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ORIGINAL PAPER

Amoral Management and the Normalisation of Deviance: The Case of Stafford Hospital

Tom Entwistle[1] · Heike Doering[1]

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Abstract
Inquiries into organisational scandals repeatedly attribute wrongdoing to the normalisation of deviance. From this perspective, the cause of harm lies not in the actions of any individual but rather in the institutionalised practices of organisations or sectors. Although an important corrective to dramatic tales of bad apples, the normalisation thesis underplays the role of management in the emergence of deviance. Drawing on literatures exploring ideas of amoral (Carroll in Bus Horiz 30(2):7–15, 1987) or ethically neutral leadership (Treviño et al. in Calif Manag Rev 42(4):128–142, 2000) we seek to bring management back into the explanation of organisational wrongdoing. Amoral theorists point to management's ethical silence, but they also describe the way in which that silence is sustained by a series of organisational characteristics. We build on this work in arguing that it is management's deliberate focus on bottom line performance, the diffusion of responsibility and high levels of organisational identification that explain the emergence of wrongdoing. We apply these ideas to the case of the UK's Stafford hospital which hit the headlines in 2009 when it was reported that poor standards of care had led to a mortality rate markedly above that expected for a hospital of its type. We conclude with a discussion of the circumstances which translate amoral management into unethical outcomes.

Keywords Amoral management · Ethics · Normalisation

Introduction

Inquiries into organisational scandals—from Deepwater Horizon to Challenger—repeatedly attribute wrongdoing to a process Vaughan (1996) describes as the normalisation of deviance. From this perspective, the cause of harm lies not in the actions of any individual but rather in the institutionalised practices of organisations or sectors (Ashforth & Anand, 2003; Palmer, 2012; Vaughan, 1996). Very much in this vein, the official inquiry into the Stafford hospital scandal in the UK concluded that organisational wrongdoing was not explained by egregious cases of individual misconduct. In the words of the final report, the leaders, managers, and others in responsible positions at the hospital did not 'deliberately or consciously' act in a way that neglected the needs of patients (Francis, 2013, p. 1367). Instead, the inquiry pointed to widespread system failure and the organisation's toxic culture (Francis, 2013).

Although the normalisation of deviance provides a good account of the emergent, systemic, and cultural character of these scandals, it says little about the role of managers. Indeed, Vaughan's (1996) revisionist account of the fateful 1986 Challenger launch decision explicitly exonerates management. In place of official inquiries which had pinned the blame on amoral managers, Vaughan (2004, p. 342) concludes that: 'The challenger disaster was an accident' emerging from 'negotiated order wrought from engineering disagreements' which were themselves nested within broader 'environmental and organisational contingencies' (1996, p. 195). Palmer (2012, p. 269) goes further, describing 'wrongdoers as mindless and boundedly rational, subject to the influence of their immediate social context, embarking on wrongdoing crescively, without ever developing a positive inclination to do so'. Although a vital corrective to dramatic tales of bad apples, the strongest accounts of the normalisation thesis reduce wrongdoing to mere accidental

✉ Tom Entwistle
EntwistleT@cardiff.ac.uk

Heike Doering
DoeringH@cardiff.ac.uk

[1] Cardiff Business School, Cardiff University, Aberconway Building, Colum Drive, Cardiff CF10 3EU, UK

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occurrence which sees some of us inadvertently operating on the wrong side of the line (Palmer, 2012).

This paper sets out to bring management back into our understanding of organisational wrongdoing. More specifically we suggest that the literatures on amoral management and the normalisation of deviance can be usefully combined to better understand how dysfunctional systems and cultures emerge. We start with the institutional focus of the normalisation literature which sees wrongdoing as emerging unwittingly from the taken for granted practices of organisations and sectors. To this we add amoral management, characterised by Carroll (2001, p. 143) as a 'posture or approach that is devoid of ethics'. We argue that management's intentional pursuit of short-term objectives through a focus on bottom line performance, the diffusion of responsibility and high levels of organisational identification have the potential to tilt an organisation toward ethical silence and unintentional wrongdoing.

We apply these ideas to the case of the UK's Stafford hospital. Stafford hospital hit the headlines in 2009 when it was reported that 'appalling' standards of care had led to a mortality rate markedly above that expected for a hospital of its type (Francis, 2013, p. 7). A regulatory investigation and two independent inquiries in 2009 and 2013 followed. Witnesses to the second inquiry testified to a litany of organisational wrongs: key parts of the hospital were systematically understaffed and under-skilled such that the emergency department had become 'immune to the sound of pain' (consultant 6, witness statement, p. 4); nursing staff falsified records (nurse 2, witness statement); managers misrepresented the hospital's structures and processes to regulators (manager 6, testimony); clinicians stayed silent or else failed to blow the whistle with sufficient vigour (consultant 1, testimony).

We make three contributions over four sections. First, we synthesise the normalisation and amoral management literatures in a bid to bring management back into the explanation of organisational wrongdoing. Second, following a description of the Stafford case and our methods of analysis, we demonstrate how three amoral signals—prioritising the bottom line, diffusing responsibility and fostering organisational identification—de-moralised the organisation in such a way as to make space for unethical behaviour. Third and finally, we suggest a set of contingencies which explain when amoral management translates into unethical outcomes.

Amoral Management and the Normalisation of Deviance

Vaughan (1996) coined the phrase 'the normalization of deviance' to describe the way in which ethically deviant practices (like accepting the use of high-risk technologies in the case of the Challenger space shuttle) become taken for granted in decision-making processes. For Vaughan (1996), the normalisation of deviance emerged from a culture which was focused on maintaining tight production schedules with maximum secrecy. Ashforth and Anand (2003 p. 6), like Vaughan, maintain that 'the system trumps the individual' as normalisation occurs through 'intertwined processes of institutionalization, rationalization, and socialization'. As deviant practices become embedded in the organisation, they are justified and excused before being communicated to new members of staff.

Palmer (2012) describes five mechanisms—from the workings of the administrative system to straightforward accidents—that might explain 'normal wrongdoing', but aside from the chapter on administrative systems, he says little about management's part in the process. Indeed, he is critical of Ashforth and Anand (2003) and Brief et al. (2001) on the grounds that they assume, first, that 'organizational wrongdoing spreads from top to bottom in organizations' (Palmer, 2012, p. 174) and second, that 'leaders initiate wrongdoing on the basis of mindful, rational cost–benefit calculations or normative assessments.' Instead, he argues that wrongdoing often begins at lower hierarchical levels and that ethical decision-making is bounded, instinctive and emotional (Palmer, 2012). Like Palmer (2012) and Vaughan (1996), focuses on wrongdoing as the accidental or emergent consequence of complex systems and tightly bounded ethical decision-making.

Taken together, Vaughan's (1996) work on the normalisation of deviance and Palmer's (2012) account of normal organisational wrongdoing, highlight the importance of institutionalised patterns of behaviour but they understate management's privileged position in the construction of these institutions. In place of Kagan and Scholz's (1984, p. 67) picture of managers rationally calculating the costs and benefits of disobedience, Vaughan follows new institutional theory (DiMaggio & Powell, 1991) in describing wrongdoing as guided by formal and informal norms or rules. These 'cultural beliefs' as Vaughan (1996, p. 37) describes them, 'create unreflective, routine, taken-for-granted scripts that become part of the individual worldview'. Exonerating managers from purposeful disobedience, Vaughan (1996) sees wrongdoing as originating in institutional arrangements which evolve at the environmental or sectoral level.

Ashforth and Anand (2003, p. 6) explain however that leaders 'control many of the levers of institutionalization'. Indeed, they suggest, that 'leadership plays a potentially huge role' in these processes by 'rewarding, condoning, ignoring or otherwise facilitating corruption' (Ashforth & Anand, 2003, pp. 6–7). Bearing this out, Sims and Brinkmann (2002, p. 27) give the example of the way in which the managers of Salomon Brothers moulded 'a corporate culture that eventually resulted in unethical and illegal behavior by its members.' Drawing on a case study of a virtual reception

business, Jenkins and Delbridge (2017) similarly describe the way in which managers sought to embed deception into the working practices of their employees. While these cases of unethical leadership may be relatively rare, they serve to make the point that management matters in the evolution of organisational wrongdoing.

Management is not of course omnipotent. Recognising management's superior access to information resources but imperfect capacity to communicate, signalling theory focuses on the messages that managers send and the way in which they are received (Connelly et al., 2011). In this vein, Banks et al. (2021, p. 5) define ethical leadership as a form of 'signaling behavior' in which leaders communicate 'moral emotions' and 'prosocial values'. Signals can take many different forms from changes in formal institutional arrangements to informal interactions in conversation and email. Although intentional, signals according to Taj (2016, p. 339), are deployed 'to influence desired outcomes'. There is, however, no guarantee that recipients will receive, much less act on, the message that management has sent. Signalling theory captures the pivotal but contingent character of management's attempts to communicate with stakeholders and shape their organisation. As Bisel (2018, p. 3) reminds us, organisations 'cannot exist without communications because that is what they are'.

We use Carroll's notion of amoral management to better understand the part that managerial signals play in the institutionalisation of deviance. Carroll (1987) suggests that management can be moral, immoral or amoral. Moral management strives to 'focus on ethical norms, professional standards of conduct, motives, goals, orientation toward the law'. Immoral management, by contrast, is 'positively and actively opposed to what is ethical' (Carroll, 1987, p. 9). In between, but distinct from these two extremes, is amoral management. Either by intent or neglect, amoral managers do 'not factor ethical considerations into their decision-making, actions, and behavior' (Carroll, 1987, p. 11).

Other scholars have used different labels to describe the grey area between the ethical and unethical. For Bird and Waters (1989) the problem is not the absence of moral considerations, but moral muteness: management's reluctance to be open or transparent about them. Treviño et al. (2000) use the term 'ethically neutral management'; Bandura (1990) 'moral disengagement'; Tenbrunsel and Messick (2004) 'ethical fading'; Palazzo et al. (2012) 'ethical blindness'; and Adams and Balfour (1998) 'moral inversion'. Behind these different labels however, all are united in pointing to the way in which managers absent themselves from, or else stay silent about, the ethical issues facing the organisation. Greenbaum et al. (2015, p. 31) highlight the communicative dimension in their formal definition. Amoral management, they suggest, is 'a failure to support a socially salient ethical agenda by not using ethical communication and not visibly demonstrating ethical practices'. They go on to suggest a four-item measure of management's ethical detachment which gauges: a reluctance of supervisors to get involved; a tendency to absent themselves from ethical decisions; or else to sidestep or remain neutral on ethical matters (Quade et al., 2022, p. 282).

Although all amoral theorists point to silence, they differ in their explanation. Bird (1996, p. 143) finds 'underlying causes' at the individual, organisational and cultural level. In terms of individuals, he attributes moral silence to fears of entanglement in unresolvable commitments. Carroll (1987) suggests that silence might be attributed to an individual's absence of moral obligation or integrity. Ethically neutral leaders according to Treviño et al. (2000, p. 138), are self-centred, less caring and less compassionate. Gross (1978, p. 71) explains the emergence of these personality types by processes of self and organisational selection which mean that senior managers are 'ambitious, shrewd and possessed of a nondemanding moral code'. Aside from personal characteristics, a number of theorists use Bandura's (1990) notion of moral disengagement to explain ethical silence. From this perspective, euphemism and the biases of self-perception provide a way of coping with a clash of personal and occupational values (Bandura, 1990).

Alongside these psychological approaches, some theorists of amoral management point to the way in which high level cultural forms serve to foster moral silence. In this vein, Bird (1996, pp. 146–150) describes the prevailing economic philosophy as assuming that 'moral considerations play no significant role in the decision making of economic actors', a tendency entrenched by a legal model which turns 'moral conflicts into legal disputes'. Jackall (1988, p. 6) attributes the managerial tendency to 'bracket' off personal morality to the bureaucratisation of work in the nineteenth and twentieth centuries.

While acknowledging that ethical silence is indeed built at both the cultural and individual levels, we focus on the part amoral managers play in the purposive construction of organisation level institutions. Amoral theorists (Bird, 1996; Brief et al., 2001) recognise the importance of organisational characteristics like the bottom line mentality, the diffusion of responsibility, and employee loyalty as barriers to dissent. To date, however, little has been said about managers' active role in creating and maintaining these organisational attributes. Drawing on contemporary ideas about institutional work (Lawrence et al., 2011), we build on the amoral literature in looking at the way in which managers actively build and sustain moral silence by signalling their support for amoral institutions. The signals are amoral in two senses of the word. First, they prioritise the short-term interests of the organisation without regard to broader and longer-term ethical considerations. Second, depending on a series

of contingencies, they may lead to either moral or immoral ends (Tenbrunsel & Smith-Crowe, 2008).

In the next three parts we define the three amoral organisational characteristics and trace their lineage in the amoral management literature. We then connect with adjacent literatures which demonstrate the potential for both ethical and unethical outcomes of these characteristics. Finally, we introduce work which demonstrates the contingent way in which ethical silence translates into organisational wrongdoing.

Prioritising the Bottom Line

While, strictly speaking, the bottom line refers to the final profit or loss recorded in a set of accounts, the term 'bottom-line matters' is increasingly used to describe an 'exclusive focus on any priority that is considered the most important at the expense of other priorities' (Mesdaghinia et al., 2019, p. 492). Several authors attribute the avoidance of ethics to a tendency to prioritise the bottom line. One of the earliest, attributes the collapse of ethics in the Vietnam war to signals sent by senior commanders that the end (of defeating communism in South Vietnam) justified pretty much any means (Kelman, 1973, pp. 44–45). This 'overriding obligation' or 'transcendent mission' overpowered the 'standard moral constraints' in such a way as to permit individual soldiers to commit atrocities.

Believing that 'different rules of the game apply in business than in other realms of life', Carroll (1987, pp. 11–12) describes amoral management as 'driven primarily' 'by the profitability or bottom line ethos that makes economic success almost the sole barometer of organizational and personal achievement'. Bird and Waters (1989, p. 73) pin the problem of 'moral muteness' on a managerial tendency to be 'guided exclusively by organizational interests, practicality and economic good sense'. Treviño et al. (2000, p. 138), too, describe 'ethically neutral' leaders as focused on 'financial ends' and the 'short term bottom line'. 'Amoral reasoning' according to Brief et al. (2001, p. 475) 'results from a 'value system that places corporate success above all other concerns.' Similarly, Nielsen and Parker (2012, p. 431) highlight how amoral 'calculators' understand their organisation 'as an economic entity' whose 'main focus and priority is to expand the business, make (and sell) more products and services, earn more money, and return a greater profit to its owners.'

Prioritising the bottom line suggests recognising only the most minimal restraints on the conduct of business. Explaining this, Tenbrunsel and Smith-Crowe (2008) describe amoral decision making as guided by both business and legal frames. The first, as we have seen, elevates the economic interest of the organisation. The second suggests only minimal compliance with the requirements of the law. 'Ethical blindness' according to Palazzo et al. (2012, p. 325) emerges from the presumption that the law provides 'the only moral limit to profits' (2012, p. 327). At the very least this legal frame elevates the role of legal experts in the determination of moral matters at the same time as it disqualifies others as 'primary players' (Bird, 1996, p. 151). While obeying the law is, of course, a good thing, it has long been recognised that *mere* legal compliance may fall short of the ethical obligation 'to do what is right, just, and fair' (Carroll, 1991, p. 42). Conduct which is lawful, and which avoids 'legal sanctions', as Paine (1994, pp. 109–111) explains, nevertheless 'may be highly problematic from an ethical point of view'.

Signalling the priority of the bottom line is amoral: first, because of the absence of moral intent and second, because it can prompt both ethical and unethical patterns of behaviour (Tenbrunsel & Smith-Crowe, 2008). Palazzo et al. (2012) maintain that it is the context in which rigid business and legal frames are employed that increases the risk of ethical blindness. Its effects may be functional in that more focused work practices can increase the productivity of the organisation (Babalola et al., 2020). In a hospital context, improved focus can translate into more and better treatment and care. More focused work can however easily slip into the prioritisation of 'a very narrow set of performance expectations' (Greenbaum et al., 2021, p. 112) and the emergence of unethical behaviours (Mesdaghinia et al., 2019). Gross (1978, p. 57) explains: 'whenever an individual is placed in a position where performance is emphasized, there will be pressure to violate norms if necessary'.

Diffusing Responsibility

Alongside a focus on the bottom line, amoral theorists point to the ethical dangers of advanced forms of administrative specialisation. Scholars differ in their precise diagnosis of the problem. Gross (1978) pins the blame on processes of departmentalisation which reify and reward the attainment of subgoals. Elaborate forms of specialisation tend to focus individuals on narrowly defined roles and very specific sets of rules. Brief et al. (2001) describe these processes as fragmenting information and diffusing responsibility in such a way as to deny any one individual purview of the ethical whole. Bird (1996, pp. 177–183) describes the way in which organisational structures and cultures can frustrate vertical and horizontal communications in such a way as to isolate work units and block 'dissent, questioning and whistleblowing'.

Alongside fragmentation, and diffusion, a number of scholars suggest that routinisation is key (Bandura, 1990; Brief et al., 2001). For Kelman (1973, p. 46) the likelihood of ethical resistance within the organisation is 'greatly reduced' by 'transforming the action into routine, mechanical, highly programmed operations.' Brief et al. (2001, p.

482) warn that the combined effects of narrowly defined roles and standardisation can lead to the 'mindless, mechanical production of wrongdoing on a grand scale'.

Jackall (1988) points to a further dysfunction located in the vertical division of labour. 'Bureaucratic compartmentalization', as he describes it, prevents the communication of 'troublesome issues' from one level of the organisation to the next (Jackall, 1988, p. 194). By pushing detail down the hierarchy, specialisation tends to concentrate the ethical resolution of individual cases in the hands of middle managers who, as Jackall (1988, p. 21) puts it, 'become "fall guys" when things go wrong'. Senior management, however, is removed from the intricacies of ethical decision-making and insulated from any problematic consequences. Drawing on the case of Abu Ghraib prison, Monahan and Quinn (2006) make the case that these etiolated forms of governance can encourage norm violating behaviour at the same time as they buffer management from moral responsibility.

Other scholars express similar ideas in more abstract terms. For them, ethical problems stem from an instrumental, technical, or functional rationality that promotes the achievement of narrow, organisational goals 'in the most economically efficient manner' (Lee & Gailey, 2007, p. 542). This form of rationality neutralises ethical issues by objectifying 'people as labor costs and the environment as a set of resources to be exploited' (Lee & Gailey, 2007, p. 542). When applied to management and organisation, instrumental rationality strips decision-making of its moral content so that, as MacIntyre (1981/2014, p. 35) puts it: 'The manager treats ends as given, as outside his scope; his concern is with technique, with effectiveness in transforming raw materials into final products, unskilled labour into skilled labor, investment into profits'. MacIntyre (1981/2014) describes this rational and amoral management as focused on the service of the organisation and at the expense of broader societal values (see Moore, 2008 for a review).

Again, however, neither the division of labour—nor the broader instrumental logic that guides the efficient design of structures and processes—are necessarily unethical. Management theorists pay so much attention to departmentalisation and specialisation precisely because of their potential to deliver dramatic increases in productivity. Surpluses generated by improvements in productivity can, of course, be directed to moral ends. Although managers compartmentalise and routinise work to boost performance, there is a danger that, when carried to excess, institutional arrangements of this sort can incentivise unethical behaviour at the same time as they deny management's knowledge of or responsibility for it. Deviance is not inevitable in these circumstances, even if it is, as Monahan and Quinn (2006, p. 374) put it, a 'predictable and even productive response to such institutionalized structures'.

Fostering Organisational Identification

Finally, amoral theorists point to the importance of organisational identification. Ethicists have long been nervous of 'unquestioning obedience to authority' (Kelman, 1973; Treviño et al., 1998, p. 469). Svanberg and Öhman (2016, pp. 68–75) explain that 'authoritarian environments' in which 'staff must simply "do as they are told"' are problematic 'because ethical behaviour requires space for individuals to challenge management directives and instructions'. But obedience does not require authoritarianism. Brief et al. (2001, p. 477) explain that individuals may engage in corrupt practices simply because they believe they have a duty to comply with their manager's legitimate authority.

Long associated with a host of positive effects such as embracing loyalty, extra-role behaviours, cooperativeness and improved performance, organisational identification is largely treated positively in the management literature (Umphress et al., 2010). Umphress warns however that identification may be associated with unethical pro-organizational behaviour. As Umphress and Bingham (2011, p. 625) explain, 'individuals who strongly identify with their organization may disregard their own moral standards in favour of unethical acts that protect or help the organization'.

Unethical pro-organisational behaviour is explained in two main ways. Social identity theory suggests that we all have a basic psychological need to identify with a group and, as far as possible, to take pride in that identity. By extension, our need for a positive identity sees us invested in and protective of the fortunes of our employing organisation. Social exchange theory points to a more cognitive explanation where employees recognise and reciprocate the benefits of employment (Umphress et al. 2010). Veetikazhi et al. (2022) suggest that reciprocity might be heightened by a desire to defend valuable resources. In such a way, those who fear for the security of their employment may have particularly good reason to be protective of their organisation.

Like the prioritisation of the bottom line and the diffusion of responsibility, organisational identification has a Janus-faced tendency to produce both ethical and unethical outcomes. Caprar et al (2022) make the point that it is strong and exclusive identification which is associated with unethical pro-organisational behaviour. An exclusive identification suggests that ethical choices are decided in favour of organisational interest rather than broader professional or societal norms. As Chen et al. (2016, p. 12) explain, the dark side of organisational identification emerges when employees are asked to choose between 'defending the pragmatic interests of their organization' or else 'adhering to societal moral values'.

Contingencies, again, are important. Caprar et al (2022) point to the role of an organisation's prevailing climate or culture. An ethical climate seems likely to ensure that

pro-organisational behaviours are more ethical than not. In contrast, moral disengagement provides a rationale or justification for choosing organisational interests over societal values. Other researchers suggest that it is the combination of organisational identification and leadership style that tips the organisation into ethical problems. Bass (1999, p. 9) describes the task of the transformational leader as one of aligning the 'interests of the organization and its members'. He suggests that this can be done through 'idealized influence (charisma), inspiration, intellectual stimulation, or individualized consideration' (Bass, 1999, p. 11). Effelsberg et al. (2014, p. 90) warn however that by fostering identification in this way transformational leaders can 'increase the probability of unethical yet pro-organizational behavior'. Similarly, employees who have been imbued with 'higher workplace status may engage in unethical behaviors in an effort to reciprocate the empowerment they receive' (Wang et al., 2022, p. 17). Graham et al. (2015) find not only leadership style to be important but also the way in which leaders frame their messages. Negative frames which point to organisational threats or potential losses galvanise more effectively than positive messages. Consistent with their hypothesis, Graham et al. (2015) report that the combination of transformational leadership and loss framing inspired high levels of unethical pro-organisational behaviour.

In summary, amoral theorists have repeatedly argued that some organisational characteristics—including bottom line matters, diffused responsibility and organisational identification—favour the emergence of ethical silence. Empirical studies of these characteristics increasingly suggests that under certain circumstances they are associated with pro-organisational unethical behaviour. Following a description of our case and methods, we provide empirical evidence of the way in which managers at Stafford hospital actively sought to institutionalise these characteristics within their organisation.

Methods

Discussions of organisational wrongdoing and the normalisation of deviance have predominantly focused on individual organisations (Jenkins & Delbridge, 2017; Vaughan, 1996). In this tradition, we look at one organisation and take the testimonies and witness statements to the official inquiry into poor care at Stafford hospital as our source (Francis, 2013). Public inquiries offer a particularly detailed insight into organisational practices as they collect evidence from a large number of people, often going beyond what is feasible for an individual researcher (Hendy & Tucker, 2021).

We accept that 'public inquiries are not neutral representations of the truth' (Hendy & Tucker, 2021, p. 5). They tend to be dominated by a 'master narrative' which sets the tone of the questioning and evidence collection (Gibbs & Hall, 2007). Existing accounts of the Stafford scandal have followed this master narrative in focusing on the failure of the clinical professionals to blow the whistle (Hendy & Tucker, 2021). Reading the witness accounts and testimonies, however, we started to wonder: What was management doing? This question therefore shaped our sample of witnesses and the texts we included in our analysis.

The Francis inquiry called 164 witnesses over a period of 139 days including patient representatives, regulators, government, trade unions, professional bodies as well as representatives of the wider health economy (family doctors, social care providers and the commissioners of care). Focused on management within the organisation we drew our sample more tightly. The inquiry included evidence from 32 former and current employees of the hospital. We further restricted our analysis by looking only at those employment in the period 2005–2009 and those who submitted both oral testimony as well as written evidence. We made an exception for the chief executive who submitted only a written statement. These criteria reduced the sample to 21 witnesses. We did not include groups outside of the hospital, such as patient groups, the regulators or the greater National Health Service (NHS) bureaucracy within our sample. The Francis inquiry (2013) comprehensively discusses the role of the broader network of NHS bodies in the failures at Stafford hospital. Vaughan (1996) has already demonstrated the way in which deviance is normalised at the environmental level, we wanted to understand the part that an organisation's managers play in the process. Table 1 presents an overview of our sample.

We conduct our analysis on the raw data of witness statements and sworn testimony. The witness statements comprised 877 pages and were complemented by 2798 pages of testimonies (excluding appendices and evidence) providing a comprehensive set of qualitative data. While the witness statements presented witnesses' own accounts of events at Stafford hospital, the sworn testimonies are co-constructed with the inquiry's counsels. They are therefore characterised by a lack of clear chronology and a 'circling-back' pattern (Lucas & Fyke, 2014). The slow build-up of the questioning does not always provide easily quotable material as sometimes witnesses respond monosyllabically to lengthy questions. While the names of participants to the inquiry are in the public domain, we took the decision to anonymise the data by referencing role descriptors. We focus on the signals of amoral management rather than the ethics of individual managers.

In this secondary qualitative analysis, we adopted an iterative approach which combined inductive and deductive elements. According to Tracy (2018), the iterative approach starts with the question of what the data is telling us. While the inquiry dismissed managers as absent or naïve, their

Table 1 Sample of witnesses

Witness	Years active	Witness statement (pages, excl. appendices)	Sworn testimony (pages)	Date of testimony
Nurse 1	from 1984	32	110	3 March 2011
Nurse 2	2002–2008	18	61	7 October 2011
Nurse 3	from 2001	30	204	17 February 2011
Nurse 4	1983–2008	13	98	9 February 2011
Consultant 1	2006–2009	37	113	2 March 2011
Consultant 2	1982–2010	17	102	16 February 2011
Consultant 3	from 2003	16	139	3 March 2011
Consultant 4	from 1995	23	83	1 March 2011
Consultant 5	from 1995	30	76	16 February 2011
Consultant 6	2007–2010	30	91	2 March 2011
Administrator 1	from 1980s	27	137	10 February 2011
Administrator 2	1998–2009	41	263	17 January 2011
Manager 1	2005–2009	51	n/a	3 October 2011
Manager 2	2006–2009	56	196	22 March 2011
Manager 3	2006–2009	33	173	24 March 2011
Manager 4	2006–2009	104	204	28 March 2011
Manager 5	1987–2008	42	189	23 March 2011
Manager 6	2005–2009	38	117	7 October 2011
Manager 7	2004–2009	151	150	3 October 2011
Manager 8	from July 2008	56	137	15 March 2011
Manager 9	from April 2009	32	155	10 March 2011
Total: 21 witnesses		877	2798	

testimony suggested they were focused on managing financial and performance targets, reforming governance, and changing the culture of the organisation. We used Nvivo in this primary round of coding to focus on critical changes in the hospital such as the drive for foundation trust status, the reorganisation of the clinical floors, restructuring of governance, and the skill mix review. Following this reading we consulted the literature on ethics and management and started to 'tag back and forth between (1) consulting existing theories and predefined questions and (2) examining emergent qualitative findings' (Tracy, 2018, p. 63). For our secondary coding, we were struck by the similarity of management's account of their own work and the focus on the bottom line, the diffusion of responsibility, and organisational identification rehearsed in the amoral literature. Accordingly, we focused our analysis on the way managers signalled their priorities to their employees. Finally, we tracked the way these signals translated into a series of unethical decisions and practices such as staying silent, the falsification of records, and the understaffing of key parts of the organisation.

Our emergent definition of 'prioritising the bottom line' included signals which stress the importance of achieving financial and performance targets. The signals 'diffusing responsibility' included the creation of specialised roles, separating operations and management, and complex governance arrangements. Finally, to 'Foster Organisational Identification' managers highlighted their change agenda, the need for organisational members to support it, and the consequences of resistance. Figure 1 presents our coding framework.

Amoral Management in Stafford Hospital

Like many investigations into organisational wrongdoing, the inquiry into poor care at Stafford hospital uncovered something of a paradox. In the face of voluminous evidence of poor care, managers and clinicians protested that the hospital's performance was typical of the NHS. The former chair of the board spoke for many of its employees when she defended the standard of care provided by hospital's accident and emergency (A&E) department. 'There are many—probably the majority of A&Es in the country', she explained, 'particularly A&Es in small to medium district general hospitals, which—had very similar experiences' (manager 7, testimony, p. 107). Otherwise expressed, the exceptionally poor standard of care provided by the hospital was perceived by managers, and many staff, as typical or normal for a hospital of its type: this was a case of the normalisation of deviance.

Consistent with the literature, normalisation in Stafford seems to have emerged gradually from the structures,

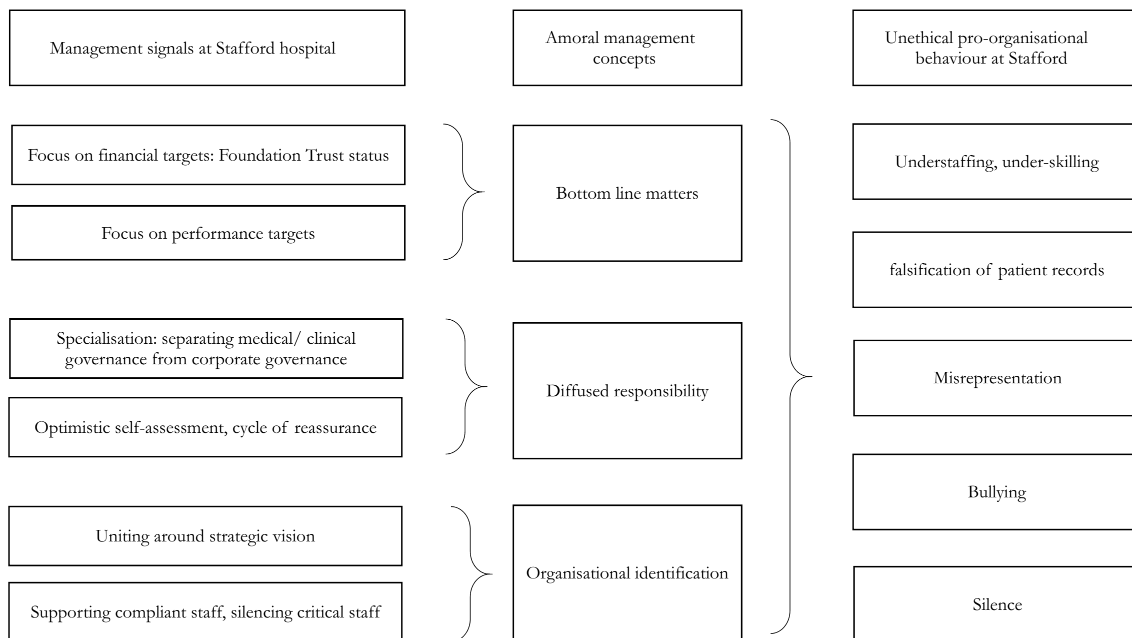

Fig. 1 Coding framework

processes and culture of the hospital and the wider NHS. Poor care was in a sense a product of performance and financial pressures communicated by a panoply of planning and regulatory bodies. Hendy and Tucker (2001) describe the way in which a 'narrative of silence' fostered a collective denial of the failings of the hospital amongst its staff. For those working in the hospital, the inadequacies of the service were unremarkable, partly because they were perceived to be systemic but also because they emerged only gradually over an extended period of time. One of the whistle-blowers explained:

> I think it had been an incremental thing where things had become harder and harder and harder and they -- and they didn't actually realise just -- just how far off acceptable standards things had slipped to, and I don't think that -- I don't think that any of them would have let that happen if it had happened over night'. (consultant 6, testimony, p. 81)

Although the normalisation literature rightly points to the way in which wrongdoing is wired into institutional structures at the organisational and sectoral level, it says little about the part management plays in the process. Managers at Stafford hospital were, however, very actively involved in the deliberate construction of these institutions in their organisation. As the former chief executive explained: '[A] strong financial base, a robust governance infrastructure and the right culture among the staff are essential' (manager 1, witness statement, p. 23). In the following three sections we make the case that the signals sent by managers at Stafford hospital—prioritising the bottom line, diffusing responsibility, and fostering organisational identification—significantly contributed to the institutionalisation of deviant practices of care. These three signals did not simply occur in parallel; they built on and reinforced each other.

Prioritising the Bottom Line

The bottom line for managers at Stafford hospital was securing coveted 'foundation trust' status. As a foundation trust the hospital would enjoy a higher level of autonomy in the UK's NHS bureaucracy. 'Every member of staff was aware that the hospital was driving towards FT [foundation trust] status', as one clinician recalls, 'it was the goal and the things we did within the trust was [sic] orientated towards achieving that' (consultant 6, testimony, p. 30). The former chief executive argued that foundation trust status would provide a sound base to improve patient care:

> it was not the case that the FT process was a distraction from getting our house in order, quite the contrary. The Board was in agreement that if we could deliver in these areas, we would be in a strong shape to provide good quality healthcare in the years to come (manager 1, witness statement, p. 23).

In the short term, however, the pursuit of management's bottom line required progress on the hospital's financial and clinical performance indicators. Action to address these two led to unethical cuts in the number of nursing staff and the

misrepresentation of the hospital's processes to regulatory bodies.

Hospitals which applied for foundation trust status were subject to increased scrutiny of their finances and performance. Stafford was experiencing financial difficulties even before the new chief executive arrived in 2005. A mix of local and national pressures together with the pursuit of foundation trust status prompted management to pursue substantial expenditure reductions. When asked whether there were any alternatives to this course of action, the chair of the board explained that 'there was no question that we had any choice but to reduce staffing levels' (manager 7, testimony, p. 15). The director of finance explained: 'We have to do the best we can with the resources we've got' (manager 5, testimony, p. 156). Table 2 below presents a timeline of saving and staffing decisions in the pursuit of foundation trust status (Francis 2013, pp.196-211).

Having signalled the necessity of budget cuts, senior managers devolved the detail of where the axe should fall to the hospital's divisions. Divisional managers proposed a workforce reduction programme, a vacancy scrutiny process and a reorganisation of the hospital's wards. The latter turned on an initiative—long cherished by the former director of nursing—to reverse the ratio of qualified to unqualified nursing staff from 60:40 to 40:60. The reduction of qualified nursing staff was achieved by allocating patients to wards 'according to nursing dependency rather than speciality' (consultant 3, witness statement, p. 7). While, for its backers, the reform promised a more efficient use of skilled staff, most clinicians were doubtful. One described the reorganisation as 'shambolic' (consultant 3, testimony, p. 158). Long 'established routines were broken down', which in turn 'led to a compromise in patient care' (consultant 3, witness statement, p. 7). This was as a project, as one manager put it, that was in 'the wrong place at the wrong time' (manager 6, witness statement, p. 14). Believing it to be wrong 'even before it was implemented' (manager 2, testimony, p. 81), the former medical director, explained that she did nothing to reverse it because concerns had 'settled down': again, deviance had become normalised.

In addition to the financial pressures, foundation trust hospitals needed to deliver performance targets specified by central government. The chair of the board explained that a failure to hit those targets 'was seen to be career limiting for Chief Executives' (manager 7, witness statement, p. 54). The chief operating officer at the time explained that 'bottom line' delivering the targets 'was the biggest bulk of—of the output of my—my role' (manager 3, testimony, p. 55). Pressure to hit the accident and emergency waiting targets prompted managers to reorganise. An 'alternative model' of working reduced the requirement for senior clinicians. Emails instructed staff: 'You will meet the four-hour wait time. Everybody's got to work to do that and you've got to get the patients out of the department' (nurse 3, testimony, p. 177). More troubling still, pressure to hit performance targets was passed down the line to nurses who were 'expected to break the rules as a matter of course' (nurse 2, witness statement, p. 3). One of the whistle-blowers recalls that: 'Rather than "breach" the target, the length of the waiting time would regularly be falsified on notes and computer records' (nurse 2, witness statement, p. 3).

Finally, the focus on the bottom line meant taking a legalistic and at times creative approach to the relationship with regulators. Rather than inspecting the actual processes and outcomes of care, the UK's regulatory system at the time of the Stafford hospital scandal, sought assurance that health providers had the appropriate administrative structures and processes in place to deliver good quality care. Stafford's managers complied with the demands of their regulators by describing their existing processes in the most glowing of terms. In such a way, managers reassured regulators that 'clinicians participate in regular clinical audit and reviews of clinical services' despite confessing to the inquiry that this was true only 'in some areas of the organisation, and not all [areas]' (manager 4, testimony, p. 72). Questioned whether compliance should have been declared in this case, the same manager explained that it was all a question of 'what did compliance look like' (manager 4, testimony, p. 72).

While the pursuit of foundation trust status could in due course have delivered positive outcomes, some clinicians questioned whether the ends could justify the means:

> There was very clearly a split view. There were some senior clinicians who felt that FT [Foundation Trust] status would give the organisation the flexibility to respond in a better way to patients. And there were also a lot of clinicians who were making the point that the things we were doing to achieve FT status did not appear to be enhancing patient care (consultant 6, testimony, p. 31).

Asked whether the hospital's 'cost improvement plan and the foundation trust application may have led directly or indirectly' to substandard care, the former finance director answered simply: 'Yes, I would accept that it may well have contributed' (manager 8, testimony, p. 88). Management's unswerving pursuit of the bottom line measures of sound finances (see also Table 2) and key performance indicators created the circumstances in which middle managers and frontline clinicians felt they had to make unethical choices which compromised care. The pursuit of the 'transcendent mission' of foundation trust status worked in tandem with the creation of a governance system which diffused accountability.

Table 2 Timeline of events

	2004	2005	2006	2007	2008	2009
Management Team	Change in chair of the board	Change in chief executive, arrival of deputy director of clinical standards	Arrival of director of operations, change in director of nursing		Trust achieves Foundation Trust status	Change in chief executive, chair of board, director of nursing, deputy director of clinical standards, director of operations
Staff position		Staff reduction by 180 FTE agreed with unions; limited use of peripheral staff, slowing down of recruitment	Reduction by 258 FTE, 10% of workforce; clinical floors project, change of skill mix	Initiation of skill mix review	Completion of skill mix review: hospital was 120 FTE nurses short	
Financial position	£1.975 m savings to be achieved	£9.6 m savings to be achieved	£10 m savings to be achieved	£4.466 m savings to be achieved	Break even	Predicted deficit of £7.1 m
Warning signs	Loss of star rating	Critical peer review	Critical peer review Critical Healthcare Commission review Critical auditor's reports	Inpatient survey; Whistleblowing about A&E by nurse; Critical Royal College of Surgeons report Dr Foster report: Stafford second worst for excess deaths	Whistleblowing about A&E by doctor; Performance notices by primary care trusts Healthcare Commission investigation	Publication of Healthcare Commission investigation

Diffusing Responsibility

When the chief executive arrived at Stafford in 2005, he not only found a hospital in financial difficulties but also one with a 'complete lack of organisation at the managerial/directorate levels and [where] most of the very basic governance structures were missing' (manager 1, witness statement, p. 5). There was a need, he explained, for a 'transparent and agreed structure' and 'ownership of governance at all levels' (manager 1, witness statement, p. 5). Whether despite or because of management's best efforts, governance at the hospital continued to be a problem four years later. The counsel for the inquiry described the new arrangements for clinical governance in the following terms:

> there was a divisional governance group, which would report to the clinical quality and effectiveness group, that . . . would report to the executive governance group. The executive governance group would report to the audit committee, and the audit committee, eventually, one might add, would report to the trust board. So, it looks as if there were four filters before anything got up to the trust board (manager 7, testimony, p. 63).

The reformed system of governance signalled a diffusion of responsibility in three ways. First it removed the board from operational detail; second it excluded clinicians from high level decision-making; and third, it allowed the assurances provided to regulators to become detached from the reality of clinical service delivery.

The new chair of the board was particularly determined to detach herself from operational matters. As she explained: 'I'm not sure that it's ever appropriate for non-executives, who are part-time and don't come from the NHS, to involve in the detail of operational matters.' (manager 7, testimony, p. 32). Indeed she, together with her new chief executive, 'decided to withdraw the NEDS [non-executive directors] who attended the [complaints] committee. I felt that it was not an appropriate use of their limited time to be involved in something that was primarily an operational matter'. At the same time as board members were taken off the consideration of complaints, senior clinicians found themselves excluded from high-level decision-making bodies. As one consultant explained 'we really had no—or appeared to have no way into the systems that she'd set up' (consultant 1, testimony, p. 122). This meant, as the same consultant continued that 'key messages about, for example, nursing numbers, slips, trips and falls, other incidents were not getting through the morass of committees to the trust board for their consideration.' Another consultant complained that these structures left them:

> completely disenfranchised because the directorate structure had been destroyed and there was a thing called a division in place. The directorate structure was a good thing because at least the consultants attended those meetings and they could voice their concerns. (consultant 2, testimony, pp. 124–125)

With so many layers between the consultants who delivered care and the managers who determined its parameters, the quality of the middle management was key. The problem in Stafford according to the medical director, was that deficiencies in this regard meant that 'clinicians were saying that their decisions were not percolated up to the board and the board decisions often didn't go down to the clinicians' (manager 9, testimony, p. 63). Indeed, there was a sense, according to one manager 'that nothing would ever be achieved by attempting to raise or report concerns' (manager 3, witness statement, p. 7). Management clearly signalled that while medical staff should focus on operational matters, strategy should be left to the board and its senior managers.

It was not only the clinicians who were kept out of the loop. Regulators too, as we have seen, were presented with a partial and at times unreliable account of the hospital's governance. Misrepresentation occurred because those responsible for answering the regulator's questions were both detached from the day-to-day processes of providing care and careless of the need to properly represent them. Asked by regulators about the number of staff working in A&E, one manager agreed (manager 6, testimony, p. 107) that her answers 'had the potential to portray the trust as safer than it in fact was.' She describes a deductive approach to evidencing compliance. 'If you have a hypothesis' she explained, 'you go out to prove it. So, you know, if we thought we were compliant, we would be looking for the evidence that said we were compliant' (manager 6, testimony, p. 94). Asked by the inquiry whether the hospital's approach represented 'a genuine attempt to improve things or is it playing the game?' the manager responds:

> it's a bit of both, really. I do think, you know, obviously my role was to make sure that we'd got policies and that we'd got systems in place and, therefore, I was trying to implement systems around the practices that we'd got and around the groups that were there. Whether it completely worked or not is, you know, sort of - you know, it's been proved that it wasn't - it wasn't embedded and it didn't work robustly (manager 6, testimony, p. 60).

In a vicious cycle of self-deception, managers told the inquiry they were reassured that regulator's believed the assurances that they themselves had falsely provided. As one senior manager put it, we took 'some comfort from the fact that our systems were tested by—first of all by the strategic health authority and then the Department of Health and then by Monitor' (manager 7, testimony, p. 50).

While the specialised structures designed by the chair and chief executive were undoubtedly intended to improve performance, they shielded the board from the collapsing standards of care apparent on the frontline. Furthermore, the clinicians who witnessed these conditions found it impossible to communicate their concerns through the hospital's morass of committees. The arrangements which divorced the board from operations and the clinicians from strategy allowed middle managers to misrepresent the capacity of the hospital to external regulators. Diffused system of governance closed down opportunities for scrutiny both inside but also outside the organisation.

Fostering Organisational Identification

Alongside 'a strong financial base' and 'a robust governance infrastructure' the chief executive sought to cultivate the 'right culture among the staff' (manager 1, witness statement, p. 23). He explained that a series of 'cultural issues' such as inertia, 'people just wanting to do the day job', lack of awareness of or interest in clinical audit, lack of understanding where the organisation was going, and lack of engagement, all needed to be addressed (manager 1, witness statement, pp. 8–9). Believing that the hospital needed 'good people with a clear remit' (manager 1, witness statement, p. 5), managers sought to charm or else bully their staff into organisational identification. Those who supported management's mission—whether enthusiastically or reluctantly—were more inclined to stay silent in the face of the wrongdoing they witnessed.

First and foremost, senior managers launched a charm offensive intended to persuade staff that the organisation was on a positive path of change and improvement. To do this, managers tried to sell both themselves and their vision for the hospital in the hope of 'setting up a strategic direction for the organisation that was owned by all parties' (manager 1, witness statement, p. 12). A demonstration of genuine interest in staff concerns could strengthen employee identification with the organisation and its change projects. Although vocal in his criticisms of the hospital's governance, one of the senior clinicians tells the inquiry that the director of nursing 'was fantastic. She was working hard to turn things around and was often found down on the wards meeting patients and trying to change things' (consultant 1, witness statement, p. 115). A nurse reported that senior management and the board communicated a 'positive attitude' which was 'very infectious'. She recalled feeling that 'she was part of a new era for the hospital where the previous problems were a thing of the past' (nurse 3, witness statement, p. 4). Even one of the whistle-blowers seems to have been charmed, as he explained, the chief executive:

> began to engage with -- with me personally, and (…) -- I could tell that it came as a surprise to him just how dire the perception, both internally and externally, of the department was. And he was -- he was clearly keen to find solutions to this, but to do that, wanted to understand what the problems were. And I had a fair amount of dialogue with him from thereon in. (consultant 6, testimony, p. 29)

Those who demonstrated the right level of commitment were promoted into positions of responsibility. Persuaded to take on the leadership of the failing emergency department, one clinician tried to compensate for staff cuts by spending 'many, many hours providing that support (for medical staff) on the shop floor, looking after patients and carers and relatives' (consultant 4, testimony, pp. 11–12). The director of nursing was tasked with reviewing the skills problem bequeathed by her predecessor even if the project tied her up for some considerable time in the impenetrable cobwebs of administrative detail (manager 4, witness statement). Active followers who demonstrated pro-organisational behaviour—even when clearly unethical—were treated supportively. One of the nurses recalled how staff with a reputation for falsifying records and bullying were dubbed the 'A' team and rewarded with pizza (nurse 2, witness statement).

In contrast, those who persistently questioned management's strategic vision faced harsher treatment. 'Criticism wasn't welcomed' as one put it: 'Management told us it wasn't our job to complain' (consultant 2, testimony, p. 22). There was, as one consultant put it, 'a climate of intimidation, fall in line, fall in line' (consultant 5, testimony, p. 130). Another described a 'blame-led culture, the attitude being that problems had to be fixed or nursing jobs would be lost' (consultant 6, witness statement, p. 3). 'It was quite normal' he continued 'for nurses to come out at the end of these meetings crying because they had been told that if they did not meet the 4 h targets, they would lose their jobs' (consultant 6, witness statement, p. 3). Others reported that they were 'specifically asked (…) not to go to the press because it would adversely affect the performance of the hospital' (consultant 2, testimony, p. 52). 'Fear' according to another consultant 'is too strong a word' but the chief executive was 'a fairly forceful personality, and I think that his presence perhaps somewhat inhibited discussion' (consultant 2, testimony, p. 55). Worried about the practice of 'falsifying patient records' in a bid to meet a target, one nurse complained: 'If I ever raised this as an issue, I was told in no uncertain terms that, if we didn't meet the targets, heads would roll and A&E would be closed, with all of us losing our jobs' (nurse 2, witness statement, p. 5). Another nurse reported that when she raised concern she was told that 'the decision had been made at a higher level, that I was only a ward sister and that I should be positive about

the change that was being recommended' (nurse 1, witness statement, p. 9).

High levels of organisational identification do of course have considerable benefits. The strategic priority of pursuing foundation trust status was widely recognised and some individuals, as we have seen, responded with exceptional commitment to their work. Encouraging engagement, and pro-organisational behaviour, however, can have unintended unethical outcomes. Sometimes writing 'lots of diktats and "do this" and "do that"', as one consultant explained (consultant 5, testimony, p. 174), 'creates perverse incentives for people to do the wrong thing'. The combined signals of rewarding and disciplining used by managers undoubtedly silenced some of the organisation's critics (Hendy & Tucker, 2021). As one consultant reflected 'I'm afraid to say that, rather like a lot of us, having made our point and perhaps not having got it across or got things changed, we got on with working with the system' (consultant 1, testimony, p. 158). More importantly however, these tactics presented the professionals working in the hospital with a conflict between their organisational and professional identities. They were encouraged, rewarded, and pressured to resolve that conflict by prioritising their allegiance to management's vision of the organisation over their duty to the profession. Apart from facilitating group-think and 'moral deafness' (Bird, 1996) the culture of organisational identification left medical staff 'immune to the sound of pain' (consultant 6, witness statement, p. 4) and silent when they should have raised concern.

Conclusion

In describing the way in which wrongdoing emerges unwittingly from the institutionalised structures of organisations and their environments, the normalisation literature has rightly refocused attention away from the role of the individual bad apple (Ashforth & Anand, 2003; Palmer, 2012; Vaughan, 1996). Rather less has been said however of the part management plays in the construction of deviant institutions. In tune with the literature on amoral management (Greenbaum et al., 2015; Quade et al., 2022), we suggest that ethical silence has a part to play in the explanation of organisational wrongdoing. We add to this literature, however, by attributing silence to the part managerial signals play in shaping an organisation's formal and informal institutional arrangements. Crucially we argue that amorality resides in the signals managers send rather than in their ethics as an individual. Following Greenbaum et al. (2015, p. 42) we too think that 'good people can practice amoral management'.

Drawing on the UK's Stafford hospital scandal, this paper makes three contributions. First, we suggest that ethical silence is explained by the presence of a set of signals intentionally sent by managers focused on short-term organisational objectives. Second, we use the Stafford hospital case to demonstrate that by prioritising the bottom line, encouraging organisational identification and diffusing responsibility through complex systems of governance, Stafford's managers gave their employees a menu of unethical choices. While no one had to choose the unethical path, Stafford's amoral management made it difficult to do the right thing. Staff working at the hospital agreed to understaff and deskill, misrepresent hospital processes and stay silent in the face of wrongdoing because of the signals sent by senior managers. Third and finally, we point to a series of contingencies which might explain why amoral signals produced unethical outcomes in the Stafford case. Understanding the circumstances in which amoral management leads to either ethical or unethical outcomes is key business for researchers (Tenbrunsel & Smith-Crowe, 2008). While the literature considers a range of moderating variables for each of the amoral signals we have considered (Balalola et al., 2020; Greenbaum et al., 2012, 2021; Effelsberg et al., 2014) the Stafford case allows amoral signals to be considered in combination.

We propose first that amoral management became wrongdoing in Stafford because of the combination and intensity of the amoral signals sent by managers. While other organisations may adopt some elements of amoral management, managers at Stafford hospital were perhaps remarkable in sending all three signals at the same time. It was the combination of management's pressure on bottom line targets, a culture of organisational identification and a structure which diffused and diluted responsibility which tipped the organisation into wrongdoing. Amoral signal piled upon amoral signal appears to increase the likelihood of producing unethical outcomes. Furthermore, perhaps because of the relative inexperience of Stafford's management team and their naïve determination to deliver a 'transcendent mission' (Kelman, 1973), each signal seems to have been transmitted with exceptional vigour. The cumulative effect of the number of amoral signals together with the intensity of their application may serve to increase the likelihood of unethical outcomes.

Our second proposition suggests that while managers in Stafford hospital may have behaved no differently to managers in other hospitals, the absence of countervailing forces tipped amoral management into unethical outcomes. Caprar et al. (2022) make the point that an ethical climate has the capacity to moderate the relationship between organisational identification and unethical outcomes. The official inquiry (Francis, 2013) focused much of its energy on the question of why clinicians—both in the hospital and the wider networks of professional and regulatory bodies—countenanced poor care and failed to blow the whistle. As Currie et al. (2019) observe, a failure to speak out can itself be construed as a form of professional misconduct. Wrongdoing in Stafford hospital could then be

attributed to the combined effects of amoral management and the weakness of ethical climate both within the hospital and the broader NHS.

Third, wrongdoing in Stafford hospital may be explained by the challenging task environment that the hospital found itself in. The quality of the care provided by the Stafford hospital was inevitably a function of the socio-economic make up of population it served, the calibre of staff it could recruit and the budget it was allocated. Evidence submitted to the inquiry repeatedly underlined the prominence of these factors. These considerations were intensified by an ambitious change agenda in the NHS which pushed organisations to demonstrate high levels of financial autonomy. In such a way wrongdoing at the hospital may be explained by the combined effect of amoral management, the demands of the task environment and the capacity of the organisation.

Fourth and finally, amoral management may have tipped into wrongdoing because Stafford—like all hospitals—required the attuned learning systems of a high reliability organisation. While it may be possible to practice amoral management in less sensitive service areas without immediate evidence of dysfunction, relatively small failures of management rapidly translate into significant wrongdoing when 'human life and well-being are on the line' (Bisel, 2018, p. 190). Bisel (2018, p. 195) suggests that high reliability organisations create mindful cultures 'by being preoccupied with failures, resisting simplifications, remaining sensitive to operations, committing to resilience, and showing deference to expertise'. No one would have described Stafford's culture in these terms.

Both ethical and unethical leadership are the focus of increasing attention in the management literature. The grey area between the two—coined amoral management by Carroll—has not received the attention it deserves. This despite the fact, as Carroll (1987, p. 12) suggests, there are good reasons to think that 'the vast majority of managers are amoral' or that, flipping between styles depending upon the circumstances, 'the average manager is amoral most of the time'. Certainly - as Stafford's beleaguered managers repeatedly complained - there is evidence to think that many other organisations in health care specifically (Jarman, 2012; Wood, 2013), and other sectors more broadly (Moore, 2008), manage in similar ways. Amoral management was not dreamt up by Stafford's managers, its roots are firmly embedded in societal level conceptions of how organisations can or should be managed (Jackall 1988; Bird 1996). Blame for that lies, in some measure, with us as management scholars who have not, with a few notable exceptions, warned of the dangers of amoral management quite as volubly as we should have.

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Ethical approval The research draws on publicly available witness statements and sworn testimony collected and published by the Francis inquiry into Mid Staffordshire NHS trust https://webarchive.nationalarchives.gov.uk/ukgwa/20150407084231/http://www.midstaffspublicinquiry.com/report. The project was registered with the Cardiff Business School Research Ethics Committee as a secondary data research project (reference 675);

Research Involving Human and Animal Rights Although the research involved human participants, we assume that all necessary consent was obtained by the Francis inquiry.

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