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Racially minoritised workers' incivility experiences, and consequences within maternity settings: A multimethod longitudinal qualitative exploration

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Abstract

Background

Workplace incivility is a global concern in healthcare, undermining staff wellbeing, organisational functioning and patient safety. In England, despite National Health Service (NHS) commitments to equality and inclusion, racially minoritised staff continue to experience inequities shaped by racism and organisational culture. How

these dynamics influence incivility and its safety consequences for staff and patients' remains underexplored.

Methods and Results

This study presents a longitudinal qualitative critical ethnography across two NHS maternity settings. Sixteen in-depth interviews and eleven eight-week WhatsApp diaries were conducted with racially minoritised midwives, administrative and support roles. Additionally, relevant documents were examined in parallel, including policies, standard operating procedures and reports identified by informants. By applying the theory of racialised organisations and an inductive analysis, findings revealed two key manifestations of incivility. First, embedded in routine work processes, such as inequitable work allocation, hostile documentation practices and inadequate support. Second, within informal social interactions, including negative stereotyping of racially minoritised colleagues and patients, and exclusionary practices.

Reported examples of incivility highlighted compromised care through treatment delays and the safety risks of emotionally depleted staff, silenced concerns, eroded team functioning and reduced psychological safety. Findings showed how structural inequities and racialisation shape everyday incivility across different roles. Informants reported weak organisational learning and strained cultures contributed to incivility experiences, exacerbated by resource depletion and entrenched racialised dynamics.

Conclusions

Despite regulatory emphasis on speaking up, mistrust, fear and silencing persisted amid ongoing inequitable treatment. Improving safety and equity in maternity care,

requires multilevel effort to strengthen antiracist leadership, better support racialised staff and address racialised incivility to improve team dynamics and patient safety.

Keywords

Workplace incivility, racism, racialisation, patient safety, emotional labour, critical ethnography, maternity care

Introduction

Workplace incivility remains a global concern for the healthcare workforce and poses a substantial threat to patient care (Freedman et al., 2024). It is defined as "low intensity poor behaviour that breaches norms of respect and is often ambiguous in intent" (Andersson and Pearson, 1999). In healthcare, incivility has multilevel consequences, causing emotional distress, disrupting team communication and contributing to turnover (Keller et al., 2020). Growing evidence shows incivility can also degrade coordination and error detection, ultimately increasing avoidable harm (Freedman et al., 2024).

Despite the increasing diversity of the healthcare workforce (Garratt et al., 2024), there remains a paucity of evidence on incivility experiences among racially minoritised[1]hospital workers (Joseph et al., 2024). This gap constrains equity-focused analyses capable of illuminating the structural conditions shaping incivility

[1] The use of the term 'Racially minoritised' is in alignment with recent critical race scholarship and sensitivity to power-laden naming, this study uses "racially minoritised staff" to foreground how racialisation is produced, rather than to treat minority status as a passive descriptor. This term emphasises relational process and institutional marginalisation.

experiences. In 2023, the English National Health Service (NHS) Workforce Race Equality Standard reported that 89% of hospital trusts found Black and Minority Ethnic staff were more likely than white staff to face harassment, bullying, or abuse from colleagues (NHS England, 2024) and although incremental improvements were noted in 2025, racialised disparities persisted (White, 2026). These behaviours sit at the more severe end of a recognised continuum of unprofessional conduct, with workplace incivility representing a lower-intensity form that can escalate if unaddressed (Andersson & Pearson, 1999). Racial inequities in discipline, progression and decision-making further reinforce these patterns (Rhead et al., 2020; NHS England, 2024), with international evidence suggesting systemic drivers (Joseph et al., 2024; Aunger et al., 2024). Scholars across sectors similarly demonstrate that marginalised groups experience distinct and often more harmful outcomes of incivility (Kabat-Farr et al., 2020; Labelle-Deraspe & Mathieu 2023; Jorgensen et al., 2023). However, much of the literature remains descriptive, uses racial categories uncritically and fails to foreground the processes of racialisation (Joseph et al., 2024).

Maternity services are uniquely relational and high stakes, requiring multidisciplinary teamwork, trust, effective communication, and interprofessional coordination to uphold maternal and neonatal safety (Liberati et al., 2021). Public inquiries in the UK over the past decade have revealed how structural challenges such as staff shortages, excessive workloads, poor leadership and unclear roles and responsibilities can create environments of cultural tension, strained relationships, emotional distress, and intersectional vulnerability (Ockenden et al 2022; Kirkup et al., 2023; Silverio et al.,2022; Peters et al., 2025). However, there remains limited understanding of incivility in maternity settings and its effects on staff and care. While racially minoritised staff are

known to encounter incivility from different sources including colleagues, managers, women, and visitors (Joseph et al., 2024), this has seldom been explored within the context of maternal care.

Existing research in maternity and neonatal services shows that incivility undermines team communication, morale, and patient safety, particularly during high-risk scenarios such as obstetric emergencies and neonatal handovers (Galosi 2018 and Pierce et al., 2025). However, most studies rely on simulation or systematic reviews and rarely address structural or racialised dimensions of incivility. This study addressed this gap by examining how racialisation shapes experiences of incivility in maternal settings.

Theoretical Framework

To address the identified gap, this study draws on the theory of racialised organisations (Ray, 2019) alongside literature on quality and safety in healthcare. Ray (2019) argued that organisations are not race-neutral structures; rather, they embed and reproduce racial hierarchies through formal policies, informal norms, interactional logics, and structural arrangements. Racialised organisations are sustained through four interrelated mechanisms including, 1) structural privileging of whiteness (e.g., a system of privilege and cultural dominance for those racialised as white), 2) policies that appear "neutral" disproportionately disadvantage racially minoritised groups, 3) everyday interactional norms that prioritise majority cultural capital and 4) the institutionalisation of power asymmetries within everyday routines of decision-making, resource distribution, and status.

Research Aims and Questions

Although research on workplace incivility is growing, much of it conceptualises incivility as an interpersonal behaviour and relies on cross-sectional surveys that obscure the racialised dynamics shaping how it is produced and experienced. This study addresses these gaps by applying the theory of racialised organisations to maternity care and using longitudinal qualitative methods to examine the following four research questions:

1) How do racially minoritised hospital workers experience incivility?

2) How do power relations and workplace dynamics shape the experience and impact of incivility?

3) In what ways are incivility experiences understood to influence patient care processes and outcomes?

4) How do organisational policies, practices, and routines contribute to shaping or reinforcing incivility experienced by racially minoritised hospital workers?

Methodology and Methods

Research design

This qualitative study adopted a critical ethnographic approach to explore how racially minoritised staff experience incivility in NHS maternity care and how wider organisational contexts shape these interactions. Critical ethnography interrogates power, inequity, and normative practices while centring marginalised voices (Madison,

2005). Data collection involved participatory engagement with informants as 'conversational partners', guided by reflexivity and ethical care to minimise harm during sensitive disclosures. We employed a multi-method design involving semi-structured interviews, an eight-week WhatsApp diary, and document analysis, to generate rich, situated accounts of organisational influences (Ray, 2019). Qualitative interviewing provides rich, context-sensitive insights into lived experiences, uncovering hidden mechanisms and social processes in health services that quantitative methods often miss, especially for complex, subjective phenomena like incivility (Green & Thorogood, 2018). In addition to semi-structured interviews, a longitudinal WhatsApp eight-week diary approach enabled informants[2] to recall uncivil behaviours closer to the 'event' over a longer time, aiming to reduce retrospective bias. Incivility was defined as "low-intensity deviant behaviour with ambiguous intent to harm, violating norms of mutual respect" (Andersson & Pearson, 1999).

Using routinely collected data on workplace civility from the 2021 NHS Staff survey we identified maternity departments across three hospital trusts that scored low, average and high on civility survey items. We also used publicly available Workforce Race Equality Standard (WRES) data to ensure that we included sites with more and less ethnicity diversity amongst maternity staff. Ethical approval was obtained from the Health Research Authority (HRA) and local research and development capacity and capability processes at participating Trusts. Organisational anonymity was a prerequisite of involvement in the research. Reporting corresponds to the consolidated

[2] Informants refer to racially minoritised workers consented to the study. This was chosen as an alternative to 'participants' to acknowledge their contribution of knowledge through sharing information about their experiences. It puts emphasis on their role as a source of information rather than being studied (Madison, 2020).

criteria for reporting qualitative (COREQ) research guidelines (Tong et al., 2007). The two study sites were large NHS teaching hospitals offering acute and specialist services, including maternity and neonatal care. While similar in size and scope, they differed markedly in workforce composition: Site Y (North of England) employed around 7,000 staff, with 30% from racially minoritised backgrounds, whereas Site Z (South) had 9,000 staff and a higher proportion, approximately 60% from racially minoritised groups. This contrast provided an opportunity to examine how organisational diversity and context shape experiences of incivility, highlighting the interplay between workforce demographics and structural dynamics in NHS maternity care.

Study Informants and Recruitment

We recruited 16 informants through purposive and snowball sampling, using posters, onsite conversations, email lists, and key contacts. Recruitment materials included the researcher's photo, university logos and contact details, and emphasised confidentiality due to documented trust and safety concerns among racially minoritised NHS staff (Kline & Warmington, 2024; Chastney et al., 2024). A working definition of incivility and example questions were provided prior to interview to establish a relationship. Informants spanned clinical and non-clinical roles at both the sharp end (direct patient contact) and blunt end (indirect e.g., administrative and managerial roles), including non-registered roles often overlooked in incivility and safety research (Keller et al., 2020). Eleven staff also contributed to the unstructured digital diary, with researcher prompts to share experiences of both civil and uncivil behaviours. Informants included 10 clinical staff (from students to senior leads), 4 administrative/coordinating staff, and 2 domiciliary workers. Informants were

pseudonymised to ensure confidentiality and selected their own identifiers (Allen & Wiles, 2015), giving them some control over how they were represented (see Table 1). These methods captured both interpersonal dynamics and broader organisational responses.

Table 1 Description of informant characteristics for interviews (n=16) and digital diaries (n=11)

Informant chosen name	Self-identified ethnic background	Occupational role	Site	Interview length (mins)	Contributed to the digital diary?
Oaktree	Pakistani	Midwife	Z	57	No
Sparrow	Black Caribbean	Senior Midwife	Z	58	Yes
Samiya	British Asian	Student midwife and Healthcare assistant	Z	55^	Yes
Barry*	White other (mixed background – middle eastern)	Consultant Anaesthetist	Z	29	No
Jlo	British Bangladeshi	Porter	Z	59	Yes

Italy	Asian British	Student midwife and Healthcare Assistant	Z	55^	Yes
Tinkerbell	Mixed (white and Black Caribbean)	Senior Midwife	Z	51	Yes
Roxy	Asian British Bangladesh	Senior Midwife	Z	61	No
Helen	Black Caribbean	Obstetric Nurse	Y	89	Yes
Khadija	Asian British (Indian)	Coordinator	Y	49	Yes
Nina	Asian British (Sri Lankan)	Administrator	Y	77	No
Prince	White background_ Jewish	Senior Administrator	Y	64	Yes
Melissa	Black Caribbean	Midwife	Y	46	Yes
Paris	Asian British (Indian)	Patient Safety Admin	Y	35	Yes
Hibiscus	Asian British (Indian)	Midwife	Y	61	Yes
Sunshine*	Asian (Indian)	Procurement	Y	36	No

^ = Two student informants asked to be interviewed together but analysed separately.

*Only two males were represented in the sample

Interviews were conducted, based on the informant's preference, in person or via Zoom, audio-recorded, and transcribed by the first author. To capture incidents closer to occurrence and reduce retrospective bias, we used an eight-week unstructured WhatsApp diary, supported by periodic prompts to reflect on civil and uncivil behaviours. All identifiable information was removed from transcripts and both interview and diary data for each informant were processed according to University of Leeds data policies.

Data Collection and Analysis

Data were collected cyclically across methods: semi-structured interviews, WhatsApp diaries, and document analysis (local policies, protocols, organisational reports). Topic guides focused on everyday work activities, interactions, incivility experiences, consequences, and organisational responses, enabling exploration of potential decoupling between formal rules and practice (Ray, 2019). The critical ethnographic approach aligned with the general inductive data analysis enabling centering of marginalised voices, whilst maintaining methodological rigour (Madison, 2005). Transcripts and diary entries were prepared promptly, and a structured audit trail was maintained (decision logs, reflexive memos). A six-stage inductive coding approach avoided deductive assumptions and theories by privileging informants' insights and building categories inductively (Thomas, 2006, p 237). Initial coding was conducted by

XX in Word and Excel, with later stages using MIRO© to refine categories for each informant. Coded data from the informants were further combined, reduced and refined as a collective group for sites Y and Z to create site specific coding trees, ensuring nuanced representation of incivility experiences with each context. Finally step four to six were conducted on the coded data to ensure the final categories captured the complexities, nuance and richness of the incivility experiences across both sites. To support analysis and enhance trustworthiness (Guba & Lincoln 2004), monthly team meetings (XX, XX, XX and XX) were conducted to ensure data credibility, dependability and adequacy. Informants were also invited to member-check transcripts and preliminary findings, and clarifying questions were asked during the diary phase.

Patient and Public Involvement and Engagement

The TACT (eThnicity rAce and inCivility in hospiTals) Advisory Group was established in October 2021 for a scoping review and continued to support this study (Joseph et al., 2025). It comprised of sixteen racially minoritised hospital staff and eight patients, carers and members of the public and was formed to provide critical insights and support decision making in this research. The group contributed to the study design, recruitment plans, and materials, meeting at regular intervals to provide feedback, pose questions and critique. They 1) suggested shortening the diary study duration from 12 to 8 weeks, 2) provided key contacts to approach in the clinical team, 3) gave vital information to include in the orientation of informants in initial interviews and 4) offered advice on the acceptability of incentives. The study materials were also reviewed for

comprehension (e.g., terminology, phrasing, clarity, acceptability) and sense-making activities were conducted during analysis.

Ethical Considerations

Incivility is a highly emotive and sensitive topic, therefore, to protect informants discussing workplace incivility and racialised experiences, robust ethical protocols were implemented. Emotional risks were addressed through distress and debriefing protocols, flexible diary formats, and informant-led contributions to the digital diaries (Creese et al., 2022). Informants were encouraged to reflect on both civil and uncivil behaviours to reduce psychological burden. Anonymity was ensured through secure data handling and management aligned to the University of Leeds data policies. Culturally sensitive pseudonyms were chosen by informants, and an option to share demographic information following the interviews, fostered trust and enhanced authentic responses. Informants were offered reimbursement for their and three informants refused to accept. The researcher (XX), navigating shared experiences of marginalisation, accessed psychological support (XXX) and team-based debriefing to manage exposure to potentially traumatic content.

Findings

Our analysis identified two interrelated modes through which incivility manifested: routine work processes including work allocation and documentation, and hostile informal social communication, involving rudeness, exclusion, and gossip. These

passive and active forms of incivility had safety-critical implications for staff and for women[3], shaping the working conditions of racially minoritised staff.

Findings are organised by the research questions and presented as inductively derived categories grounded in informants' accounts. Table 2 synthesises these empirical patterns and maps them onto the tenets of racialised organisations. Using the preceding analysis, the table illustrates how informants' experiences reflect patterned organisational mechanisms shaping incivility.

Routine work practices as sites of incivility

Unfair work allocation was frequently described, particularly towards newly qualified or internationally recruited staff. SPARROW recounted an internationally educated midwife regularly assigned complex cases without appropriate support.

"*She was on CTG [cardiotocography] monitoring and they were arguing that the international midwife wasn't interpreting the CTG correctly, except they don't have CTG monitors…where this particular midwife came from…so she should have never been allocated that woman…she should have been working with somebody else*".

These allocations reinforced group-based assumptions and shaped expectations about who "should" perform certain tasks. Task allocation also functioned as informal punishment for those who spoke up, with TINKERBELL describing "being targeted for harder workloads" as a subtle form of coercion. These practices burdened racialised

[3] For brevity and consistency throughout this paper, the term 'woman' is used. This study primarily included cisgendered women without any data specific to diverse gendered identities. This does not aim to alienate, exclude or contribute to erasure as it is essential to recognise all birthing individuals, particularly transgender men, non-binary, and gender-diverse people who may not identify as women.

and lower-status staff, discouraging escalation and reinforcing feelings of being unappreciated.

These practices shaped how staff responded. Emotional strain was common including discomfort, frustration and exhaustion, often contributing to increased rumination and affecting concentration and confidence. SPARROW described an interaction with a senior consultant: “She was rude and unpleasant… it took every ounce of my energy not to cry.” Many ruminated afterwards, questioning intentions, and replaying alternative responses. Others avoided confrontation to preserve working relationships or protect themselves from further punitive allocation. JLO explained, “…It’s not worth it… they don’t really know me as a person and just carry on.”

Documentation-related incivility involved obstructive behaviours that impeded access to records, altered information without discussion, or signalled mistrust in their competence. At site Y, HELEN recalled a single pharmacist ignored her repeated requests to return drug charts needed for medication administration, “*Everybody else stopped what they were doing and started listening, except that woman. She continued to talk.”* Incivility from women or partners involved passive and active uncivil behaviours which impeded care communication and practices including ignoring requests for information, dismissing care instructions or shouting at care providers. For example, BARRY explains ‘*a patient here ripped a load of expletives at me…in my mind saying I'm not putting up with that I’ll come back in a minute*‘.

Others reported hesitancy from colleagues to co-sign medications, reluctance to update observations, or dismissive attitudes towards students during form signoffs. Some informants directly challenged these behaviours, but others hesitated due to

power differentials or fear of being labelled troublesome. SPARROW recalled being dismissed after escalating a consultant's behaviour: "...don't mind her, she's just like that", illustrating how senior staff were protected and allowed to continue uncivil practices that were experienced as discriminatory.

Hostile informal communication

Alongside routine work processes, informants encountered incivility through informal social communication. These accounts highlight how incivility also operated at the interface of staff-patient interactions, often intersecting with racialised dynamics within the team.

Informants experienced racialised comments, intrusive comments about identity, and dismissive responses shaped by assumptions about language, culture, or competence, from colleagues, women and families. During clinical shifts, SPARROW heard comments such as, "...*she's little and Asian, so she is going to complain all the way through or she's tall, broad German woman, she's going to spit her baby out."*

Negative biases were reinforced, even outside of work. Several informants across site Y shared a past incident where a midwife shared a video mocking an Asian woman in labour asking for pain relief with an accent and non-verbal movements. HIBISCUS questioned the hidden prejudicial beliefs of her colleagues, "... *is this what they are thinking in the back of their heads... to think someone did that as a laugh really affected me. And it stays with me."*

Entrenched cliques and favouritism shaped belonging,access to support and opportunities. ROXY connected cliques to unchecked organisational cultures, where

certain behaviours were deemed permissible, "*It's entrenched sedimented cliques… pack mentality… because people are left to their own device and there's no accountability*." OAKTREE described her mixed-heritage mentee feeling marginalised by certain groups, illustrating how exclusion operated across racialised lines. These dynamics particularly affected new, junior or rotating staff who were often used to address staffing shortages yet simultaneously exposed to heightened vulnerability when incivility undermined their learning and integration. In response, some staff enacted compensatory practices; for example, MELISSA described informally supporting Black trainee doctors who were denied equitable learning opportunities. Such informal networks mediated access to support and professional development, at times reproducing organisational inequities while also fostering emergent strategies of resistance and mutual aid.

Incivility from women and partners added further strain, often accepted as routine, including exposure to profanity, hostile attitudes, being ignored, expertise dismissed and on one occasion being filmed without permission. Responses ranged from empathy to protective escalation when safety was threatened. HIBISCUS recalled a mother filming staff while they cared for their daughter, '…*the midwife asked her, 'can you stop filming?, and she said 'no cause its completely in my right, just make sure you're doing what you need to'*. Such interactions signalled to informants the devaluation of staff safety, feeling othered, or an object of scrutiny.

Across these contexts, informants relied on coping strategies involving peer support, documentation, humour, and spirituality. MELISSA detailed prayer as grounding: "…that's my peace of mind, that's my solace."

Direct and indirect consequences of incivility

Incivility had wide-ranging consequences for staff, teams, and care processes, with informants explicitly linking these behaviours to diminished safety preparedness and erosion of maternity care quality. Reported consequences included emotional and cognitive disruption, delays and suppression of information, a culture of fear and caution, and a pervasive sense of helplessness.

Across both sites, informants described profound emotional and cognitive disruption following uncivil encounters. Feelings of hurt, anxiety, and frustration were common, alongside physical effects such as sleep difficulties, headaches, and sickness absence. These impacts were cumulative and particularly pronounced for students, internationally educated midwives, and newly qualified staff. SPARROW illustrated this vulnerability, "*[she] phones in sick for her next shift… and so it begins! The anxiety of coming into work and working with certain people."* Such experiences diverted attention from clinical work and generated a sense of dread that undermined confidence. As ROXY described, enduring entrenched disrespect in leadership settings as a longer-term toll, *"It's …emotional baggage and career hindrance."*

Cognitive diversion manifested as rumination, uncertainty, and self-doubt. A single uncivil incident could preoccupy informants' thoughts for extended periods, diminishing concentration, situational awareness and psychological wellbeing. SUNSHINE captured this, *"It was like haunting me whole night… I was not happy."* These disruptions depleted emotional resources and compromised informants' capacity to anticipate or respond to risks.

Incivility also interfered with care processes through delays, avoidance, and suppression of information. Informants reported incomplete or late documentation, unsafe task allocation, and strained communication. Several informants from Site Y raised concerns about inaccurate or absent notes, echoing external regulatory findings. Hostile interactions around task allocation further impeded care, reinforcing assumptions that racialised staff should undertake specific clinical tasks. As HELEN reflected, *"…if I'm already doing something. Don't wait until I'm finished to come and tell me patients' needs. You can do it because you are trained to do it."*

Strained relationships compromised timely escalation and help-seeking. Staff who felt belittled or dismissed hesitated to request support, even when clinically warranted. OAKTREE explained, *"It might knock your confidence … you might not want to go and ask for help. So that's again, putting the patient at risk."* Cross-departmental incivility intensified vulnerability; one example involved a labouring woman moved repeatedly between triage and the labour wards with hostile remarks related to competence, and SPARROW noted how this *"increased her anxiety… potentially increasing [the labouring women's] adrenaline and shutting down her labour."* Everyday work also slowed when colleagues withheld support or engaged minimally in team care. As HELEN observed, *"It's an unhealthy place… because we are not working together."*

A climate of fear and caution developed as another significant consequence. Incivility reinforced racialised and gendered stereotypes, prompting heightened self-monitoring that eroded psychological safety for racially minoritised staff. Many informants adapted their behaviour to avoid negative interpretations, with the risk of misperception itself becoming a safety hazard. As HELEN reflected, *"It's easy for them to see us as being*

aggressive… it makes you a lot more self-conscious… when you are too self-conscious, you tend to make errors." Students and newly qualified midwives were particularly vulnerable to mislabelling and stereotype threat, with SAMIYA explaining, *"I just felt suffocated… they've got this one perception of me now and it's not going to change*." Such early experiences shaped career intentions and risked undermining current and future workforce diversity.

Women and families also contributed to a sense of helplessness, particularly when organisational protections were limited. Informants described feeling "*frightened,"* "*demoralised,"* or "*paralysed"* when confronted with hostility. HELEN articulated the dilemma, *"It gives a bad feeling inside and it makes you feel paralysed because we are socialised to think that the patient is always right."* Some informants avoided certain patient allocations, and in some cases uncivil patients were moved to the end of clinical lists, risking delayed recognition of deterioration.

Perceptions of organisational influences of incivility

Informants identified multiple organisational factors that shaped the frequency, intensity, and impact of workplace incivility. These factors reflected failures in learning and actioning from leadership, under-resourced cultural and training infrastructures, and racialised workplace contexts that normalised disrespect and diminished psychological and professional safety. These organisational dynamics were reported to create environments in which violations of mutual respect became routine and difficult to challenge, particularly for racially minoritised staff.

A prominent concern across both sites was the perceived inaccessibility and apathy of management. Leaders were described as detached from the realities of the shopfloor

reinforcing mistrust, resentment, and an entrenched “us and them” divide. PRINCE captured this sentiment, *“…by sitting in their ivory tower offices and not coming to see the minions… it makes you feel like they don't care… And I think that demotivates staff.”*

Informants in listening and equity roles viewed them as symbolic, with limited authority or organisational support to respond to generalised and racialised incivility concerns. KHADIJA summarised this as, *“…a cycle of staff not being listened to or listening with no action”*. Informants reported that even when leaders articulated supportive values, the absence of accountability rendered these commitments hollow. As ROXY shared, *“You'll have leaders… that will talk the talk, but do not walk the walk… it's all empty words… Who is holding those people to account?”* The perception that leadership rhetoric lacked scrutiny, or consequence reinforced cynicism and contributed to the permissive environment in which incivility could flourish.

Strained organisational culture and climate further enabled uncivil behaviours. Informants frequently linked incivility to structural pressures such as low staffing, heavy workloads, and limited time, which created emotional volatility, impatience, and poor communication. HELEN reflected*, “People feel pressured and understaffed…things that are done in subtle ways… people are just being petty.”* The normalisation of *“petty”* behaviours and chronic complaining shaped daily interactions. For some, this created a pervasive negativity that overshadowed job satisfaction. JLO explained, *“When I go to work I can't… enjoy my job. There's always some kind of drama… it's just a bit draining.”*

Training provision was also perceived as tokenistic and disconnected from relational practice. Service pressures limited access to civility training, and content lacked

practical relevance. As TINKERBELL observed, *"You can sit and read it… but actually in practice, you have to kind of be in it… It's almost like token measures of trying to teach and train."* This gap between policy and practical enactment contributed to weakened cultural humility and inconsistent behavioural expectations. Despite organisational values emphasising equality, respect, and trust, informants shared stark inconsistencies in how these values were enacted. SUNSHINE stated, *"There is no [Trust acronym] value… Equality is not there, accountability? I don't know. Respect. No, also trust."* Responses to external reviews or regulatory findings were seen as reactive and insufficiently resourced, a point SPARROW summarised in this broader statement of values and expected compliance without structural investment *"You want all of this to improve… But we're not gonna give any money for it… It feels like the support isn't there externally, as it should be."*

Racialised organisational contexts further shaped incivility. Many informants described poor diversity management, entrenched cliques, and patterns of favouritism that advantaged some staff while marginalising others. KHADIJA characterised this as a system where success was determined by *"who you know rather than what you know,"* reinforcing social power structures. Additional cultural labour, such as interpreting, disproportionately fell to bilingual racially minoritised staff and was seldom recognised as OAKTREE observed, *"You do more extra work"*

Finally, several informants highlighted the backdrop of racialised public discourse and subtle prejudices that permeated workplace interactions. MELISSA described how *"sometimes it's very hard to identify rudeness because of the subtlety… You know it's there, but you cannot actually put your hand on it."* These biases shaped not only staff

experiences, but also clinical interactions, such as assumptions about pain tolerance among darker-skinned women, as raised by HIBISCUS. Student midwife, SAMIYA described witnessing these biases in maternity triage affecting whether the woman's pain would be believed and leading to subsequent visits, she recalls, *"I try and advocate for the women… they say stuff like she doesn't even look like shes in that much pain…alot of the times that would result in like them having to come back multiple times."*

Structural pressures, insufficient organisational learning, weak accountability, and racialised environments were perceived to interact and shape the everyday landscape of incivility, with significant implications for workforce wellbeing and equitable maternity care.

The four headings in Table 2 correspond to the core tenets of racialised organisations and are used to group related empirical findings.

456 *Table 2 Map of the tenets of racialised organisations and empirical data*

Tenets of racialised incivility	Summary of empirical evidence	Example Illustrative quotes
1) Structural privileging of whiteness	Racially minoritised staff were more likely to be dismissed, disbelieved, or allocated unsafe work, signalling whose competence was prioritised. For example, SPARROW, recounted how an internationally educated midwife was allocated a complex case without support, while SAMIYA observed that racialised women's pain was routinely minimised. MELISSA, a Black midwife, perceived she was judged more harshly than white peers after a drug error, suggesting that racialised assumptions shaped both professional	"…she should have never been allocated that woman…" (SPARROW) "…they might not take the pain threshold for like ethnic minorities … they always didn't take them as much as seriously as say like a white person" (SAMIYA) " I made a drug error…and she really wiped the floor with me … the fault was in the system" (MELISSA)

	accountability and the care offered to women and families.	
2) Policies reproducing inequities	Seemingly neutral policies failed to protect racialised staff. TINKERBELL, a senior midwife, noted that formal mechanisms offered no local support when experiencing partner incivility, due to human-rights framing. Similarly, SUNSHINE, a procurement officer, described how Trust values such as equality and respect were not enacted, with racialised staff disproportionately experiencing a lack of accountability. These dynamics show how disconnected policies from practice produced unequal outcomes.	"We've absolutely no recourse… we can't affect his [partner] human rights." (TINKERBELL) So it should be like equally everybody…what you call [Trust acronym] value. The [Trust acronym] value is not happening, especially there…Equality is not there, accountability? I don't know. Respect. No, also trust…There is no [Trust acronym] value' (SUNSHINE)

3) Everyday interactional norms prioritising majority cultural capital	Banter, cliques, and subtle exclusion reflected dominant cultural capital and made minority staff feel othered. For example, SPARROW described racially stereotypical “banter” and HELEN described modifying her tone and emotional expression to avoid being perceived as “aggressive,” demonstrating how racialised feeling rules required heightened self-monitoring and contributed to stereotype threat. These norms reinforced in-groups and out-groups, making it difficult for minoritised staff to challenge incivility or access support.	"… nobody said anything directly, just the banter… things that were stereotypical to this other race” (SPARROW) [They] see us as being aggressive… it makes you a lot more self-conscious, which is unnecessary because when you are too self-conscious, you tend to make errors (HELEN)

4) Institutionalised power asymmetries	Unsafe allocations, delays, and routine workarounds were normalised through organisational power asymmetries that determined whose risk was tolerated. ROXY compared entrenched cliques to those identified in previous maternity scandals which reinforced minimal accountability. OAKTREE, a multilingual midwife, explained being repeatedly asked to undertake extra interpreting labour, illustrating how racialised staff became absorbers of organisational strain. This reveals how institutional histories and workforce hierarchies shaped racialised distributions of labour, responsibility, and risk.	Its entrenched sedimented cliques, the pack mentality that was identified in Morecombe Bay. So these cliques are created because people are left to their own device and there's no accountability." ROXY "...it puts you at a disadvantage because let's say for example a lady needs a phone call and she needs an Urdu interpreter. They would then say are you OK to just do the phone call and then you do more extra work..." OAKTREE

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Concluding Discussion

Workplace incivility is widely recognised as a threat to organisational culture and staff wellbeing, yet its racialised dimensions remain underexplored in global scholarship (Keller et al., 2020; Joseph et al., 2025). Drawing on qualitative data from racially minoritised staff across two NHS maternity units, this study shows how incivility operates as a racialised, multi-level organisational mechanism in routine maternity care. Using a racialised-organisations lens, it generated three categories covering care processes and informal communication, safety impacts, and organisational influences shaping incivility experiences. This analysis positions incivility as an overlooked organisational safety hazard that should be explicitly integrated into patient safety policy and governance.

Incivility experiences in maternity care processes and informal communication

Incivility was embedded within core care processes including communication, documentation and work allocations that are recognised system-wide pressures in maternity systems (Liberati et al., 2021). However, informants described these operational shortcomings as taking on racialised dimensions in practice, disproportionately affecting workloads, access to information, support and a sense of safety. These uneven impacts reflected how existing hierarchies shaped who was resourced, included, or protected in day-to-day work. Such patterns mirror wider evidence showing that racially minoritised healthcare workers are often held individually responsible for systemic risks despite having limited control over decisions that shape their work (Kline & Somra, 2021; Woodhead et al., 2022).

Informants described incivility as subtle and cumulative, enacted through tone, exclusion, dismissiveness, gossiping, banter and cliques, patterns consistent with global evidence (Keller et al., 2020; Woodhead et al., 2022). Consistent with Ray's (2019) argument that ostensibly race neutral organisational practices maintain racial hierarchies, these behaviours were structured and unevenly distributed across racialised and hierarchical lines. Informants shared heightened exposure to incivility from multiple sources, alongside fewer protections or routes to redress, reinforcing occupational hierarchies that are both racialised and gendered. Our findings challenge accounts that frame incivility as a generalised violation of respect (Smith, 2022), demonstrating instead how racialisation shapes its form, frequency, and impact. While recent efforts to enhance conceptual clarity and to distinguish incivility from other forms of unprofessional behaviour are important (Aunger et al., 2026), such approaches risk abstracting incivility from the social conditions in which it is produced. Adopting a social science perspective, this study theorises incivility as an interactional mechanism through which racialised structural and relational conditions are enacted and reproduced in everyday practice. In doing so, it shows how incivility differentially exposes racially minoritised staff to harm and erodes safety-critical processes, thereby linking racialisation directly to organisational safety outcomes.

Partner incivility, expressed through the invalidation of knowledge, being ignored, or direct disrespect, was reported as a key concern, which supports review findings on the prevalence and impact of rudeness from patients and visitors (Townsley et al., 2023). Similar to Cottingham et al., 2018, we found a lack of localised protocols to address such behaviours, reflecting broader evidence that healthcare organisations position racially minoritised women in roles marked by increased emotional labour, limited

autonomy and poorer support (Wingfield, 2010). Building on Wingfield's analysis of emotion work as unequally distributed along racial lines, Ray's (2019) framing of organisations as racialised structures, whereby majority organisational norms constrain the agency of racially minoritised staff, clarifies how this additional emotional labour functioned as a distinctly racialised burden.

In responding to incivility, many informants adopted avoidance strategies, including ignoring behaviours or withdrawing from interactions. Such responses are consistent with established typologies of coping with incivility, including retreat and emotional regulation (Cortina & Magley, 2009; Cortina et al., 2022). Our study observed collective protective strategies through informal peer support and advocacy, highlighting solidarity and resilience among racially minoritised staff. This extends predominantly individualised models of coping by foregrounding relational strategies within racialised organisational contexts, which may require further research.

Incivility poses a threat to safety and care quality

Informants consistently linked incivility to both indirect and direct compromises of patient safety. Emotional depletion, cognitive distraction, delays in communication, and reduced help-seeking emerged as key mechanisms through which incivility compromised care. These effects accumulated over time, eroding teamwork, trust, confidence, and willingness to speak up, aligning with safety science research demonstrating how relational breakdowns and heightened social emotions increase the likelihood of error and adverse events (Sattar et al., 2024; Freedman et al., 2024).

Importantly, incivility disrupted escalation pathways. Informants were dismissed or ignored in clinically important situations and those who felt belittled or dismissed

questioned whether to seek help or raise concerns. These delays and reluctance of colleagues to support them directly undermined core patient safety principles reliant on open communication and timely escalation (Francis, 2013; Mitchell et al., 2023). Psychological safety was unevenly distributed across maternity teams; rather, it is shaped by racialised power relations that determine whose voices are legitimised within safety-critical moments. Further, informants' accounts of attributional uncertainty reinforced the racialised nature of incivility. Staff frequently questioned whether behaviours were racially motivated. This reflects contemporary forms of "race-neutral" or colour-blind organisational cultures (Bonilla-Silva, 2018), whereby racialised hierarchies and experiences are systematically denied as individual failings or lacking significance. This uncertainty constituted safety-relevant harm, as it generated sustained emotional and cognitive labour, diverting attention from clinical vigilance and decision-making. Such findings extend research linking workplace mistreatment to reduced cognitive capacity and increased error risk (Freedman et al., 2024; Bradley et al., 2015).

Incivility from patients and families further compounded safety risks. While maternity care prioritises relational and patient-centered approaches (Silverio et al., 2022), racially minoritised staff described feeling unsupported when facing hostility from women and visitors, leading to avoidance behaviours and, in some cases, delayed care.

Organisational influences shape incivility experiences

A central contribution of this study lies in its examination of organisational listening mechanisms as patient safety infrastructures. Formal reporting and speaking-up systems were commonly experienced as dismissive, slow, or ineffective, often

reframing concerns as interpersonal issues rather than safety threats. This mirrors national evidence that racially minoritised staff are less likely to raise concerns and less likely to see action when they do (Kline & Warmington., 2024). Ray's (2019) concept of organisational decoupling helps explain why formal commitments to equity and safety coexist with persistent racialised incivility. Informants experienced a disconnect between organisational rhetoric and lived reality. Listening mechanisms appeared oriented toward preserving organisational legitimacy rather than addressing harm, reducing trust and reinforcing silence, which aligns with indicators of a toxic organisational culture found in a study that analysed 462 tweets from #MedTwitter (Mesinioti et al., 2026). These findings suggest that interventions focused solely on individual behaviour change through civility or compassionate leadership training are insufficient when racialised organisational structures remain intact (Jones et al., 2022; Okeahialam et al., 2025). Ray's (2019) notion of whiteness as a credential helps explain why existing safety and civility interventions often fail racially minoritised staff. Professional norms, emotional restraint, and "appropriate" communication were implicitly aligned with white, middle-class standards, positioning racially minoritised staff as risky or unprofessional when expressing concern or distress (Motro et al., 2021). Although recent analysis of a Twitter thread suggests a broader NHS culture of fear around speaking up (Mesinioti et al., 2026), racially minoritised informants described additional layers of self-monitoring and tone-policing to avoid being perceived as aggressive or difficult. This suppression of voice creates safety risks by limiting honest communication and timely escalation in high-risk maternity environments. These findings reinforce calls to conceptualise patient safety as

inseparable from workforce equity and inclusion (Mitchell et al., 2023; Tsuei et al., 2025).

Addressing incivility therefore requires multilevel transformation at institutional and policy level rather than individual-level behavioural fixes (Mir et al., 2020). This includes embedding racism literacy (including subtle uncivil behavioural manifestations) within leadership and safety roles, integrating racialised incivility into safety management and intelligence systems, and holding organisations accountable for inequitable listening outcomes. Without such shifts, safety initiatives risk reinforcing the very hierarchies they seek to dismantle.

Implications for theory, policy, and practice

This study shows that racialised incivility is not solely an interpersonal lapse but a system threat to maternity safety. In high-risk teams, safe care relied on psychological safety to enable timely escalation, coordinated teamwork, and trust, yet racialised disrespect suppresses speaking-up, disrupts clinical communication, and erodes relational safety. This increases the likelihood that early warning signs are missed or not acted upon (Edmondson, 1999). Dominant patient safety frameworks often reference "system factors" without specifying how structural inequities shape those systems (Schulson et al., 2022; Tsuei et al., 2025), leaving racialised risks unaddressed. This gap enables incivility to persist and weakens vigilance, reflecting the persistent cultural fragilities endemic across maternity services, identified in the national maternity and neonatal investigation interim findings (Amos, 2026). Embedding equity explicitly within maternity safety policy is therefore essential, including strengthening accountability by

595 providing protections for staff voice and resourcing listening mechanisms with racism
596 literacy.

597 The increasing number of migrant staff into UK maternity services places an obligation
598 on organisations to provide safe, equitable, and inclusive conditions for internationally
599 educated recruits. Recent reviews show that internationally educated nurses and
600 midwives often experience discrimination, limited recognition of prior expertise, and
601 uneven support, making diversity management a core component of patient-safety
602 governance rather than a peripheral Human Resources concern (Mpando et al., 2025).
603 Consistent with system-level findings from the Ockenden Review (2022), which
604 identified dismissiveness, poor teamwork and closed organisational cultures as core
605 contributors to unsafe maternity care, incivility must be treated as a safety signal rather
606 than solely a behavioural issue. This aligns with wider calls for safer, more open and
607 equitable maternity services (Francis, 2013; Kline & Somra, 2021;Amos, 2026).

608 **Strengths and limitations**

609 This study has several strengths. It draws on longitudinal, multimethod qualitative data
610 to examine an underexplored phenomenon in a high-risk maternity context,
611 foregrounding the experiences of racially minoritised staff who are often marginalised in
612 patient safety research). Informants accounts reflected lived experience that is integral
613 to understanding how racialised incivility is perceived and enacted in practice
614 (Madison, 2020). The combined use of interviews and WhatsApp diaries enabled
615 analysis of both immediate and cumulative experiences of incivility, illuminating how
616 racialised incivility undermines core safety mechanisms such as escalation, situational
617 awareness and psychological safety. These findings identify organisational contributors

to incivility that represent actionable targets for intervention development and offer a framework for future ethnographic inquiry.

Several limitations should be acknowledged. The study was conducted across two NHS maternity units, and findings are therefore not statistically generalisable (Green & Thorogood, 2018). The sample included several racially minoritised groups and healthcare worker roles and these broader categorisations may obscure within-group differences. Future research should examine racialised incivility across diverse organisational settings and consider how intersecting identities, roles, and career trajectories shape safety-critical experiences including collaborative care and escalation pathways.

Conclusion

This study demonstrates that incivility experienced by racially minoritised maternity staff is structurally produced and sustained through racialised organisational processes that shape whose concerns are heard, legitimised, and acted upon. By applying the theory of racialised organisations, the findings reveal how everyday incivility heightens systemic patient safety risks, compromising communication, vigilance, and relational care. Addressing incivility requires multi-level organisational approaches that place racial justice as central to patient safety, not at its margins.

List of Abbreviations

NHS – National Health Service

WRES – Workforce Race Equality Standard

CTG – Cardiotocography

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Declarations

Ethics approval and consent to participate

Ethical approval was granted for all research material from University of Leeds School of Psychology ethics committee (PSYC-671) and the governance and legal compliance approval sought and obtained from the Health Research Authority (23/HRA/0699). All procedures were conducted in accordance with the ethical standards of the institutional research committees, the Declaration of Helsinki, and the UK Policy Framework for Health and Social Care Research.

Consent for publication

All authors have reviewed the manuscript and consented to this publication.

Availability of data and materials

The datasets generated and analysed during the current study are not available from the corresponding author to protect individual privacy and maintain confidentiality.

Competing interests

The authors declare that they have no competing interests.

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