A midwife’s exploration into how power & hierarchy influence both staff and patient safety

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Abstract
My experiences as a legitimate informal whistle-blower have afforded me an understanding of the dichotomy that is Trust allegiance and misplaced brand loyalty over and above both patient and staff safety, such that when poor care is spoken of as a potential or experienced from either angle, the general rule within healthcare management is not to acknowledge, reflect, mitigate and learn in order to improve, but instead to gaslight, deny and subordinate such that from a staff safety perspective they are caught between a rock and a hard place. This paper explores some of the opportunities which healthcare organizations could embrace to positively influence the effects of power and hierarchy on staff safety.

Aims: This paper discusses the bigger picture of maternity services safety.

Methods: This is a discussion piece.

Findings: For some healthcare staff it is preferable to remain quiet, not rock the proverbial boat, and maintain deeply loyal allegiances to their employers over and above public protection. For others, the journey of honesty, integrity and tenacity carries a high price in terms of personal energy, health and financial compromise.

Conclusion: This exploration into how power & hierarchy influence both staff and patient safety has identified and briefly explored some of the tensions created by misplaced brand loyalty inherent within healthcare institutions, and the legacy of harms resulting.

Keywords
Maternity services, power & hierarchy, staff safety, whistleblowing, healthcare safety, incident reporting

My experiences as a legitimate informal whistle-blower within United Kingdom (UK) maternity services have afforded me an understanding of the dichotomy that is Trust allegiance and misplaced brand loyalty over and above both patient and staff safety. When poor care is spoken of as a potential (near-miss), or experienced from either angle (staff member or patient), the general rule within healthcare management is not to acknowledge, reflect, mitigate and learn in order to improve, but instead to gaslight, deny and subordinate such that from a staff and patient safety perspective employees are caught between a rock and a hard place, as echoed by Francis and Duffy. Sadly the scope of leadership and organisational performance has become negatively entwined with the cultural components of power and hierarchy, where ‘power is defined as the ability to control people and events’ whilst hierarchy is described as ‘a system in which people or things are arranged according to their importance’ (web reference). This paper explores some of the opportunities which healthcare organizations could embrace to positively influence the effects of power and hierarchy on staff and patient safety.

Midwives could be considered as a group working under oppression, and Leap observed that internal conflict comes as a response to exclusion from power. For

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me this meant that when I formerly reported unsafe staffing in 2013 as a very experienced and capable midwife, the fallout was a catalogue of false allegations against my professional practice by a group of middle managers, rather than actually addressing the safety issues which were upheld in a subsequent internal review.

Emerging data from the current Parliamentary review into maternity services safety in England, assimilated with my prior knowledge and experience, has helped me revisit what it has meant for me to work as a ‘Tiger Midwife’ over the last two decades within the UK, fiercely defending patient, students and colleagues working within a systemic culture of blatant bullying and its subsequent harm in a pervasively negative healthcare culture. The current state of maternity services did not occur overnight, or in isolation, and it has taken many years for staff and patient concerns to be overtly acknowledged.

Greenhalgh wrote that the research value of narrative used in storytelling is in the placing of experiences in particular positions in time, and so the cultural bullying within contemporary maternity services works as a function of ‘power relations’, seen where there are ‘strong hierarchies’, such as maternity services. Culture definitions share basic socialised values and repeated behaviours, and Francis attributed the ‘insidious negative culture’ that he found when investigating Mid Staffs Hospital to disengaged management and leadership responsibilities.

Dixon-Woods et al. in their research on variations in NHS Culture and Behaviour, found that poor delivery of care was sometimes attributed to poor organisational and IT systems, something which the NHS Long Term Plan and the Topol Review have sought to remedy. What was found to be fundamental to culture within the NHS was good support and management, and this support was inconsistent in their large review despite being fundamental to safety. Dixon-Woods et al’s conclusion was to “nurture caring cultures” within the NHS.

For many healthcare staff the feelings of value, respect, engagement and support are missing within their employment equation and this is evidenced in both national and local staff satisfaction surveys. When I raised the alarm within Maternity Services, senior managers were already acutely aware that we had a sickness absence rate of 19%, fully impacting both on unsafe patient and staff safety, and yet their silence in 2013 was deafening. The RCM ‘Why Midwives Leave- Revisited’ report revealed that some 80% of staff who had left the profession might consider a return if there were a change in culture, and the RCM have since instigated their ‘Caring 4 you’ campaign to highlight access to breaks and an understanding of staff wellbeing. Their RePAIR Project (Reducing Attrition and Improving Retention) highlighted a pure attrition rate of 31% within Midwifery. In 2019 the WHELM Study noted that the UK Midwifery participants component of this study exceeded population norms for personal and work-related burnout, stress, anxiety and depression compared to other participating countries. There have been public calls for ‘Compassion in the Workplace’ for healthcare workers, and this has been particularly emphasized in the light of the Covid-19 global Pandemic.

Crowther et al. delved into a possible solution to confronting these themes with their paper on sustainability and resilience, finding that ‘self-care’ and the ‘cultivation of relationships’ were common themes to different models of care. In her discussion piece on ‘Midwifery-running down the drain’, Beech wrote about institutionalised bullying in the face of complexity between state and hierarchy, and conflict between medical and social models of birth, with staff forced into conformity and established authority simply in a bid to cope with poor resources and poor staffing. She declared that it is this system which allows institutional bullying to flourish such that it has become embedded in NHS structures as supervision and regulation.

At the time (2013) this particular maternity unit was investing 480K on a midwifery led birthing unit, which many staff felt was at the direct expense of safety elsewhere within the unit. We simply did not have enough staff, but the emphasis was on promoting normal birth. An alternative might have been to improve facilities everywhere within the unit with this money, creating equity in experiences for women. We had a ward with ancient showers turned on with rusty spanners, toilets with cracked sewerage pipes, and an unreliable fan operated system for ventilating a concrete building such that at times we had to close beds when the ceilings and walls were soaked with condensation. In a standing room only meeting I had asked our Head of Midwifery who was going to staff this new area, and her reply was that she did not know. My staffing safety concerns were acknowledged, initiating a delay in the opening of this unit, but only by a few months.

One positive legacy of The Kirkup Report - Morecombe Bay maternity investigation, has been to challenge a change in terminology of the normal birth mantra from Maternity Services, a directive which caused a great deal of harm to many families in what became a rather dangerous and desperate bid to retain midwifery autonomy, inhibiting safety conversations and completely blinded to the harm this was causing to patients and to multi-professional working relations. ‘The self-labelled Midwifery Musketeers’ noted within the Kirkup Report, and also within...
James Titcombe’s book “Joshua”, were a group of front-line clinical Labour Ward managers advocating for normal birth at any cost, and were not unique in terrorising delivery suites as this has been documented across the world. Several Midwifery research papers over the previous twenty years have cited such bullying as a root cause for staff simply not returning, precisely because of the atmospheres prevalent. 70% of NHS Resolution claimants against harm in the UK have been made within the Maternity Services care sector, with a total pay-out over the previous decade of over 4 billion pounds. Three of the senior members of midwifery staff involved in my personal battle to speak out for safety in 2013 were Supervisors of Midwifery, whose specific role was meant to be to safeguard maternity services. Raising concerns comes with a high price, and it took several more years before the UK government finally intervened to remove this highly contentious Supervision of Midwifery role, with an extraordinary review in Guernsey, alongside the Kirkup Report, evidencing the need for change which culminated in Nursing and Midwifery Council (NMC) amendments. A recent episode of the current Parliamentary review into the Safety of Maternity Services in England conducted by the UK government again highlighted the dangers of this normal birth terminology, with senior healthcare figures denying its current use despite evidence to the contrary, and so it would seem this particular battle of ‘risk as fluid’ is ongoing.

Montesinos asked midwives to come together to change their culture as she described the numerous hearings she has successfully survived on her professional journey. She cited Kirkham’s exploration on conflict of interests in the culture of healthcare, with the root cause being the Midwives Act of 1902 as the original controlling power source in demanding midwives to conform. Kirkham has written extensively in her explorations on horizontal violence in midwifery, and what happens when midwives are unsupported, again citing the hierarchical structure of the NHS as a climate which does not value kindness or consideration, and which breeds disrespect. She made an astute point in noticing that the major source of motivation and job satisfaction for midwives is derived from relationships, and these extend to being valued, which includes relationships with colleagues and managers. To this end it will be interesting to see how quickly those returning NHS staff registering on the Covid-19 temporary register realize their reasons for having left the profession in the first place, and this feedback will be a useful barometer of the culture which is midwifery.

Kirkham wrote in 2007 that to prevent bullying as the distorted coping mechanism that it is, we need to change the structure and the culture that we work within. To do this we need a continuum of positive support, challenging the culture of neglect. Institutional defensive practice in obstetrics may be linked to this unhealthy workplace culture of bullying which “negates professional autonomy” (p.6). Bailey offers the theory of ‘Salutogenesis’ (meaning ‘the origins of health’), as a view of health promotion which transcends the medical model of ‘risk-centred care’, citing Antonovsky who recognised the complexity of humanity in which we are all ‘capable of moving across the continuum’ of health and disease (p.6). This theory appears to fit with both Kirkham and Dixon-Woods et al’s approach to promoting the value of staff by focussing the balance of healing workplace culture deficits on enabling the positive benefits of power and hierarchy within workforce and group dynamic health promotion rather than risk-avoidance penalty. This works by healthcare staff developing a strong sense of self-worth, the ability to understand a situation for what it is; to find meaning in the challenge; and the utilisation of resources to resolve that aspect of quality in one’s life.

Barriers to Employee voice have become entrenched in cultural cues as opposed to opportunities for speaking out, with Martin et al. encouraging those involved in healthcare services to look at organisational-cultural influences on voice and psychological safety. I believe that this closed and negative culture is a natural consequence of fear derived from misuse of power and hierarchy. For staff ‘speaking out’ is a risky enterprise of low benefit, where “the uncomfortable reality is that the professional benefits of silence often outweigh the balance of personal integrity” (p.189).

In my particular experience numerous false allegations were made against me as a consequence of raising my head above the parapet, and the colleague who had accompanied me to my initial HR meeting was advised five years later that ‘her professional cards had been marked’ as a result of her participation with my internal whistleblowing. The manager who raised this point had not even been employed by the Trust in 2013, illustrating the legacy of speaking out as a very particular professional suicide. Many maternity services staff are still afraid to speak out about safety issues because they are all too painfully aware of the potential repercussions from within trust if they do, even when theirs is the voice of reason.

The reality is that some leaders do not listen and some actively suppress staff through “aggression or indifference” and it is this “ambivalence to employee voice” which undoubtedly causes the most harm within healthcare services (p.3). Kline advises that ‘inclusion’ should be a core competency for healthcare leadership values, and that inclusivity and compassion
create ‘psychologically safe workplaces’ by building healthier relationships between staff and reducing patient mortality. This inclusivity is supported by Edmondson in her book ‘The Fearless Organisation’, and seen in the revised NHS People Plan 20/21 which has fresh aims directed at looking after each other and addressing discrimination.

Running alongside the revised People Plan, with its renewed appreciation for diversity, is the work of HSIB whose summary of themes arising from maternity safety investigations highlights poor communication in all aspects of the themes emerging be they ‘escalation’, ‘handovers’ or ‘early recognition of risk’. Appreciation of the cultural difficulties inherent within maternity services, along with clear evidence researched independently from individual internal trust investigations goes a long way towards supporting and vindicating the healthcare staff who have already spoken out, although perhaps coming too late for those staff who have already endured ‘moral injury’, but it does provide an element of hope for the culture of change to come.

Hunter et al. advised focussing on ‘collective leadership’ within NHS healthcare management which could ‘facilitate a sense of agency’, reducing the divisive them and us culture described within their research data (p.34). Certainly this view is purported by the NHS Leadership Academy, and viewed by Bailey et al. as the creation of “a narrative of collective accountability” (p.3), where we are challenged to reshape cultural norms. Our pre-existing cultural legacies may prevent the culture of openness that healthcare changemakers seek. Martin et al. make the astute observation that there exists some healthcare staff who cannot actually see what is wrong in patient and staff safety, and these are quite possibly the most difficult healthcare workers behaviours to change within such diverse healthcare service micro cultures. Bailey et al. question whether the weight of our healthcare past may make securing real change fragile, asserting that we need to value openness and not use ‘tools of performance management’, moving on from “normalised incuriosity” (p.6).

When healthcare staff join their particular professions they invariably sign up to Codes of Conduct which ethically compel public protection, and within the UK we have very particular moral principles embedded within the NHS Constitution. This exploration into how power & hierarchy influence both staff and patient safety has identified and briefly explored some of the tensions created by misplaced brand loyalty inherent within healthcare institutions, and the legacy of harms resulting. The overall aim of this paper has been to reveal what happens to staff when they speak out to address safety issues, and to explore the repercussions of this phenomena for healthcare safety if it is not addressed. Staff need to feel safe, and they haven’t for quite some time. There are many ethical considerations to this topic, but my main point is that in general trusts do not perform by ethics, but rather on their own self-created reputations and misplaced brand loyalty. For some healthcare staff it is preferable to remain quiet, not rock the proverbial boat, and maintain deeply loyal allegiances to their employers over and above public protection. For others, the journey of honestly, integrity and tenacity carries a high price in terms of personal energy, health and financial compromise.

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