture' in recent healthcare inquiries, in this article I position inquiries as a sociotechnology of accountability and seek to explore how they are remaking accountabilities. To call an inquiry a 'sociotechnology of accountability' is to say that it is a set of knowledge-making

practices that carry assumptions, in this case about work, skills, cultures, how individuals and groups should and shouldn't interact, and about the proper distribution of work between different professional groups. It draws attention to a fundamental premise of Science and Technology Studies (STS), that the social, the scientific and the technical are irredeemably bound together, and that through these knowledge-making practices accountabilities are configured, and inclusions and exclusions are created. Although the rise of inquiries has been noted, it is a topic yet to be analysed through the lens of STS. In responding to this gap in the literature, I am interested to elicit how 'culture' is constituted and made visible, and in considering whether it can be made accountable in any meaningful way. Research and theorising in STS has elucidated how intensely entangled humans are with their material environment, with technologies, and with the thoughts, actions, practices of those around us, and with this in mind I seek to examine recent shifts in how accountabilities are configured and distributed amongst various entities – human, non-human, individual, and collective. While the context examined in this article is particular to healthcare, the conceptual problem – where one person claims or is made the author of collective (human and non-human) action – plays out in many different arenas. Prasad (2007:542) describes an analogous situation in the invention and patenting of MRI. He argues that the conflict 'arises because techno-scientific research occurs through distributed cognition involving different actors, and a claim for an invention requires individualized authorship of a novel development'. In science as in healthcare then, structures of authorship and accountability are built around individualised notions of cognition and action that are purified and idealised versions of how collaborative practices happen.

To explore recent attempts in healthcare to account for collective responsibilities I examine *The Report of the Morecambe Bay Investigation* (2015). This inquiry (chaired by Dr Bill Kirkup CBE, and hence known as the 'Kirkup Report') investigated the high rate of maternal and neonatal deaths at Furness General Hospital (FGH, one of three hospitals comprising Morecambe Bay Hospitals Trust) and found serious failures in clinical care resulted in 11 neonatal and 1 maternal death over a period of 9 years. The report examines clinical practice, responses of the Trust (internal investigations), and

external investigations. In this article, however, I restrict my focus to events at the level of clinical practice so as to facilitate detailed study of the relationship between the individual and the cultural, and how these accountabilities are configured[iii]. I first explore how the inquiry format structures accounts and accountabilities, I then examine how 'culture' is constituted and made visible in the Kirkup Report. In the final section, I discuss the new and old forms of accountability enacted by inquiry reports.

My analysis is informed primarily by three overlapping schools of thought, all of which have made important contributions to my understanding of how capacities for action are configured amongst persons and things. Firstly, the call to study practices symmetrically that emerged early in actor-network theory prompts an examination of how work gets done without presupposing who or what are the important actors. Agency is reconceptualised from an inherent capacity of individuals to a product of the relations between persons and things. As Suchman (2009: 4) puts it, 'human agency is always inextricably tied to the specific sociomaterial arrangements of which we are part'. Complementing this focus is the resonant concern within feminist studies of science and technology regarding who or what is and is not recognised in discourses of technoscientific practice. Suchman (2009: 7) again explains that feminist orientations have elucidated the (often ignored) labours essential to ongoing sociotechnical assemblages and the capacities for action they enable.

These lines of work have sensitised me to the invisible work that surrounds a dominant narrative. Invisibility stems from distinctions between foreground and background, action and embedding context, and is a point of contact with ethnomethodological studies of science and technology. Heath and Luff (2000) explain that in ethnomethodology the situation of action is far more significant than the notion of 'context'; actions are essentially dependent for their meaning upon the context at hand, rather than being 'influenced' by a background context. These preoccupations inform my desire to explore shifts in accountability, to see whether the inclusion of 'culture' works

towards a decentred form of accountability or whether in some way it consolidates traditional ideas about capacities for action.

HOW INQUIRIES STRUCTURE ACCOUNTS AND ACCOUNTABILITY

Before examining the forms of accountability inquiries enact, I first explore how their knowledge-making practices shape the forms of evidence on which inquiry panels adjudicate. The perceived independence and credibility of an inquiry is established in large part by the composition of the inquiry team. They are often chaired by a legally qualified person, such as a judge, who is assisted by a panel of experts with relevant content knowledge (Walshe and Higgins, 2002; Elliott and McGuinness, 2002). The merits of a strong legal framing have been noted as impartiality, skill in managing complex evidence (Elliott and McGuinness, 2002: 16), and the ability to conduct inquiries justly (Smith, 2000). Dingwall (1986: 505), however, suggests the primary purpose for the use of lawyers is symbolic in that the law's apparent independence of sectional interest serves to depoliticise the arising issues. Furthermore, Walshe and Higgins (2002) point to the 'subtle juridification' this legal framing lends the process. This finds expression in the way individuals are called upon to give testimony, cautioning them that their conduct may be questioned. Dingwall further suggests that in this quasi-judicial model the protection legal processes offer can be missing, for example, by expecting higher than average standards of practice. The authors of the Kirkup Report recognised, and attempted to ameliorate, potential juridification in order to engender a 'collaborative approach'; the interview protocol specifically noted that interviewees were not 'witnesses' and did not 'give evidence' (p207), however, a collaborative approach may have been undermined by the routine confiscation of phones, tablets, and recording devices during the interviews. Further, there is some dispute over the legal powers inquiries hold. Elliott and McGuinness (2002:15) stated that inquiries have 'no clear legal status', whereas Walshe and Higgins

(2002) claim that public inquiries (such as the Mid Staffordshire NHS Foundation Trust Public Inquiry) have wide statutory powers to gather evidence and require witnesses to appear. The Morecambe Bay Investigation was not commissioned as a '*public* inquiry' as this was not considered conducive to the privacy and tact the investigation required (2015:197). Thus, despite considerable insistence by the investigating team, there were still occasions when individuals refused to be interviewed. Demonstrating their editorial role, the panel note their disapproval in the report and even published one person's refusal letter in the appendices.

Regarding the inquiry's terms of reference and panel of experts, Elliott and McGuinness (2002:16) suggest that these 'may reflect the dominant paradigms regarding causality' which, in the train crash and stadia disaster inquiries they studied, required the appointment of engineering professors who focused on explicit knowledge and technical issues to the neglect of 'the social elements of the system'. Likewise, in the Morecambe Bay investigation, Dr Bill Kirkup CBE was appointed as chairperson by the Secretary of State. Dr Kirkup, a medical doctor (with prior experience of serving on inquiry panels), then appointed a panel of experts who, except for a professor of healthcare research and law, were all clinicians holding leadership roles in paediatrics, obstetrics, nursing and midwifery. 'Evidence' in healthcare inquiries usually takes the form of performance statistics (such as hospital episode statistics and mortality rates which are subject to expert statistical analysis), medical records and documents from organisations such as regulatory bodies, hospital trusts, and coroners. The review of medical records involves a specific approach that combines technologies of assessment with the panel's expertise. In the Morecambe Bay inquiry, all the medical records of maternal deaths, stillbirths and neonatal deaths between January 2004-June 2013 (plus others where concerns about care had been raised), were reviewed by a clinical member of the panel to identify 'notable factors' using a validated tool designed by University of Leicester. For those cases identified as warranting comprehensive review, this was followed by two clinical members of the panel assessing whether the (recorded) care met relevant benchmarks (16 sets of national guidelines). In each case, care was graded according to a 4 point scale of suboptimal care where 0

meant no suboptimal care and 3 meant major suboptimal care, again using an assessment tool designed and validated by the University of Leicester. Of interest are the definitions and judgements embedded within the grading scale. Grade 1 is where there is evidence of suboptimal care but different management would have made no difference to the outcome, grade 2 is as grade 1 but in which different management *might* have made a difference to the outcome, and grade 3 is as above but where different management *would reasonably be expected* to have made a difference to the outcome. Given the arguments presented earlier about the erasure of contexts and the strengthening of connection between action and outcome that occurs in documented accounts, one might surmise that a hindsight bias would be difficult to avoid.

In addition to documented evidence, individual interviews are undertaken, recorded and transcribed. While collating this evidence, considerable effort is made to conduct the inquiry transparently. Hearings may be conducted in public or transcripts made publicly available and reports are published (Walshe and Higgins, 2002). During the Morecambe Bay investigation, there were four 4 face-to-face meetings of the panel with affected families, the interview protocol was published as part of the report, and summaries of interviews published on the inquiry website. In the report, verbatim quotes are attributed to named individuals, and a list of interviewees and their job titles appended. Such public testimony makes for a particular kind of accountability. In its favour, it promotes transparency, builds public confidence that the inquiry has been conducted conscientiously, and potentially allows for a sense of justice and redress. However, it also individualises accounts, delineates one person's role and actions from another's, draws lines of responsibility between one person and another. Furthermore, the inquiry team exercise total editorial control over how the transcripts are utilised in the final report – inclusions, exclusions, and contextualisations are at the command of the inquiry team. Moreover, the attribution of accounts to named individuals can provoke already troubled working relationships, and the retribution whistleblowers can receive is well known[iv] . Consequently, Walshe and Higgins (2002) point out that inquiries can contribute to the assignation of blame and mechanisms for retribution.

When it comes to interpreting the evidence, Brown (2003:104) argues that the evidence is organised to align with the prevailing understandings of how people and organisations behave[v] . Indeed, a 'systems approach' is often evident; this involves tracing the lineage of 'mistakes' through the organisation to uncover the circumstances that produced such opportunities for error. As Dekker (2011: 33) points out, for more than 20 years the 'context' has been taken more seriously:

> We now regularly look for sources of trouble in the organizational, administrative, and regulatory layers of the system, not just the operational or engineered sharp-end. The shift from sharp-end failures and operator error to blunt end and organizational factors is certainly not complete, but at least legitimate today.

Often, however, the influence of these sources is not explicitly noted; the Kirkup Report contains no references to published sources – social science, human factors or otherwise. Despite this, in the summation of the report, a theory of 'drift' is employed to explain the disparity between practices at FGH and elsewhere. Snook (2000:194) developed the concept of 'practical drift' to refer to 'the slow, steady uncoupling of local practice from written procedure'. This happens because of the necessity for 'practical action' when formalised rules do not match the situation at hand:

> When rules don't match, pragmatic individuals adjust their behaviour accordingly; they act in ways that better align with their perceptions of current demands. In short, they break the rules. (Snook, 2000:193)

Over time, because of constant demands for local efficiency, practice drifts away from documented procedures. When these practices meet no resistance, they are reinforced and become institutionally accepted (Snook, 2000:194), and being passed on through processes of socialisation, drift continues largely unchecked. However, it may be Dekker's (2011) formulation of 'drift into failure' that is being employed. Dekker, a human factors analyst, has perhaps more currency in healthcare literature. Dekker (2011:14) describes 'drift into failure' as:

> Local decisions that made sense at the time given the goal, knowledge and mindset of the decision-makers, can cumulatively become a set of organised circumstances that make the system more likely to produce a harmful outcome. Locally sensible decisions about balancing safety and productivity – once made and successfully repeated – can eventually grow into unreflective, routine, taken-for-granted scripts that become part of the worldview that people all over the organisation or system bring to the decision problems.

In this formulation, and alongside Snook, Dekker explicitly draws on the influential work of Turner (1978), Perrow (1984), and Vaughan (1996), who have respectively emphasised the man-made, normality, and cultural bases of organisational failure. Dekker (2011: 39) further suggests that from the inside, drift is invisible:

> From the outside, such fine-tuning constitutes incremental experimentation in uncontrolled settings. On the inside, incremental nonconformity is an adaptive response to scarce resources and production goals. This means that departures from the norm become the norm. Seen from inside people's own work, deviations become compliant behaviour.

'Deviations' as compliant behaviour is an insight most clearly articulated in Vaughan's concept of the 'normalisation of deviance'. She intricately traced the factors that combined to produce a cultural disposition among NASA engineers and managers towards the rationalisation of risk and the normalisation of deviant findings. Vaughan (2016: 65) says:

> By "normalized", I mean that behaviour the work group first identified as technical deviation was subsequently reinterpreted as within the norm for acceptable joint performance, then finally officially labeled (sic) an acceptable risk. They defined evidence that deviated from an acceptable standard so that it *became* the standard.

> … The work group brought their construction of risk and their method of responding to problems with the SRB joints to the next incident when signals of potential danger again challenged the prevailing construction of risk. Risk had to be renegotiated. The past – past problem definition, past method of responding to the problem – became part of the social context of decision making.

By 'normalization of deviance' Vaughan does not mean that inappropriate behaviour gradually became more normal. Rather, Vaughan is at pains to explain the conditions of uncertainty within which the engineers worked and how their 'precise, objective, and rule-following' practice conveyed an image at odds with this uncertainty. Moreover, the idea that rule-following is inherently good and 'drift' inherently bad has been questioned. Rowley (2011), for example, shows that sometimes interventions that aimed to secure safety jeopardise it (as in the case of inferior quality 'single-use' equipment designed to counter the risk of cross infection) and that safety can be achieved more effectively through innovative – but deviant – practices (as when re-usable items of emergency equipment that perform better than their single-use counterparts are used as single-use). Implicit though they may be, theories about the causes of organisational failure make their way into inquiries and, in the Kirkup Report, find expression in the emphasis on culture and the utilisation of 'drift' as a way of explaining events.

In summary, inquiry panels have wide discretionary powers to define the scope and nature of the problem. The credibility and authority of the inquiry draws, in large part, from the prestige of the inquiry team, and the legal framing conveys independence and objectivity. Evidence, which takes the form of statistics, documents, medical records and personal testimony, is structured towards individualisation of accounts and the allocation of personal responsibilities. Evidence is selected, scrutinised and edited by the inquiry team, giving them considerable latitude to shape what is considered, how it is framed, and of course, to conclude on the matter. This evidence is arranged

according to current understandings of organisational failure which have introduced the concept of 'culture' into explanatory frameworks. Transparency is achieved through making the evidence, the process, and the findings publicly available, but potentially comes at the cost of provoking troubled working relationships and exposing 'whistleblowers'.

MAKING 'CULTURE' VISIBLE

Given that the structure of inquiries leans towards the individualising of accounts, 'culture' as a cause of healthcare failures presents a tension in how an individualising framework might accommodate collective responsibilities. Demonstrating the priority 'culture' has attained, the Francis Report, positioned 'culture' as a cause and explanation of healthcare failures. The inquiry found in existence:

> 'a culture of fear in which staff did not feel able to report concerns; a culture of secrecy in which the trust board shut itself of from what was happening in its hospital and ignored its patients; and a culture of bullying, which prevented people from doing their jobs properly.' (p10)

A culture of fear *explains* the non-reporting of incidents, a culture of secrecy *explains* the denial of appalling standards of care, and a culture of bullying *explains* why people didn't do their jobs properly. This positioning of culture as a cause and explanation of healthcare failures has become commonplace in contemporary discourses on patient safety, it posits cultural change as a lever for improvements and introduced a growing number of cultural assessment tools that aim to disaggregate and measure cultures (for an evaluation of such tools see Mannion et al, 2009). However, sociological work around patient safety has problematised the implicit conceptualisation of culture as something that can be known and manipulated in predictable ways. Hillman et al

(2013), for example, illustrate how the implementation of a falls reduction target on elderly care wards unintentionally created cultures of restriction that undermined the independence and dignity of patients. Davies and Mannion (2013) question the assumption that culture is somehow contained within a workplace. They point out that Mid Staffordshire Trust was responding to a policy drive towards foundation status (giving Trusts more independence than standard NHS Trusts). They therefore call for more sophisticated understandings of cultural dynamics and their relationship to healthcare policy (Davies and Mannion, 2013).

Moreover, from the perspective of one schooled in STS (particularly an ANT-version of STS), the status of culture as an explanation is problematic for more fundamental reasons. Law makes the argument in relation to 'the social', but the rationale applies equally to 'the cultural'; he suggests that 'the social' is not pre-given but a product of a network or system. As such, it cannot serve as an explanation, but is itself in need of explanation:

> … any move to a system logic tends to undo social foundations as an explanatory resource. This is because it assumes that since systems have their own relational logic, the latter is likely to reshape the social just as much as the technical. And this in turn means that the social is unable to explain anything. Though it exists, it is just as much in need of explanation as the technical. (Law, 2008: 631-2)

Latour (1984) had applied the same reasoning to 'power', repositioning it from something that explains differences of privilege to a *consequence* of social relations and thus something to be explained. The message is that culture should not be viewed as a homogenous and stable entity that acts on others but something that is relational and evolving, that both informs and is informed by those relations, consequently, it is *how* particular cultures come into being that interests me. The Kirkup report uses the term 'culture' sparingly, mostly when interviewees use the term. However, it gives a strong sense of the culture of the unit by paying detailed attention to themes of repeated failures of knowledge and skills, sets of routinely substandard practices, persistently dysfunctional

working relationships between different staff groups, the geographical and professional isolation of the unit, and particularly for midwives, the role of professional ideology. It is clear that when taken together, these are conceptualised as constitutive of the unit's culture as the report states: 'The Trust has made significant progress recently, but it is essential that this is maintained, and *organisational culture is notoriously resistant to change*' (p185, my emphasis). In effect, then, the Kirkup Report provides a window on the constellation of elements that produced an organisational culture conducive to perilous failures in the care of pregnant and labouring women and their newborns, and it is this I would like to explore.

The term 'culture' has a chequered past and its usage connotes different things at different times to different people (see Kuper (1999) for a history of how the term has been employed in anthropology). However, for my purposes, Traweek's (1992:437-38, original emphasis) explication is helpful:

> To anthropologists, 'culture' is not all about vestigial values, 'society' is not all bout agonistic encounters, and 'self' is not about autonomy and initiative. A community is a group of people with a shared past, with ways of recognizing and displaying their differences from other groups, and expectations for a shared future. Their culture is the *ways*, the strategies they recognize and use and invent for making sense, from common sense to disputes, from teaching to learning; it is also their ways of making things and making use of them and the ways they make over their world.

Martin (1998: 36, my emphasis) likewise explains, 'We are not looking for a thing; we are seeking to understand *processes* by which things, persons, concepts, and events become invested with meaning.' I'm interested in *how* culture was made at the maternity unit of FGH, how practices and interactions came to take the shape that they did. The Kirkup Report, however, gives me a particular view on this, one filtered through its authors. Whilst Brown (2003:97) points out the value of inquiry reports for rendering visible 'what are often latent aspects of organizations, sheds light on how

people make sense of complicated and problematic social situations, and how low-probability, high-consequence events are dealt with', Suchman (1995:63) reminds us that

> culture is always relational. Rather than describing attributes of a population from some neutral position outside the field of view, accounts of cultural meanings and practices are inevitably created from particular standpoints that set up the lines of comparison and contrast between the speaker/writer and the persons and practices described.

Like ethnographers, the authors of the Kirkup Report are writing culture, a process that enfolds both authors and subjects. Therefore, rather than taking the report as a 'true' description of the culture and events at FGH, I examine how culture is configured and made visible in the Kirkup Report, a process that elucidates both the perspectives of the authors and the practices of the healthcare workers at FGH. I examine to what effect culture is made visible, specifically, if and how it reshapes accountabilities.

As mentioned above, the Kirkup Report gives detailed attention to clinicians' substandard knowledge, skills and practices, persistently dysfunctional working relationships between different staff groups, the role of professional ideology, and the geographical and professional isolation of the unit. It is to these themes I now turn.

Dysfunctional working relationships

Early in the report, lines of division are drawn in the working relationships between the different professional groupings:

> We found that none of these groups [midwives, obstetricians and paediatricians] were able to work effectively together, with repeated instances of failure to communicate important clinical information about individual patients. We were told that there was a "them and us" culture in the unit. (p13)

A language of 'them and us' has elsewhere been noted to characterise interactions between midwives and obstetricians (Foley and Faircloth, 2003: 173), here, however, the insularity of professional groupings produces a problematic lack of communication:

> The obstetricians have poor working relations with the paediatricians and the paediatricians do not have good relations with each other. More than one paediatrician described the paediatric consultants as "a dysfunctional team". The relationship between the obstetricians and the midwives is, we believe, more subtle and is reflected in their clinical practice, with evidence that the midwives sought to avoid involvement of the obstetricians in the care of their patients, while the obstetricians remained content to wait to be called (and sometimes then to be dismissed again as no longer needed). (p64)

The report gives examples of how poor clinical knowledge was exacerbated by the reluctance to collaborate; obstetricians delivered babies of high-risk mothers in the unit (rather than transfer them before birth to better equipped clinical settings) against the advice of the paediatricians. Paediatricians, however, were also unwilling to transfer babies to other clinical settings; they adopted a 'wait and see' approach with babies likely to need neonatal intensive care, missing the optimal time for transfer and necessitating difficult emergency transfers. The relationship depicted between the midwives and the obstetricians is one of disengagement; obstetricians are cast as complacent, content to be excluded, and midwives are portrayed as fiercely protective of their 'normal childbirth' boundaries. The report documents how midwives took exclusive control of the risk assessment process for pregnant women and, often without discussion with the obstetricians, repeatedly misclassified women as 'low risk' and therefore to be cared for by midwives alone.

That professional boundaries play a role in securing or threatening patient safety is not news. Indeed, Dixon-Woods (2010:16) identified safety as a 'site of organizational and professional politics' and highlighted how junior staff can struggle to draw attention to problems, and equally, how those

of parallel standing could refuse to defer to colleagues, both situations that incurred negative consequences. However, what is interesting about the situation at FGH is the insight if offers as to how professional ideology plays into professional politics and boundaries.

Professional ideology

The role of the midwife is to support women in pregnancy and childbirth irrespective of the level of intervention they require. However, in the UK, if pregnancy and childbirth are deemed to be 'normal', midwives can legally provide total care without involving obstetricians (Gould, 2000)[vi]. Nevertheless, the rate of medical intervention in ostensibly 'low-risk' births has been a longstanding concern within midwifery and obstetrics (Johanson et al, 2002) and for the previous 12 years the Royal College of Midwives' campaigned for 'normal birth' indicating its importance as a site for political action. The characterisation of 'normal' from 'high risk' births is both a routine, but deeply political, part of midwifery work that defines the scope of autonomous practice and secures, within its boundaries, the authority of midwifery knowledge. 'Normal' or 'natural' (the terms are used synonymously in the report) childbirth is thus a concept central to midwives' occupational identity and legitimates their autonomy of work (Foley and Faircloth, 2003:183). At FGH, however, the enthusiasm with which women were categorised as 'normal' and thus eligible for midwifery-led care received particular criticism:

> midwifery care in the unit became strongly influenced by a small number of dominant individuals whose over-zealous pursuit of the natural childbirth approach led at times to inappropriate and unsafe care. (p13-14)

In other circumstances enthusiasm for a philosophy of 'normal birth' and the valuing of low intervention rates has been associated with reducing 'unwarranted' intervention and lowering Caesarean Section rates (Johanson et al, 2002). To an STS audience, the problematic status of 'normal' and 'natural' – its slippery and value-laden character – is well understood (for example, see

van Hilvoorde et al (2007) for a discussion of the natural and the artificial in elite sport). Moreover, Vaughan elucidates how the need to balance competing risks can work to support the dominant ideology of practice. She explains how the concept of 'acceptable risk' was utilised by NASA engineers and managers to amend the design of the spacecraft rather than redesign thus affirming the dominant ideology of the engineers: a belief in technological redundancy. The Kirkup Report, however, is silent on the competing risks involved in the risk assessment process and it portrays the actions of the midwives as a classic example of 'boundary work' (Gieryn, 1993: 784) in which distinctions are made between the practices of one group and another for professional gain. Gieryn (1993: 792) argues that boundary work is likely to be employed in circumstances 'when the goal is protection of autonomy over professional activities'. Accordingly:

> We also heard distressing accounts of middle-grade obstetricians being strongly discouraged from intervening (or even assessing patients) when it was clear that problems had developed in labour that required obstetric care. We heard that some midwives would "keep other people away, 'well we don't need to tell the doctors, we don't need to tell our colleagues, we don't need to tell anybody else that this woman is in the unit, because she's normal'. (p14)

Portrayed in this way, the midwives are cast as vehemently resistant to obstetric input, and wilfully courting risk. Following Vaughan (p133), however, it is possible to see the midwives actions as one of conformity; the midwives actions could be understood as attempts to uphold their professional philosophy of promoting 'natural' childbirth.

Moreover, the authors of the Kirkup Report figure culture as a pernicious vector for the 'spreading' and location for the 'embedding' of erroneous practices: 'these incorrect and damaging practices spread to other midwives in the unit, probably quite widely' (p14) and 'this deeply flawed approach became more widespread and embedded in the practice of the unit (p64)'. The excerpt below describes how an insular culture perpetuated events.

> Based on what we heard, we believe that staff reinforced each other's view that the care they were providing was acceptable, not sub-optimal. The midwifery staff were already a close-knit group (we heard that off-duty midwives would drop into the unit just to chat), and it is clear that in response to this perceived external threat they developed a 'one for all' approach, and in fact described themselves as "the musketeers" [reference to email correspondence between 2 named midwives]. (p17-18)

Here then, it is suggested that the midwives closed ranks when their autonomy appeared to be threatened. The 'musketeers' label, emblematic of the protective, uncritical predisposition that characterised professional self-regulation until recently, readily lends itself to scandalising the public and thus dominated press coverage of the inquiry.

Geographical and professional isolation

The report conveys the culture of the midwifery unit as one strongly influenced by the ideology of 'normal childbirth' which functions to provide freedom from scrutiny, it is a culture that is exclusive, protective and almost sealed off from outsiders. In building this picture, the report is focused largely, but not exclusively, on humans; care is taken to outline how organisational structures and geographical location contributed to the problematic culture of the unit and its management. It is noted how repeated service reconfigurations distanced the unit from its higher level managers and, below, how the geography of the region contributes to the insular culture:

> Barrow-in-Furness is a relatively inaccessible town comprising a pocket of post-industrial deprivation on the edge of an area of scattered, rural, more affluent communities. Many of the non-medical staff were born and raised in the town, trained in the hospital and have worked there ever since. Medical staff have proved hard to recruit and there has been little opportunity for joint working or shared

> experience with other sites. All of this has contributed to the isolation of the hospital and its clinical practice. In such settings, practice can 'drift' away from the standards and procedures found elsewhere, and this can remain undetected until it has deviated a long way and obvious problems develop. In the maternity services at FGH, this 'drift' involved a particularly dangerous combination of declining skills and knowledge, a drive to achieve normal childbirth 'whatever the cost' and a reckless approach to detecting and managing mothers and babies at higher risk. (p183)

Loosely employing a metaphor of 'drift', one gets a sense of cultural detachment that distances staff and practices from reference points (standards and guidelines, or how practice happens elsewhere) and the internal affirmation of the sufficiency of care discourages ownership and responsibility for adverse outcomes when they occurred.

NEW AND OLD ENACTMENTS OF ACCOUNTABILITY

As Suchman (1995: 63) observes, 'Things are made visible so that they can be seen, talked about, and potentially, manipulated' and in the Kirkup Report culture is depicted so that its effects might be known and in some ways addressed. However, culture is not an independent thing to be held accountable, but something constituted by practices, shared ways of working, patterned interactions, and materialised in overstretched managerial structures. These are collective, distributed and non-human forms that conventional frameworks of accountability struggle to accommodate. Next, therefore, I consider the forms of accountability enacted in the Kirkup Report and the continuities and discontinuities with conventional forms of accountability.

i) Individual and decontextualised

The Kirkup Report goes to some length to untangle the events, relationships, and circumstances seen to contribute to the problems at FGH. Yet, in the final analysis, a conventional and individualised form of accountability takes priority:

> The prime responsibility for ensuring the safety of clinical services rests with the clinicians who provide them, and those associated with the unit failed to discharge this duty over a prolonged period. (p183)

By the end of 2008, it states, the problems 'must have been obvious to experienced staff within the maternity unit' but that 'the response remained shaped by the dysfunctional nature of the unit' (p16), treating incidents superficially and as isolated events and with defensive, inadequate investigations. One specific midwife, the maternity risk manager (named in the report), is highlighted for the distinct role she played:

> we believe that she was part of the close-knit midwifery group of 'musketeers' and, as a former Royal College of Midwives union official had continued to act in a staff representative role supporting individual midwives. She was central to deciding whether and how incidents would be investigated, often by herself. (p17-18)

Here, collective cultural responsibilities are backgrounded and at the foreground is one particular midwife and an individualised form of accountability. Her approach to the investigation of safety incidents was characterised as inadequate, overprotective, and seen to feed the midwives' perception that they were being unfairly criticised. In response to a series of 'difficult questions' the Trust solicitor had compiled, the maternity risk manager is reported to have prepared and circulated a set of 'model answers', a response the panel identify as 'clearly wrong' (p19). Moreover, a compelling account of the wrong-doing of the midwives involved, and particularly the maternity risk manager, is constructed by noting the unexplained disappearance of key clinical records and detailing how one line of defence, that a neonate was not hypothermic, changed in the face of

incontrovertible evidence to a defence of ignorance, by all midwives involved, as to the significance of a low temperature in a neonate (a cardinal sign of infection that should trigger medical review).

At this point all contextualisation is absent and, as Vaughan (2016: 70) states, 'Robbed of the social and cultural context that gave them meaning, many [actions] became hard to understand, controversial, and, in some cases, incriminating'. Whilst it might not mitigate the circulation of model answers, one could note that the maternity risk manager had been working within a model of professional regulation that, for the most part, operated 'behind closed doors' where informal and quasi-formal mechanisms of self-regulation and non-criticism had long reigned (Rosenthal, 1995), and its collusive, protective nature had been for a long time, if not condoned, at least accepted. In this sense, light touch, internal, and informal mechanisms of self-regulation were entirely in keeping with the prevailing norm.

She is not alone, however, in being attributed personal responsibility as the clinical director of the Obstetrics and Gynaecology unit also receives severe criticism. The report notes how 'it was difficult to identify evidence of strong and decisive leadership' (p59). Moreover, he faced sharp questioning at interview:

> "You are a clinical director yet you don't ask questions of your consultants. You don't ask questions of the head of midwifery, even though you're accountable for the quality of the care in the Unit. You push things up to the chief executive and you don't follow up when things don't happen. I don't get what your professional role is as clinical director. Everything seems to flow through you. I don't understand what you do."
>
> His response was
>
> "Tell me, what do you expect more? If you have concern, you express your concern to your superiors. What more can you do?" (p59-60)

This is one of the few occasions in the report when the *interviewers* are quoted verbatim. In doing so, the authors convey how hard they pressed the Clinical Director to account for his inadequate leadership and highlight his striking denial of responsibility.

Although individualised forms of accountability are conventional, when individuals are held accountable for collective norms and practices the outcome, rightly or wrongly, is resentment:

> …the strong view amongst staff that they were being unfairly criticised on occasions became overt hostility to those challenging this view. This underlying feeling was evident at times from the approach taken by interviewees in responding to our questions, and was sometimes apparent in email correspondence. The most notable example is an email from one midwife to another concerning a Nursing and Midwifery Council (NMC) investigation that was entitled 'NMC Shit' [the names of the midwives and date of the email are footnoted in the report]. (p18)

In an environment adrift from contemporary working practices, wherein substandard care had been normalised, and believing that upholding the normality of birth equates to fulfilling professional obligations, then being singled out and penalised for collective values and practices feels unjust and invokes responses of denial and resistance. Sagan (1993) comments that human errors and organisational failures are political events for which credit and blame must be assigned and such allocations often serve to protect the interests of the most powerful, therefore, finding 'operator error' a cause is more likely in hierarchical and tradition-bound organisations. Moreover, the 'naming and shaming' exemplified in the report's structure (of attributing documentary evidence and quotations to named individuals), the verbatim quotes of sharp questioning and resistance to criticism is, as Greer and McLaughlin (2012: 289) observe, a form of 'ritual public punishment and humiliation'.

ii) Individual yet contextualised

Despite embracing the individualised accountability stripped of context as above, sometimes there is a careful noting of circumstances that have shaped, and perhaps mitigate, an individual's role. This form of accountability is an attenuated version of the conventional individualised form seen above. Here, in contrast to the Clinical Director of Obstetrics and Gynaecology, the Clinical Director of Paediatrics' efforts to change practice are described in detail; he wanted to spend a day/week working with the FGH consultants, joining them on their ward rounds. However, this intervention was perceived as intimidating and resulted in written complaints about the clinical director's 'bullying and intrusive management style' and management training for the Clinical Director . As Prasad (2007:545) points out, 'articulation of agency occurs in a particular way in order to strengthen a claim'. In the report, the paediatrician's attempts to change practices and the constraints he met are recovered, strengthening the impression of this individual as one who takes responsibility, recognises problems and acts accordingly, even in the face of widespread inertia. The panel's more sympathetic treatment is perhaps evoked by the paediatrician's insight and readiness to share responsibility:

> He said that he believed there are issues at all levels, and made the point that if there are many reasons for the quality of services to be poor, no one individual feels responsible… In relation to the clinical incidents, the clinical director felt that the midwives became disproportionately the focus of attention, and that the paediatric team, himself included, was overlooked and bypassed. He also believed that the obstetricians were less in focus than they should have been (p60)

The paediatrician frames events in terms of 'a problem of many hands': 'a problem that arises in contexts where multiple actors – organisations, individuals, groups – each contribute to effects seen at system level, but it remains difficult to hold any single actor responsible for these effects' (Dixon-Woods and Pronovost, 2016: 485). In this sense, as Tombs and Whyte (2007) have argued, systems that seek to individualise blame and responsibility can obstruct proper redress rather than assist it,

and indeed, the paediatrician also makes this point, suggesting that level of blame attributed to the midwives was disproportionate and that the role of obstetric and paediatric consultants deserved wider recognition. The scandalising 'musketeers' label made the midwives an easy target and perhaps deflected attention from the obstetric and paediatric consultants, or perhaps it is another manifestation of the hierarchical and gendered working relations in healthcare, along which lines culpability for failures is distributed accordingly.

iii) Collective (human)

So although named individuals are singled out for attention, the type of attention they receive is carefully differentiated. Some individuals, it seems, were felt to be more culpable than others. However, there are also attempts to introduce a collective form of accountability, particularly in repeatedly highlighting the lack of awareness and questioning of a dysfunctional culture:

> It is evident that none of these manifestations of poor working relations are in the best interest of patients, but there is a lack of awareness among staff of their responsibility to help solve these problems. (p64)

Throughout the report, the lack of challenge is frequently noted conveying a sense in which everyone is implicated in the complacency seen to sustain the problems for so long. Nevertheless, the ease with which one might raise a challenge is not shared equally amongst practitioners, as Martin and colleagues note (2015: 635), 'the capacity to respond is itself unevenly distributed and enmeshed within complex configurations and logics of power.' Accordingly, the authors of the Kirkup Report focus particular attention on the obstetricians:

> Obstetricians working in the unit were well-placed to observe these lapses from proper standards, and it is clear that they did, but seemingly lacked the determination to challenge these practices. (p14)

According to the Kirkup Report, obstetricians observed these practices and understood the risks they held. They were in a position, practically and authoritatively, to act but failed to do so. Accountability is shared across the obstetric consultants yet their lack of action is decontextualised. Aveling and colleagues (2016:228) observed that when problems become so naturalised they are either invisible or considered inescapable, this has 'the effect of depressing aspirations and normalising low expectations for quality of care, so that opportunities to improve care even when it was possible to do so were neglected.' If the primary purpose of inquiries is to 'learn lessons', then the effects of normalising low expectations would be worth noting. .

Below, the lack of challenge is again noted, though the implication here is not one of complacency but lack of understanding:

> … A third [interviewee] told us that there were "a couple of senior people who believed that in all sincerity they were processing the agenda as dictated at the time… to uphold normality… there've been one or two influential figures who've perpetrated that sort of approach and there's nobody challenging…"' (p13-14)

This comment goes some way to explaining the midwives' resistance to blame to which the authors of the Kirkup Report took such exception. The attribution of blame feels unjust, not just because individuals are held accountable for collective action, but because through their cultural lens, their actions were not wrong, they were 'normal'. They were doing what, as midwives, they were charged to do – uphold the normality of birth. As Aveling et al (2016: 223) put it, 'The deeply ingrained nature of guiding norms meant that some actions and omissions were not readily visible to some staff as violations of standards for which they should have to account.'

To address the dysfunctional working relationships between the different groups of practitioners, the Kirkup Report specified certain measures which allow for 'guiding norms' to be exposed to a wider audience and cast in a different light. The Trust should:

> promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within the terms of employment. (p185)

Although mandatory cooperation is something of an oxymoron, this measure does at least attempt to make porous the boundaries between different professional groups and stress the overlap between paediatric, obstetric, midwifery and neonatal practices.

iv) Collective (non-human)

Debates around non-human agencies have developed understanding about its specificities and relationality,– in that agency need not be characterised by intentionality, that unconscious or inert things can contribute to the shaping of events as much as intentional human actors, and that 'actions' are not bounded, discrete entities, they occur in relations (see Goodwin, 2008). Likewise, then, a deeper understanding of how non-humans can be incorporated in collective forms of accountability is required. Non-human elements cannot be held accountable as humans are, as they do not act in the same way. In the Kirkup Report, making culture accountable meant tracing relationships, making visible their shaping of events, following the threads that connect practices to professional ideologies, elucidating how a remote geographical location can contribute to sets of practices detached from national standards. Acknowledging this remoteness, the Kirkup Report insists staff at FGH connect with national standards of practice, possibly necessitating periods of practice elsewhere. The Trust should:

> review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against

> all relevant guidance from professional and regulatory bodies … and identify requirements for additional training, development and, where necessary, a period of experience elsewhere. (p185)

These measures aim to re-establish connections with wider reference points – professional guidance and standards of practice as they are interpreted and enacted elsewhere. Relations, then, are to be forged in ways that aim to ameliorate the remoteness of the geographical location. Henke (2007:136) highlights the need to understand the ecology of built environments as this illuminates 'a specific history of growth and improvisation in response to structural constraints' and 'helps us to see the full complexity of risky places'. Illustrating Henke's point, the authors of the Kirkup Report attend to the role played by the built environment in facilitating multidisciplinary teamwork. The Trust:

> should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour (p187)

Here, the proposed adaptations embed a set of responsibilities into the built environment. By permitting knowledgeable observers – midwives and obstetricians – particular views on activity, the built environment confers a responsibility on the viewer to act or intervene, should the situation require it. So in a network of relations where practitioners are as skilled and knowledgeable as they ought to be, and where their practice can be observed, the built environment would work against the kind of complacency of being excluded discussed above.

CONCLUSIONS: THE REMAKING OF ACCOUNTABILITY IN INQUIRY REPORTS

I have proposed that inquiries are a sociotechnology of accountability that is gaining in prominence. It does not replace regulation by professional bodies[vii], but it does augment the existing moral, legal and professional ways in which a practitioner's actions may be scrutinised and held to account. Inquiries are different to pre-existing forms of accountability in many ways but, in particular, it is worth noting that they cut across professional boundaries, a factor that disposes them well to examine the connectedness of actions and relations between actors. Additionally, Greer and McLaughlin, (2016: 15) note the likelihood for inquiries to 'connect individual scandalous transgressions with systemic institutional failings'. Therefore, we have a sociotechnology of accountability that, although it is constructed in such a way as to lean towards conventional, individual forms of accountability, current understanding of organisational failure as well as the breadth of the inquiry allow for the visibility of interprofessional relations and predispose the inquiry to look at organisational and collective factors. These features go some way to explaining the proliferation of forms of accountability enacted in the Kirkup Report and place inquiries squarely at the heart of the individual-collective tension in accountability. In respect of this tension, Goodwin (2014:57) has argued that what is needed is 'a model of accountability that can address relations rather than individuals' as in current forms of professional regulation 'the distributedness of decisions, and the dependencies of collaborative work, escape recognition'. To a degree, the use of culture in the Kirkup Report works towards this aim. The report makes culture visible through depicting routine practices and patterned interactions, through attending to how the remote location and the built environment of the hospital contributes to the way practice develops (or 'drifts') over time. Yet, despite frequently aired concerns about the potential for collective forms of accountability to diminish individual accountability (see for example Wachter and Pronovost, 2009, and subsequent debate), this is one thing utilising culture in the Kirkup Report has not done. Collective forms of accountability are not replacing individual ones, rather forms of accountability are proliferating, and inquiries are thus extending existing technologies of accountability.

What does it do then, to make culture visible? It casts light on how the depicted relations between practitioners are informed by the politics of organisations, (such as midwifery professional bodies that valorise 'natural birth'), how this plays into the politics of work within an organisation such as FGH, and the effects this can have on safety. Since the publication of the Kirkup Report, the Royal College of Midwives have ended their campaign for 'normal birth'. Some commentators deny this is a response to events at FGH and subsequent inquiry, positioning it as a general progression of the campaign in response to a changing social and cultural environment (Hundley and Teijlingen, 2017). However, the focus the Kirkup Report placed on the negative consequences zealous pursuit of professional ideology can hold is unprecedented and was widely reported in the news media. It therefore seems reasonable to surmise that the Kirkup Report made a significant contribution to the 'changing social and cultural environment'.

I also scrutinised the format of the inquiry and how this structures accounts and allows particular views on events to emerge. At each point in its construction, details, contexts, and perspectives are introduced and filtered out. The report is compelling, yet I have tried to resist being swept along by the authority of the report and its narratives of culpability and instead remain alert to the authorship practices of the investigating team, in particular where contexts are included and where they are absent, for it is in these contextualisations that accountabilities are conferred and mitigated, and where culture is constituted and made visible.

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[i] Healthcare in the UK is primarily delivered via the 'National Health Service' (NHS). The NHS was established in 1948 on the principles of providing universal coverage, financed through general taxation and therefore free at the point of use. These principles persist although in a more diluted form. Some people choose to supplement this provision with private healthcare and there have been considerable attempts to introduce market forces into the structure and financing arrangements of hospitals and general practice, most notably by successive conservative governments in the 1980s. Therefore, the UK has a state-owned system of healthcare which co-exists with private insurance schemes and privately owned profit-making hospitals and clinics. Doctors enjoy considerable autonomy and commonly work within the NHS and privately (Bradby,2009). These changes to the organisation of the NHS, along with broader moves to increase the transparency and accountability of medical decision making, have resulted in a complex and non-uniform landscape of medical practice, authority and autonomy. Consequently, Dopson (2009:50) argues that despite all the organisational changes, 'The evidence does not support the idea of the medical profession losing power (indeed medical power remains strong and influential in healthcare delivery) and managers gaining it, but suggests a more complex picture with some professionals gaining, others losing ground and others adapting and taking on managerial responsibilities.'

[ii] An NHS Trust is an organisation within the NHS serving either a geographical area or specialist function (eg ambulance service). In the context of this article, 'Trusts' refer to a number of hospitals, serving a particular geographical area, governed by one executive board. The Board has oversight of financial and governance arrangements.

[iii] Investigation of the governance arrangements of the Trust Board and overseeing bodies such as Monitor makes up a significant proportion of the report and, particularly the activities of the Trust Board in their response to incidents, are connected to events at the level of clinical practice. However, it is impossible to explore the response of the Trust Board and wider governance arrangements and activities at the level of clinical practice to a satisfactory depth in one article. Governance arrangements of the Trust Board will therefore be explored in a separate publication.

[iv] Stephen Bolsin, for example, the consultant anaesthetist and whistleblower on the failings in paediatric heart surgery at Bristol (which led to the Kennedy inquiry that vindicated his concerns) was unable to find another position in the UK and moved to Australia to continue his career (BMJ, 2016).

[v] Brown(2003) also points out the circularity involved, in that much of our understanding of organisational failure has been culled from analyses of inquiry reports.

[vi] The circumstances in which a woman should be transferred to obstetric-led care are now laid down in a NICE guideline (Intrapartum care for healthy women and babies, Clinical guideline [CG190]: December 2014). This updated a 2007 guideline which is no longer available but judging by the dating of new advice in the 2014

version it would appear as if these circumstances were not specified in previous versions. See table 5 in Gould (2000) for the characteristics considered constitutive of 'normal' birth prior to NICE guidance.

[vii] Seven midwives have been through disciplinary procedures, two of whom have been struck off the NMC register, and another suspended (BBC News, 2017).