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The NHS: Sticking Fingers in Its Ears, Humming Loudly

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Abstract Evidence exists that the UK National Health Service (NHS) has had, over many years, persistent problems of negative and intimidating behaviour towards staff from other employees. The evidence also suggests the organisational responses to negative behaviour can be inadequate. A conceptual model of organisational dysfunction was proposed to assist in explaining those responses and the overall culture in the NHS (Pope and Burnes 2013). Through research this model has been tested. Based upon the findings, an extended and developed model of organisational dysfunction is presented. A qualitative approach was taken to research the organisational responses to negative behaviour, and the reasons and motivations for those responses. Forty-three interviews and six focus groups were conducted. There seem to be "islands" and "pockets" with a positive culture; however, the generalised evidence suggests the NHS is systemically and institutionally deaf, bullying, defensive and dishonest, exhibiting a resistance to 'knowing', denial and "wilful blindness"; a dysfunctional, perverse and troubled organisation. Totalitarian and Kafkaesque characteristics are identified. The NHS could also be described as a coercive bureaucracy and under certain definitions, a corrupt entity. The NHS appears to be an organisation with a *heart of darkness;* a "self perpetuating dysfunctional system". There may be widespread "learned helplessness". It seems to be a "good news factory", rejecting and hiding any "bad news"; retreating from reality. The NHS appears to have "lost its way" and its focus/purpose as an institution. The dysfunctional organisational behaviours manifest in the NHS need to be addressed urgently as there is a detrimental, sometimes devastating, impact on the wellbeing of both staff and patients. The NHS needs to embrace an identity of being a listening, learning and honest organisation, with a culture of respect.

Keywords NHS · Bullying · Organisational silence · Corruption · Protection of image · Selective moral disengagement

Introduction

Research on negative behaviour between staff was conducted in two NHS Primary Care Trusts in 2005 (Burnes and Pope 2007; Pope and Burnes 2009). It was concluded that negative behaviour from NHS staff to other employees had a detrimental impact on individuals, including witnesses. There were implications for the quality of the patient care delivered.

Between 2005 and 2008, attempts were made to share the findings of the research at the organisational, regional and national levels of the NHS. In 2005, as the findings were about to be shared in a meeting, the trust directors unexpectedly left the room. In 2006, an offer was made to present the findings to the Board, but this was refused. At the regional and national levels of the NHS, requests were made for more effective action to be taken. Some commitments were made, but were never acted upon. It appeared there was a complete lack of interest in the problems of negative behaviour.

The local scenario is explored conceptually in Pope and Burnes (2013) and a model of organisational dysfunction in the NHS proposed (Fig. 1). Reasons for the apparent disinterest and the seemingly bizarre and irrational responses

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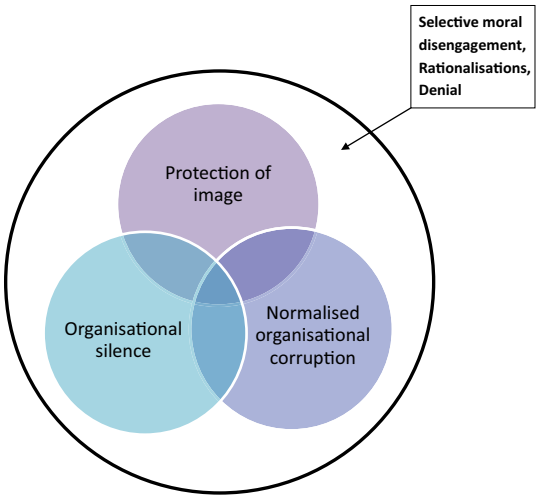

Fig. 1 Model of organisational dysfunction in the NHS (Pope and Burnes 2013, p. 684)

of the directors are discussed. It is considered that the concepts of organisational silence, normalised organisational corruption and protection of image provide some of the answers to this behaviour, as does the theory of selective moral disengagement. The desire to protect the image and the individual and collective self-esteem was thought to be the dominant influence in the situation.

It was concluded in Pope and Burnes (2013) that

> …organisational behaviour in the NHS can be dysfunctional, not always rational, and perverse…Organisations and the individuals within them can hide and retreat from reality and exhibit denial; there is a strong resistance to voice and to 'knowing'. The persistence and tolerance of negative behaviour is a corruption and is not healthy or desirable. Negative behaviour is one of the 'elephants in the room' for the NHS. (p. 691).

For the purpose of this article, negative behaviour is defined as: "Any behaviour that is disrespectful and undermines/violates the value/dignity of an individual. It is behaviour that harms individuals and organisations" (Burnes and Pope 2007, p. 300). It includes incivility, aggression, bullying, harassment or abuse.

This article covers the following:

Section 2: Literature Review The literature review firstly covers negative behaviour in the NHS and the theory of selective moral disengagement. The review continues by exploring the concepts of organisational silence, normalised organisational corruption and protection of image.
Section 3: Methodology Describes the qualitative methodological approach and the methods employed in the research study.
Section 4: Findings The findings are described under the headings of thirteen of the Framework Themes. Explicit and implicit assumptions/beliefs are identified.
Section 5: Analysis and Discussion Comparisons are made between the findings and the proposed model of organisational dysfunction. The model is extended and developed.
Section 6: Conclusions and implications Conclusions are drawn and implications for practice outlined. Some recommendations are made.

Literature Review

Negative Behaviour in the NHS

In Pope and Burnes (2013), an extensive literature review was detailed on the topic of negative behaviour within the NHS. The review identified some key themes as follows:

- "The NHS appears to have a widespread and persistent problem with negative behaviour between staff…
- Negative behaviour can be accepted, ignored and denied.
- The responses to, and management of negative behaviour in the workplace can be inadequate.
- Negative behaviour between staff can have a detrimental impact on patient care.
- Questions are asked and calls for action are present, but there is little evidence of NHS organisations taking effective action" (p. 683).

This review is more selective and includes more recent literature. Various research studies, and other sources identify problems with negative behaviour in the NHS and the often inadequate responses, e.g. Adams (1992), Quine (1999), Hadikin and O'Driscoll (2000), Randle (2003, 2006), Hume et al. (2006), Lewis (2006a, b), Randle et al. (2007), Burnes and Pope (2007), Edwards and O'Connell (2007), Paice and Smith (2009), Pope and Burnes (2009), Department of Health (2009), Bowles and Associates (2012), NHS Wales (2013), Health and Social Care Northern Ireland (2013), NHSScotland (2014) and National NHS Staff Survey Coordination Centre (2015).

As part of a national study of ill-treatment in the workplace, a large NHS trust of some 30,000 staff is referred to in "Trouble at work" (Fevre et al. 2012). "…swearing, screaming and aggressive gestures seemed to be a common occurence for many staff both in face-to-face meeting and on the phone" (p. 157). "…tension between clinicians and administrators/managers seemed to be a fact of life" (Fevre et al. 2011, p. 27). Fevre et al. (2012) suggested the key predictor of a troubled workplace was

that "…individuals did not matter there" (p. 52). Ballatt and Campling (2011) in "Intelligent kindness: reforming the culture of healthcare" make comments about leadership behaviour referring to the silencing and bullying of staff.

Mandelstam (2011) describes the NHS as a "…pyramidal, command and control structure" where "…targets and other imperatives emanate from the centre" (p. 232). "… a culture of dangerous, indiscriminate obsequiousness and servility" has been created. There are "…two key lubricants needed to ensure that priorities and targets are hit, come what may and no matter how detrimental: fear and bullying" (p. 231).

Research on negative behaviour was conducted in seven trusts in the North East of England (Carter et al. 2013). Twenty percent of the 2950 participants reported being bullied by other staff to some degree, and forty-three percent reported witnessing bullying in the last 6 months. For most, the source was a supervisor or manager (51.1 %). They concluded that negative behaviours and bullying were a persistent and significant underreported problem in healthcare organisations. "…managers often failed to act when staff reported bullying, resulting in no change or a worsening situation" (p. 7) and "Workplace cultures in which bullying behaviours remained unchecked…relayed the message that bullying was acceptable" (p. 7).

Experiences of physiotherapy students on clinical internships are explored by Stubbs and Soundy (2013). The fifty-two students experienced incivility and various bullying behaviours which had a negative impact on their wellbeing. The perpetrator was mostly the clinical educator (62 %). A qualitative study was also undertaken (Whiteside et al. 2013) with eight final year students who had experienced at least one incident of bullying behaviours during their clinical internship. "…bullying can have profound and adverse effects on the health of the students" (p. 6).

"Bullying is rife in the NHS, as staff surveys show. Bullying and coercion are seen as ways of getting things done. It comes all the way down the line" (Drew 2013). In some hospitals "…disrespect, bullying and dishonesty are still the all too common day-to-day experience of many" (Drew 2014, p. xii). "Of course no trust ever admits to this problem. Few…deal with it decisively, and in some it is a management tool" (p. 177). He also describes a culture of secrecy, "…management cronyism" (p. 175) and elitism where there is a lack of accountability and the "…managerial clique typically enjoy a startling level of immunity" (p. 177).

The inquiry report on the failings of the Mid Staffordshire hospital identified a negative workplace culture of fear, bullying, target-driven priorities, disengagement from management and leadership responsibilities, low staff morale, isolation, lack of openness and candour, acceptance of poor behaviours, reliance on external assessments and denial of concerns. "Unfortunately, echoes of the cultural issues found in Stafford can be found throughout the NHS system" (Francis 2013, p. 1361).

The "Freedom to speak up" report on raising concerns in the NHS (Francis 2015) notes that "Bullying and oppressive behaviour was mentioned frequently, both as a subject of concern and as a consequence of speaking up" (p. 10). There were

> …more references to bullying in the written contributions than to any other problem. These included staff raising concerns about bullying, or being afraid to do so, bullying of people who had raised concerns and frustration that no-one ever appeared to be held to account for bullying (p. 12).

Selective Moral Disengagement

The theory of selective moral disengagement (Bandura 2002) assists in explaining the process and psychological mechanisms by which moral self-sanctions are selectively disengaged from inhumane and reprehensible conduct. The inhumane conduct is cognitively restructured into "…a benign or worthy one" (p. 101). Mechanisms are described that cognitively redefine our actions to lessen and remove feelings of guilt and self-censure. In other words, selective moral disengagement is how we can all do bad things more comfortably.

This includes moral justification, palliative/advantageous comparisons, euphemistic language; displaced and diffused responsibility; minimising, ignoring, or misconstruing the consequences of actions/denying, distorting, disputing harmful effects; dehumanisation/disparaging opponents and victims; and attribution of blame for our damaging actions. Figure 2 as in White et al. (2009, p. 42) identifies the points "…in the process of moral control at which moral self censure can be disengaged from reprehensible conduct" (Bandura 2002, p. 102). Selective moral disengagement features "…most prominently in patterns of behavior that serve the user in some way, but injure others" (Bandura 1986, p. 375).

Reviewing failures within international health systems, including the UK, Walshe and Shortell (2004) identify that "…the capacity of individuals and organizations for self-deception and post hoc rationalization in the face of unwelcome information often plays a part in their inaction" (p. 107). Regarding the Bristol Royal Infirmary (BRI) tragedy, Weick and Sutcliffe (2003) identified socially acceptable rationalisations and justifications as critical to reinforcing and confirming the actions of a failing health system which was unable to learn.

Mandelstam (2007) describes the "…excessive use of emotive but empty language" (p. 166), the language of

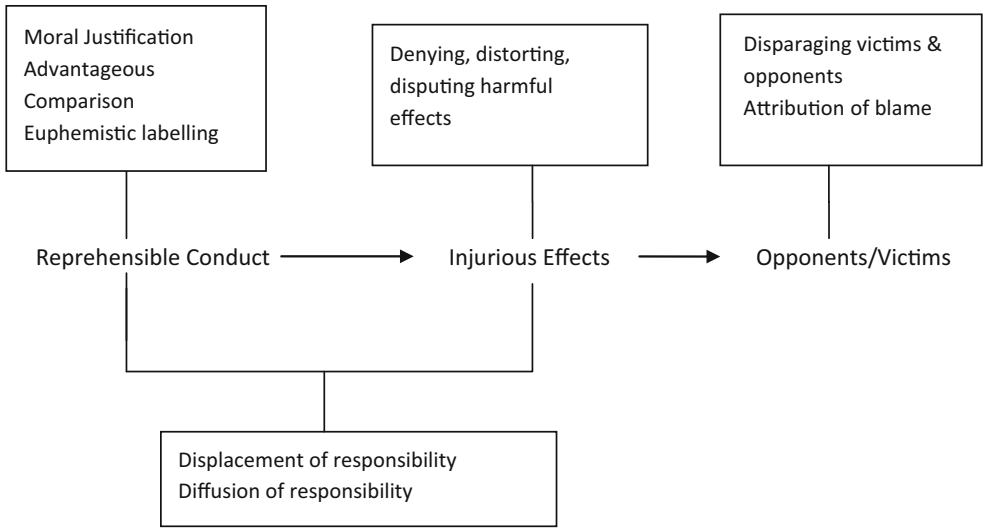

Fig. 2 Mechanisms through which moral self-sanctions are selectively disengaged from detrimental behaviour at different points in the moral control (White et al. 2009, p. 42)

euphemism, doublethink or doublespeak and misrepresentation. There is a chasm between the "…official line and the real world" (p. 70). In the context of cuts in services, there is also the 'stardust' of the brightness and jollity of the websites and the use of mantras (e.g. "changing for the better"; new models of care would "develop and thrive" and be "dynamic" (p. 168).

Riddington Young et al. (2008) liken the NHS to East Germany with the Stasi security police, referring to their use of "…euphemisms, double speak and downright lies" (p. 14). Taylor (2013) refers to the 'big lies' in the NHS.

"The Francis Report gave no comfort that a culture of denial did not exist across the NHS as a whole" (Public Administrations Select Committee 2014, p. 5). There is "…confusion in the language. A complaint is a complaint…Other euphemistic terms for "complaint" should be banned" (p. 36).

Organisational Silence

A comprehensive conceptual model has been detailed by Morrison and Milliken (2000) looking at the organisational characteristics and beliefs resulting in a climate of silence. Employees know the truth about problems, but they "…dare not speak that truth to their superiors" (p. 706). The outcome is 'organisational silence' and an inability to learn and change. There are implicit managerial beliefs of "…employees are self interested", "…management know best" and "…unity is good and dissent is bad" (p. 709). Managers fear and reject negative feedback and tend to respond negatively to dissent. There is centralised decision making with a lack of informal and formal upward feedback.

This, for the employee, results in feelings of not being valued, a lack of trust, decreased motivation and satisfaction, withdrawal and turnover, as well as "Sabotage/deviance" and stress (p. 718). The organisational outcome is less effective organisational decision making and decreased error detection and correction. The model is supported by the research of Milliken et al. (2003), Vakola and Bouradas (2005) and Park and Keil (2009).

"…positive information is likely to flow up organizational hierarchies much more readily than negative information" (Milliken et al. 2003, p. 1473), which "…can compromise an organization's ability to detect errors and engage in learning" (p. 1473). There can be a "…skewed transfer of information" and a "…misleading "rosy" outlook" (Milliken and Lam, 2009, p. 240). "…an organization's ability to learn about the effects of its actions can be severely disabled" (p. 242).

Morrison and Rothman (2009) explore "Silence and the dynamics of power" (p. 111). "…the power imbalance inherent in organizational roles is perhaps *the* most important factor that makes employee silence such a common experience" (p. 112, italics in original). Alford (2001) considers that whistleblowers offer truths which are "…experienced as a threat to power" (p. 3). To "…run up against the organization is to risk obliteration" (p. 4). Organisations are also "…the enemy of individual morality" (p. 35).

Organisational Silence in Healthcare

Nurses in Western Australia described many serious examples of misconduct with detrimental outcomes for patients (McDonald and Ahern 2000). There were official

reprisals for twenty-eight percent of the whistleblowers and all of the whistleblowers reported unofficial reprisals. Whistleblowing had a devastating impact and the nurses suffered "…profound professional effects" (p. 319).

Speedy (2006) writes about workplace violence which they consider is common in the nursing profession, and the silence that results. "An environment in which there are issues that are not discussable is created when fear of retribution keeps targets and witnesses silent" (p. 247). Henriksen and Dayton (2006) consider organisational silence and the hidden threats to patient safety.

Organisational Silence in the NHS

Kennedy (2001), Alaszewski (2002), Weick and Sutcliffe (2003) and Kewell (2006) identified a culture at the BRI where there was a resistance to the raising of concerns and identification of problems, as well as a culture of fear.

It is revealed in Commission for Health Improvement reports that employees attempted to "…blow the whistle on abuse, corruption or malpractice but were largely ignored" (Faugier and Woolnough 2002, p. 315). "…too many bosses 'need to know' only good news" (p. 319). "Constraints upon NHS managers to speak their minds freely place an ultimate limit on learning organisational development" (Sheaff and Pilgrim 2006, p. 1).

The inquiry reports into the disaster at Mid Staffordshire hospital (Francis 2010, 2013) identified that people did try to raise concerns about poor patient care. "The tragedy was that they were ignored" (Francis 2010, p. 3). "A picture was starting to emerge of a deep-rooted culture of silence where any dissenting voices were cruelly dealt with" (Bailey 2012, p. 145).

Mandelstam (2011) considers there is "…a health care world of mostly muted, not raised voices. And, too often, silence" (p. 256). "Individuals raising concerns—or ideas—face high anxiety and vulnerability to being ignored, or even punished" (Ballatt and Campling 2011, p. 186). Pink (2013) started expressing his concerns in 1989 about the lack of appropriate care and lack of staff. Trying to talk to someone was like "…speaking to the deaf" (p. 98). He was up against a "…wall of silence and indifference" (p. 64). "…there is no freedom to speak the truth in the NHS" (p. 241).

Regarding discretionary awards for doctors, "If you want one of these awards, you clearly need to toe the line and keep your mouth tightly shut" (Riddington Young et al. 2008, p. 127). A paediatric consultant (Drew 2014) raised multiple concerns about the services provided by a particular hospital, including circumstances around the death of a child. "…blowing the whistle can be a career-ending act" (p. xi).

Various public bodies have published reports identifying major problems around raising concerns in the NHS and the implications for patient safety (e.g. Public Accounts Committee 2014a, b; Health Select Committee 2015). The independent review "Freedom to speak up" (Francis, 2015) identified that people were reluctant to speak up because of fear of the repercussions on them as an individual and their career. "…there is a culture within many parts of the NHS which deters staff from raising serious and sensitive concerns" (p. 8). Still "People do not feel comfortable challenging those they see as in positions of authority and hierarchies within hospitals are a barrier to staff raising concerns" (Lampard and Marsden 2015, p. 20).

Normalised Organisational Corruption

"Corruption is a persistent feature of human societies" (Pinto et al. 2008, p. 685). Not only are individuals being seen as corrupt, but organisations themselves "…are increasingly being construed as corrupt entities" (p. 670). Unethical, antisocial, dysfunctional and deviant behaviour overlaps somewhat with the "…notion of corrupt behavior" (Ashforth et al. 2008, p. 671).

"Self-interest is always a strong driving force of behaviour, as is the tendency to justify its pursuit" (Gabor 1994, p. 336). Ashforth and Anand (2003) describe a theoretical model of the three pillars of institutionalisation, rationalisation and socialisation, producing normalised corruption (Fig. 3).

The three pillars are "…mutually reinforcing and reciprocally interdependent". "Once corruption sets in, the mutually reinforcing processes…create an unholy trinity that actively resists change" (p. 37). Euphemistic language is one of the most important factors facilitating the rationalisation and socialisation (Anand et al. 2004, p. 47).

Blaug (2014) refers to corruption as "…a general failure to orient to the common good, a crisis of moral judgement and an aggrandised and *hubristic* distortion of individual thinking" (p. 2). "…for leaders, corruption manifests itself

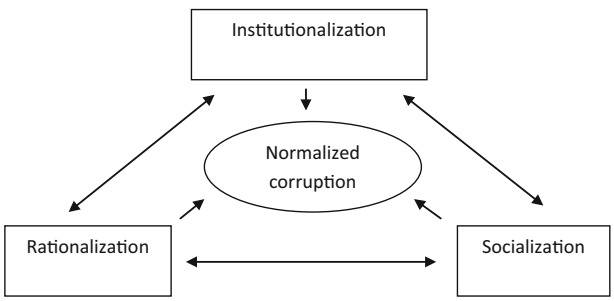

Fig. 3 The three pillars of normalisation (Ashforth and Anand 2003, p. 3)

as aggrandisement and insularity; for subordinates and citizens, common symptoms are dependence, apathy and blind obedience" (p. 4). There is "…learned helplessness" (p. 21).

At Enron, where corruption was "…becoming pervasive across the organization" (Beenen and Pinto 2009, p. 275), "Bad behavior was subtly rewarded, and good behavior was punished" (p. 280). "…Evil becomes good, and good becomes evil" (p. 281).

Pinto et al. (2008) describe two types of corruption. An organisation of corrupt individuals is where a significant number of its individuals act in a corrupt manner "…primarily for their personal benefit" (p. 688); a bottom up phenomenon. The corruption threshold is the point where "…corruption has become so widespread that it characterizes the organization as a whole" (p. 688) e.g. an 'uncivil' organisation or 'organisational silence'. The second type is the corrupt organisation where a group acts in a corrupt manner for the benefit of the organisation; usually a top down phenomenon. "…typically, the dominant coalition, organizational elites, or top management team—undertake, directly or through their subordinates, collective and coordinated corrupt actions that primarily benefit the organisation" (p. 689).

"The main challenge to working with dignity is the continuation of unilateral management power…and the resulting patterns of mismanagement and abuse" (Hodson 2001, p. 259). "The workplace is an arena suffused by power relations" (Hodson et al. 2006, p. 385). "…the interplay of relational powerlessness and organisational chaos gives rise to bullying" and chaos creates openings for the abuse of power (p. 382). A bureaucracy can be facilitative or coercive. Hodson et al. (2013) provide a "…Kafkan vision of bureaucracy" (p. 256). "The Kafkaesque aspects of bureaucracy…produce deceit, duplicity, bad faith and non-accountability…these problems…reflect its inherent nature" (p. 273).

Bauman (1989) considers the abuse and cruelty of the Holocaust was the outcome of a rational bureaucracy. "…responsibility is essentially 'unpinnable'" (p. 163). He refers to "…the easiness with which most people slip into the role requiring cruelty or at least moral blindness—if only the role has been duly fortified and legitimised by superior authority" (p. 168).

Clegg et al. (2006) in their exploration of "…total institutional power" (p. 176) and total organisations, consider that "At the core of modern organisations there is a *heart of darkness"* (p. 29, italics in original). "…the heart of organization is power and at the heart of power is a darkness that has been bleached out of contemporary accounts of power in organizations" (pp. 29–30).

Whyte (2015) in "How corrupt is Britain?" describes the "*Structures of impunity*" (p. 20, italics in original) and the widespread failure to address corruption and hold people to account.

Research in the private and public sector, but not the NHS, considers the responses of HR professionals to negative behaviour (Harrington 2010). HR professionals consistently supported and protected the line manager and the organisation. In the case of the manager as alleged perpetrator, HR sought to legitimise and rationalise the manager's behaviour. Blame was attributed to the target. Peer-to-peer negative behaviour was constructed as work-related interpersonal conflict and manager-to-employee claims seen as a problem of employee underperformance. None of the manager-to-employee claims were labelled as bullying (Harrington et al. 2012). Behaviours were rationalised "…as manager incompetence, over promotion, a lack of training or having the wrong 'tools in their manager's box'" (p. 401). Words were used such as inappropriate or counterproductive to describe the behaviours; behaviour was repackaged. Underpinning everything was the protection of the relationship between the manager and the HR professional.

It is untenable to expect them [HR] to "…service policies concerning manager-employee conflict with equity and neutrality" (Harrington et al. 2012, p. 405). HR personnel "…favoured management with considerable negative implications for employees, and currently, the employee voice appears denied" (p. 405).

Normalised Organisational Corruption in Healthcare

Corrupt as literally meaning "…rotten, depraved, wicked. Corruption refers to decomposition, moral deterioration; perversion from its original state" (Ibrahim and Majoor 2002, p. 21). They use the words 'ailing' and 'rotten' to describe health systems and view the problem as "…an organisation or corporation that has deviated from the core goal of delivering health" (p. 20).

From narrative qualitative research conducted in two Australian public sector health organisations (Hutchinson et al. 2009), a link is made between bullying and corruption. "…participants described bullying, and the organizational systems and processes that perpetuated or condoned the behavior as unethical, corrupt or evil" (p. 217). Five aspects of "…bullying as organizational corruption" (p. 217, italics in original) are described.

There is: "*…silence and censorship: the institutional backdrop",* of "…secrecy and cover up in which corrupt conduct was able to flourish" (p. 217). People were fearful of raising concerns and those who did were punished; "*…networks of predatory alliances"* of established informal networks (p. 217). The alliances were powerful and there was a "…bullying hierarchy" (p. 219); "*…corrupting legitimate routines and processes"* for personal gain (p.

219); "…*reward and promotion"* where career prospects were advanced within the alliances (p. 221) and "…*protection from detection"* within these groups (p. 222). People misused their position for "…personal power and political gain" (p. 226). "The worse you behave, the more you seem, to be rewarded" (p. 213).

Normalised Organisational Corruption in the NHS

"…there are worrying perverse incentives operating within the NHS that undermine its ethical intention…but a blind eye is deliberately turned" (Ballatt and Campling 2011, p. 187). "A fundamental aspect of perversion is the process of *turning a blind eye*" (p. 140, italics in original), which "…breeds corruption" (p. 140). Mid Staffordshire "…illustrates directly what is meant by the 'pull towards perversion'" (p. 141). They comment on the suspension and silencing of the collective conscience in that situation.

"NHS 'targets' may have a blunting effect on compassion" (Newdick and Danbury 2013, p. 3). There are unintended and dysfunctional consequences of performance management (Mannion and Braithwaite 2012). There has been a "Severing of power from responsibility" (Goddard 2008, p. 205). Power is held by managers, but responsibility has been devolved.

The NHS is "…definitely very sick" and the "…malignant mass is the Management System", which is "…sapping it of all its strength" (Riddington Young et al. 2008, p. 219). The NHS has "…already reached serious levels of incipient totalitarianism" (p. 177). Some experiences "…would not be out of place in Kafka's *The Trial*" (p. 105, italics in original). Drew (2014) found himself "…tumbling again into the world of Franz Kafka's Joseph K. I was being treated as a criminal but was unable to find out what my crime was" (p. 223).

Traynor et al. (2014) suggest there is an over use of disciplinary procedures by managers and a tendency towards punishment of UK nurses. There is evidence of "…poor managerial practice and managerial action designed to conceal processes" (p. 56). Nurses can be "…scapegoated for system failures" (p. 56).

Whyte (2015) refers to corrupt practices linked to the NHS. There is influence over health policy from peers and other politicians with interests in private health companies, e.g. owning shares and sitting on boards. Also, inappropriate relationships and lobbying of politicians to affect parliamentary decision making and further private concerns, e.g. private finance initiatives. There are pressures on "…hospital managements to massage the figures" (p. 15).

Failure is often rewarded in public life…Patients and their families who have suffered as a result of this cry "Shame!" but little changes (Drew 2014, p. 186).

Protection of Image

Institutions promote their "…righteous image" (Douglas 1986, p. 112), and "…endow themselves with rightness" (p. 92). They "…create shadowed places in which nothing can be seen and no questions asked" (p. 69).

Denial and defensiveness were often the responses to sexual harassment in large companies in the United States. Peirce et al. (1998) considered the findings reflected the work of Brown (1997) on organisational narcissistic behaviour; the need to maintain a positive self-image, and the ego-defensive behaviours required to preserve self-esteem, both individually and organisationally.

Brown (1997) interprets the 'shadowed places' (Douglas 1986) as relating to the pervasiveness of rationalisations. Groups and organisations, "…literally have needs for self-esteem that are regulated narcissistically" (p. 649).

> Just as individuals seek to regulate their self-esteem through such ego-defense mechanisms as denial, rationalization, attributional egotism, sense of entitlement, and ego aggrandizement, which ameliorate anxiety, so too do groups and organizations (Brown 1997, p. 643).

Idealisation and fantasy are other collective ego-defences (Brown and Starkey 2000).

Promoting a positive organisational image becomes very important when individual self-esteem is so closely linked to that of the organisation's identity and sense of legitimacy. Information that threatens an organisation's collective self-esteem is "…ignored, rejected, reinterpreted, hidden or lost" (Brown and Starkey 2000, p. 103).

There is a healthy level of ego-defences and self-esteem in any individual or organisation. However, there are pathological extremes of either too low or too high defence of self-esteem and image (Brown and Starkey 2000). In the organisation that overprotects its self-esteem, there is a retreat from reality and an inability to learn and change. A reality-based organisation is one where people "…face the facts of their situation and accept responsibility. It does not enable the use of denial to avoid the facts or evade responsibility" (Duchon and Burns 2008, p. 362). It is suggested that ego-defences can be mitigated by embracing the identity of a learning organisation, of becoming a 'wise' organisation (Brown and Starkey 2000).

When we join organisations "…we become like centaurs: part human; part organisation" (Blaug 2014, p. 4). With increased status, there is a blurring of the boundary between the person and the organisation and an increased defensiveness. "Increasingly, you *identify* with the organisation…Any slight against the organisation is now one against your very self" (Blaug 2014, p. 94, italics in original).

"…It can even be mere threats to the image of the organization as perfect" (Schwartz 1987a, pp. 333–334). In a totalitarian organisation "…productive work comes to be less important than the maintenance of narcissistic fantasy". "Totalitarianism represents a turning away from reality" (Schwartz 1987b, p. 52).

In "Wilful Blindness: Why we ignore the obvious at our peril" Heffernan (2011) discusses numerous situations where human beings choose not to see and to know. Silence and denial is brought together in "The elephant in the room: Silence and denial in everyday life" (Zerubavel 2006). "Like silence, denial involves active avoidance" (p. 9). Denial itself is also denied. "…the very act of avoiding the elephant is itself an elephant!" (p. 53). "As moral beings we cannot keep on non-discussing "undiscussables."" (p. 16). There is a need to break the "…insidious cycle of denial" (p. 16).

Protection of Image in Healthcare

In international health system failings, Walshe and Shortall (2004) identify that "The culture of secrecy, professional protectionism, defensiveness, and deference to authority is central to such major failures" (p. 103). "…some health care organization leaders act defensively to protect the institution rather than its patients" (p. 107).

Protection of Image in the NHS

Francis (2013) identified a "…lack of openness to criticism", "…lack of consideration for patients" and a "…defensiveness" (p. 65). "…self promotion rather than critical analysis" (p. 44). "…for all the fine words…there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism" (p. 184).

Kewell (2006) researched themes and 'language games' used within the BRI inquiry transcripts. Seven main language games were identified. The third is "…about staff bullying and whistle blowing" (p. 365). The seventh, 'reputation', underpins and "…functioned at a deeper level than all the others" (p. 365).

Bowles and Associates (2012) identified a requirement for 'gloss' and positive 'spin'. "…a reluctance to pass bad news too far up the management chain" (p. 24). Ballatt and Campling (2011) describe the denial driven by the need to dispel anxiety. Problems are ignored or "…rationalised away'" (p. 76). The active resistance to 'knowing' and acknowledgement "…is at the core of the 'pull towards perversion" (p. 141).

When things go wrong, managers in the NHS "…look for face saving measures" (Mandelstam 2011, p. 243). Concealment is one of those measures, including "…outright lies and deception" (p. 243). "A closed and secretive culture of leadership and senior management tends to build up a parallel universe, in which everyone pretends that all is well" (p. 244). Denial and concealment and an appalling catalogue of repeated mistakes and neglect is described by Steane (2007).

"…on and on went the spin" (Bailey 2012, p. 177). "…the hospital hated the bad publicity" (p. 223). People were in denial at all levels about the harm caused. Notes and records were "…distorted and altered" (p. 168). "…they just didn't care and they also didn't care if they were dishonest" (p. 286). The NHS "…appears to be pathologically unable to improve" (p. 295). Appearances were more important than whether the patients were ill-treated (Pink 2013). It is a very risky business to talk about any matter "…that managers believe will dent the shiny corporate image" (p. 3). People "…accept nothing and admit nothing" (p. 25).

Dixon-Woods et al. (2014) identified "problem-sensing" or "comfort-seeking". Comfort-seeking is "…focused on external impression management and seeking reassurance that all is well" (p. 6). It tended to "…demonstrate preoccupation with positive news" (p. 6). Their research "…found sobering evidence that NHS organisations are not always smart with intelligence, and need to gear more towards problem-sensing rather than comfort-seeking" (p. 9). Leaders were "…more concerned about their own reputations than the care of the sick children" (Drew 2014, p. 5). Senior managers had built up an "…illusory picture" (p. 160). A "…kind of wilful blindness" (p. 183).

There are different perceptions of reality (The King's Fund 2014). "While 84 per cent of executive directors felt their organisation was characterised by openness, honesty and challenge, only 37 per cent of doctors and only 31 per cent of nurses felt the same" (p. 6). In "Failure at the top: Where does transformation drive come from if the leaders themselves don't see it?" Vincent (2014) refers to "Leadership blindness" in the NHS, where there is "Denial and defensive reasoning" (p. 5).

The NHS has a "…very high public and political profile" (Francis 2015, p. 9). "…there is often intense pressure to emphasise the positive achievements of the service, sometimes at the expense of admitting its problems" (p. 9). The Kirkup report (Kirkup 2015) identified "…serious failures of clinical care" in a maternity unit (p. 5). There was "…a pattern of failure to recognise the nature and severity of the problem, with, in some cases, denial that any problem existed" (p. 5). There is a culture of defensiveness and a lack of transparency (The Patients Association 2015; Public Administration Select Committee 2015).

Methodology

The research study explored the organisational responses to negative behaviours between staff in the NHS and the reasons and motivations for the responses. Within the ontological position of critical/subtle realism (Snape and Spencer 2003), an epistemology of constructionism as described by Crotty (1998) and the theoretical perspective of critical inquiry (Crotty 1998; Gray 2009), a qualitative approach was taken. The chosen methods were focus groups and interviews.

After gaining ethical approval from the university ethics committee, six focus groups were held of varying sizes and a total of forty-three semi-structured interviews were conducted between December 2010 and December 2012. Informed consent was obtained from all individual participants included in the study.

The sample of participants was influenced by a number of factors and requirements:

- Key requirement for substantial experience of the NHS
- A range of staff across clinicians and managers
- A broad spectrum of roles
- Trade union and non-trade union experience
- People external to the NHS, who perhaps could view the situation more objectively
- People from a wide geographical area, multiple Strategic Health Authority regions and the different countries of the UK
- Information from individuals and groups
- Practical issues regarding access

The six focus groups consisted of the following:

(1) Trade union representatives from two trade unions and two UK countries (6 people—5 in clinical roles and 1 non-clinical)
(2) Risk managers/quality assurance roles across one region (8)
(3) Trade union representatives from one trade union within a region (10 representatives in clinical roles and 1 Full-time Officer)
(4) Occupational health professionals at manager and director level (4—2 with clinical backgrounds and 2 non-clinical)
(5) Organisational support team (4—in clinical roles)
(6) Managers from two UK countries (6—1 with clinical background, 5 non-clinical)

The people attending the focus groups represented multiples of organisations and most had previously worked in different organisations. Some were currently working in several organisations. Of the total (39), seventeen were known to have some sort of trade union role.

The interview participants were twenty-three women and twenty men. Twelve had some sort of trade union role. Most of the interviews (28) were purely conducted via e-mail. The mediums of face-to-face and telephone were also used, or combinations of medium. The participants were contacted through direct contact, via a third party, through national and regional organisations and on three occasions, through other participants. Three of the interviewees were also participants in the sixth focus group. Seventy-seven other people were contacted in the lengthy and difficult process of attempting to find a broad spectrum of willing participants. The sensitivity of the topic may have impacted on the willingness to take part.

The final forty-three interview participants from across all the countries of the UK were 2 Nursing Assistants; 2 Nurses; 1 current and 1 ex-Physiotherapist; 1 ex-HR Manager; 1 ex-Social Worker; 2 Psychologists; 2 Directors of Public Health; 4 Doctors (various senior roles); 1 Assistant Director of Workforce Development; 2 ex-Chief Executives; 1 ex-Chair; 1 Non-NHS Strategic Advisor; 5 Senior Managers; 7 Chief Executives; 2 representatives of external organisations; and 7 current and 1 ex-trade union Full-time Officers.

Thirty-one of the interview participants came from 31 different organisations. Many of these people had worked previously in other organisations in the NHS. The trade union officers and the other more external roles (12 people) were linked to and worked with multiples of organisations, some at regional or national levels across the UK.

Across the focus groups and interviews, there were contributions from five trade unions: Royal College of Nursing; Chartered Society of Physiotherapists; Unison; Unite and Managers in Partnership.

The form and structure of data gathering varied depending on the roles of the participants. Two requests were, however, constant to all of the participants. Each person in the interviews and focus groups was asked to respond to the same statement either in writing or verbally.

"From your personal observations and experience of work situations within the NHS:

(1) Please describe the culture of NHS organisations
(2) To summarise—use up to only three words to describe the culture of NHS organisations"

The '3 word summary' was very instrumental in helping to form the Framework Themes. Most participants were also asked to comment upon the original scenario of the directors unexpectedly leaving the room at the beginning of a presentation on negative behaviour.

The Framework Method of thematic analysis was used to analyse the data (Ritchie and Spencer 1994; Ritchie et al. 2003). Gale et al. (2013) consider the Framework Method is increasingly being used in health research and is a flexible and systematic approach to qualitative analysis. To compliment the main analysis, interesting descriptive

words/phrases and metaphors were also highlighted in italics to enhance the meaning and understanding of the findings (Elkind 1998; Tracy et al. 2006).

The limitations of qualitative research are recognised. It is, however, considered that this research study fulfils the important principles of generalisation "…broadly summarised under four broad headings: full and appropriate use of the evidential base; display of analytic routes and interpretation; research design and conduct; validation" as described by Lewis and Ritchie (2003, p. 277). Also, due to the wide geographical spread across the UK of participants from a large number of organisations, and a wide range/diversity of roles, it is believed that some representational generalisations can be made.

Findings

3 Word Summary

The '3 word summary' words were first grouped to assess the most commonly used words. These were Hierarchical (x9); Defensive (x6); Bullying/harassing (x6); Top down (x5); Bureaucracy/bureaucratic (x 5); Variable (x5); Control (x5); Oppressive (x4); Pressure/pressured (x4); Not/uncaring (x4) and Lack (x4).

Based upon the literature review, data from the '3 word summary' and other data, fourteen Framework Themes were finally identified: Structure/form/groups; Positive characteristics; Hierarchical/top down/power; Bureaucracy/policy; Finance/business/targets; Change/variable; HR/other roles; General lack/dysfunction; Raising concerns/communication; Negative behaviour; Self-interest/relationships; Scenario; Selective moral disengagement/ego-defences and Actions. These themes, omitting the theme on Actions, will be used as the headings to provide a brief descriptive overview of the findings.

Overview of Framework Themes

Framework Theme 1: Structure/Form/Groups

Interesting descriptions and metaphors were used to provide a picture of the NHS. These include a *whale*, *shoal of fish, vast political machine, political pawn, a huge monster* with hundreds of different companies and *a superstructure.* It is also, a *"…weird dysfunctional family"*. The NHS is *a citadel with broken walls, a train, tanker, ship, a gang, club* and *secret society.* It is insular, enclosed, strange, peculiar, *brittle, stretched and lean*.

The NHS is too big, the reason for *just cannot turn that ship round;* one *monolithic* organisation and employer. No one knows what is going on in the *vast machine* and large *systems* restrain. It is a leadership challenge to *pull threads together.* The NHS is *born*, beloved, respected and a *national treasure*. It is unimpeachable with people not being allowed to criticise it. The Department of Health has *tentacles which reach down* into every trust controlling, which results in the "…horrible culture".

There are greatly varying cultures, *pockets and islands* of a different and positive culture within a large organisation which could be described as "…awful". There are many varying *tribes, clans and silos*, which do not communicate and talk to one another; all fighting. There can be much conflict.

Framework Theme 2: Positive Characteristics

Some positive services are provided. Positive words such as caring, supportive, dedicated, hardworking, effective and professional were used. Staff are focused on getting the best for the patients. Sometimes this is to the detriment of staff health and wellbeing. "People who work for the NHS generally give of their all". There is selflessness, and devotion to an ethical code. There can be a culture of continuous improvement and a willingness to change.

However, when people made positive statements, they would often qualify them. "Even managers, are to some degree caring". There are some good and enlightened managers. The organisation is there to care, "…mostly do". There are some decent people, one or two people, in very senior positions, who have good values; "…do their best in a *nightmare situation"*.

Regarding leadership and management at senior director level, the metaphor of a nursery rhyme was used. "*There was a little girl and she had a little curl right in the middle of her forehead. When she was good she was very, very good but when she was bad she was horrid*".

One person said they wanted to believe that the underlying culture was caring and supportive. There are a lot of things that "…*eat away at concern"*.

Framework Theme 3: Hierarchical/Top Down/Power

The NHS is "…*hundreds of layers deep"* with "…too many tiers". The phrases such as *the top*, the *top level/tier* are often used. There is the "…hierarchy of elites". Managers are the "…*cock of the walk"*, with people on "…fabulous salaries *at the top*". The NHS is "…arrogant and elitist *at the top"*. HR think they are "*God's gift*, like *sat on a pedestal"*. *S*enior managers are *"…as Gods* and very powerful". There is *empire building* within directorates.

Phrases such as *the bottom*, *ground floor*, *shop floor*, *coal face*, lower staff, *low down the pecking order*, ordinary folk, underlings, lowly occupations, people *at the bottom rowing and running* are used. People *at the bottom*

are not valued as they should be. "Some [managers] *10 a penny* like us"; expendable. People are "Not appreciative of clinical/lower banded staff".

There is a "…tendency…towards *totalitarianism"*. The central domination is a major problem, and worsening. There is "…central *kowtowing"*. One person's image was of "*Hitler in his bunker"*. Another said, "It's like…there is some power wielding person like a Hitler figure going to do something really nasty to them. Under great threat. Something really, really nasty". There are 'enforcers'.

Certain senior levels and groups have a lot of power, while others feel powerless and lack autonomy. There is a desire for power, status, privilege and position and "…power matters".

Framework Theme 4: Bureaucracy/Policy

There is "…bureaucracy and *red tape"* and the NHS is "…overly bureaucratic". Everybody can be "…trammelled by the rules". "Even a chief executive of a health service hospital has very little freedom to do as they wish, or individual clinicians for that matter". Staff are *"…tied up in bureaucracy"*. "Trying to get a response based on a sensible moral argument is difficult there appears to be little leeway outside of the rules".

People can "…feel powerless against an insensitive bureaucracy/system" and "…policies are overwhelmingly full of rules and specific guidance rather than allowing discretionary action". Bureaucracy *paralyses. "*Too often policies are used as a way of closing down a complaint or problem prematurely due to 'lack of evidence'". The NHS is very good at "…ticking the right boxes". "…a pressure, to tick, to tick those boxes". Paperwork *"…bogging people down*, *can't do hands down clinical work";* too busy writing. When people try to raise concerns about the level of paperwork, people do not want to hear. Failure to fill in paperwork is becoming a disciplinary offence.

The purchaser provider split just introduced "…*trolley loads of unnecessary bureaucracy"*. It is a "…*bureaucratic machine"* and there is a lack of humanity, care and compassion.

Framework Theme 5: Finance/Business/Targets

The NHS is under huge pressure, lacking capacity and target driven. *"*…things could actually start *collapsing*". "Getting resources is like *getting blood out of a stone"*. The whole NHS, "…*utter chaos on the move,* all the time". There are "…dangers of *over trading"*.

There are "…c*onstant hoops to jump through",* "…high pressure to meet government targets" and "…perverse financial incentives". Saving money is put before patient care. Management have a "…complete obsession with cost". There is a "Bullying intolerance of failure to meet irrelevant targets, regardless of the consequences". The only thing valued/rewarded is the delivery of targets. The focus on cutting budgets is a "…dangerous madness". It is "Not just efficiency anymore, it's madness; unsafe madness".

There is a fear of failing and pressure to cheat. There are conflicts of interests, bribes, fraud and financial irregularities. There is "Institutionalised dishonesty…people *fiddle* waiting lists times, targets or the finances". CEOs/senior managers can be"… offered to another organisation as a *free good*, in terms of the salary being paid". Managers "…expect to get large payments when they are sacked for failings". They "…do not get "struck off" like clinical staff. Usually they reappear at another hospital on a higher salary". The prevailing culture is of no accountability.

Framework Theme 6: Change/Variable

The NHS is "…nothing like it was"; "…bears no resemblance". The culture "…hasn't always been like this". The NHS has changed from a "…benign dictatorship" to a "…malign organisation controlled by professional managers". "…this horrible centralising controlling culture is more recent…I do put it down to the rise of general management".

Many participants referred to constant changes or restructures. There is little, or no time for consolidation, leading to paranoia and paralysis. The NHS is constantly changing, but in many ways not changing, and very slow to change. "Trying to make changes in the NHS is like trying to run through treacle". Priorities are constantly changing and shifting leading to a lack of planning and situations where nothing seems to be finished.

"There seems to have been a significant cultural shift…being non-punitive, to being very punitive, and the culture of "learning from mistakes" seems to have been lost. Openness in the organisation has been discouraged".

There is variation of cultures, situations and services. "It is a mixed workplace culture. In some places it is supportive, learning orientated…In other places it is *dark*, blame orientated with leaders not taking responsibility for poor decisions and blaming others".

Framework Theme 7: HR/Other Roles

The change from Personnel Manager to Business Partner was not viewed positively, indicating a lack of neutrality. Some people were very clear the HR/Business Partner role is there to support the organisation; a *management tool. "*...101 *% in league* with managers, and *biased as hell";* "…*organisations hatchet men"*. It was considered sad

when there are genuine *whistleblowers* raising concerns HR was "…always on the *opposite side of the line"*.

"…sometimes the HR departments, have got 'NHS think'". They were perceived as being aware of problems, but not taking action. They "…facilitate bullying on many occasions". There can be "…bullying at the *top level,* but HR is in the middle of it". One person thought HR were corrupted and "…embroiled in organisational failure". They can be seen as pressurising, *bulldozing* and bullying staff. "HR directors they're…corporate…'*singing a corporate tune*'…detached as those bad detached NHS managers of all sorts". An SHA HR Director with vision for staff wellbeing was considered an exception.

"…most non-executives are also, are pretty much a waste of space…usually 'go native' very quickly…just completely passive and useless". Concerns were expressed about trade unions and the need to be stronger and more independent. Local representatives may have a *cosy relationship* with managers. Trade unions are involved in the negotiation of confidentiality/gagging clauses, which is seen as a problem. With HR, they can make deals and this is not viewed as helpful. Unlike HR, Risk Managers thought they stayed with the problems; the "…*bearers of 'bad news'"*.

Framework Theme 8: General Lack/Dysfunction

The NHS is "…pressurised, regressive and chaotic". There is a lack of coordination, *joined up thinking*, connection, intelligent planning and communication. The NHS can be inefficient and ineffective. There is much description of lack in many areas, but particularly regarding training provision for all staff. There is a lack of staff, skills, ability, experience, knowledge and learning. The quality of management is often described as being poor. One person described management as "…grossly poor". Management requires a "…major overhaul".

There is a lack of good quality leadership, vision and purpose. Also a "…lack of *moral fibre"*, values, courage and honesty. There is "…ethical fading". Morality and ethics "…*can go out of the window*". A person described a state of "…learned helplessness". The dynamic of "…*survival of the un-fittest"* is detailed where the wrong behaviours are rewarded. The NHS is a "…*self perpetuating dysfunctional system*".

Many staff do not feel supported and there is a lack of morale. Staff are *struggling* and can feel exhausted and *battered*. The NHS is "…not caring for the people", it is "…uncaring". It does not act adequately in protection or improvement of patient care. At *the bottom*, there are patients dying and unhappy staff. The NHS does not have a "…learning culture".

Framework Theme 9: Raising Concerns/Communication

A person detailed the lack of ordinary communication, where no one smiles, says good morning or hello. Senior managers are remote and separate. Anything that is a criticism, anything contrary to prevailing policy or agenda and anything that puts the person or the organisation in "…*a bad light"* is difficult to raise. Complaints can end up in *electronic waste paper baskets* and risks "…de-escalated". Managers "…quickly learn that questioning things is not popular". Status affects how much people are listened to. The "…effect of management is to silence critics". "Overall there has been a very unhealthy tendency to dismiss the views of clinicians".

Clinical excellence awards can "…buy silence" and people can be bullied and "…go quiet". People are "…*deaf*" and can *close their eyes and ears*. There is retribution for raising concerns. People who question and challenge are seen as negative, as *a troublemaker*, an *enemy* and *not in the team*. They *keep their heads down* and do not want to *put themselves in the firing line,* or *put their head above the parapet*. There is a "…silent majority" and a "…*sea of silence*".

The "…endemic top-down bullying culture…suppresses constructive dissent". Words such as *witch hunts*, and *set a trap,* are used. Of "…*trying to dig dirt"* and being *"…savaged by a mob of wild dogs, who are still baying for blood"*. Experiences can be "Kafkaesque".

> From the individuals that we have worked with, their experience of trying to raise concerns often leaves them isolated, threatened, distressed and professionally compromised, with a significant impact on their health and wellbeing. Certainly the description given by some healthcare professionals of what has happened to them is Kafkaesque

Framework Theme 10: Negative Behaviour

The word 'bullying' is commonly used and bullying viewed as "…rife" and "…endemic". "…we have a lot of bullying and harassment". A chief executive described himself as a "…*circus ringmaster"*. A bullying management style is seen as acceptable. The NHS is "…still harassing". NHS organisations

> …tend to be very centralised, controlling, hierarchical, pretty closed, meaning intolerant of criticism. Not open and transparent, although they claim they are. And frequently, bullying, not always, but frequently…the prevailing culture…probably very few organisations in the NHS where it isn't widespread and endemic

There is a "…deeply engrained malaise", a culture of bullying and dishonesty. "The prevailing culture is bullying, command and control leading to fear, insecurity and cover up". The NHS is a "…malign organisation". "…management in the health service" have a "…malign influence". *"The system will eliminate*" people. People can be reluctant to raise concerns about negative behaviour.

There is a culture of disrespect. Bullying and harassing behaviours can go on for years; nothing is done. At senior level people are valued despite their behaviour. Generally, behavioural problems can be *swept under the carpet* and people like to *leave sleeping dogs lie.* Reports are given the *"…three wise monkeys treatment".* The wrong behaviours can be rewarded and there is a tendency for the wrong people to get promoted.

Framework Theme 11: Self-Interest/Relationships

People are trying to "*…create names for themselves*" and "*…build empires"*. There is pressure to *toe the party line, play the game, join the club and sing from the same hymn sheet*. If people "…want to prosper, they just join *the corporate line"*. The apex and senior management of the organisation "…protect each other". "*If you give me a pat on the back, I will give you a pat...*lot of that". There is the "…self serving complicity of the "*elite circle*" and the "*…elite closed circle* of career driven managers". Career non-executives have financial and career interests. People, "… have got their own agendas".

The words cronyism, nepotism, clique, incestuous and coterie are used. There is dependency on *grooming from above* to gain promotion. "…one minute she came in a cardigan and the next day she came in, in a cocktail dress", "…in heels, and this jacket…and the next thing we knew she had been, um, promoted". People can be "…prepared to shed the previous life" and be *chameleons* to gain advantage. "…those people are the most dangerous…just take on the next thing that is required…are almost, at work, almost value free".

Self-interest distorts priorities. "…NHS managers…if they ever had principles I think they lose them. They sacrifice them on…the altar of maintaining or developing their careers". Managers are appointed who have "*…'yes' written on their forehead"* and who are *puppets*. Managers; people need to "*…kiss their arses*". Some people "*…kiss up kick down*". The NHS is "*…rotten from top to bottom".*

Managers control clinicians via jobs, funding, clinical excellence awards and patronage. Rewards buy silence and obedience; *money speaks.* Behavioural problems do not get resolved because informal relationships affect responses. "…they know where *the bodies are buried*", and "…deals are done".

Framework Theme 12: Scenario

A few people did not recognise the behaviours described believing the scenario artificial and not plausible. Some were quite shocked at the behaviours. Many, however, had seen similar behaviours; typical of the way the NHS conducts itself in response to the highlighting of problems and concerns and in general conduct of the senior managers towards other staff. "This isn't…an unusual scenario; it is played out on a daily basis". The culture was described as dysfunctional, *sick*, *unhealthy,* and there being a culture of a "*…deep cover up of bad news".*

There was avoidance and suppression of *bad news* and managers appear to be extremely sensitive to the image of both themselves and the organisation they worked for. Managers did not like their "*…dirty linen being aired".* There is the *Elephant in the room and Ostriches with their heads in the sand.* The presentation of evidence *puts the spotlight on them.* There is a focus on providing positive information and "*…maximum gloss".* There were many mentions of people being fearful for their reputation and being seen not to know what to do. People felt threatened.

It is a case of *"…shooting the messenger" and "Sticking fingers in my ears, humming loudly;* it's not happening".

Framework Theme 13: Selective Moral Disengagement/ Ego-Defences

There is avoidance, rejection and *burial of bad news. A* desire for *good news* and the *"…rosy picture".* "It is very tempting to join *the club* and be part of the '*good news factory'*". It "…has two manifestations—great when things go well, nasty, aggressive, dishonest, vindictive…when they go wrong".

People do not want to *face up to* problems and reality. There is manipulation and corruption of data to deliver good news; dishonesty and *wilful blindness.* "…'corrupt'…to denote the deception and manipulation of the truth in relation to the denial of reality when things go wrong". People are rewarded for taking *good news* to their boss. It is the "*Iced cake syndrome*, *lovely on the outside, mouldy on the inside".* Part of a culture led by the government to "…present a *pretty picture fed up to the voters*". "…politicians want to be able to brag".

Bad news is "…swept under the carpet" and people *"…turn a blind eye".* Concerns are *brushed aside*. People do not want to *wash, expose or air their dirty linen in public.* People "…hear nothing, they see nothing and they say nothing". There is "…disattending of the highest order…from all levels". When there are problems "…they begin to go into a paranoid defensive state". *"The golden rule is keep stum', don't let it out";* the *"Emperor's new*

clothes". People can live in *"…La La Land"*. People begin to believe own rhetoric/propaganda.

There is a culture of secrecy, fear, defensiveness, denial, blame and punishment. There are many references to fear. "…secrecy…is a default of the NHS". There is rhetoric, "*…empty words"*, "*…spin", "…veneer that gets painted*", a "*…constant fabrication*", "*…maximum gloss"*, a "*…charade", "…false front"* and "*…whitewash;* a need to be seen "*…whiter than white*". Evidence is "*…air-brushed out of history*".

Several references were made to Orwell's 'Nineteen Eighty Four'. A focus group discussed the effect of acronyms which stopped thought. An interview participant described the differences in realities between the top and the bottom of their NHS organisation.

> *…no-one has got any bread to eat, and it's all absolutely ghastly and they are drinking horrible, you know, cheap, you know, spirits, and God knows what, to keep, to keep their hopes up, and there is an announcement saying, you know, it's fantastic news, the grain yields are up by a million percent this year.*

People can adapt their behaviour for reasons of self-interest and survival as in "*…concentration camps during the war*". Some people *put on a mask*.

Some rationalisations/justifications were identified such as "…we haven't got a choice", "…we have to do it", "…there is no option", "…we must do it this way" and "…there is no alternative". Some euphemisms and redefinitions were also identified, e.g. "Release staff", not redundancy; "…talent spotting" when choosing people outside of agreed, acceptable and due process; "…incompetence", "…conflict situations" and "…challenging behaviours" instead of bullying; and there were "…difficulties in communication" and "…genuine distress", but these were not due to bullying. Senior managers use words similar to the "…old fashioned phrases" of "…working smarter" and "…sweating the assets".

Underlying Assumptions/Beliefs in the NHS

Several explicit and implicit assumptions were highlighted in the course of the research.

(1) Managers are always right/tell the truth/know best
(2) Staff are liars/do not know what is best/are always wrong
(3) A manager serves the purpose/best interests of the organisation
(4) Staff do not serve the purpose/best interests of the organisation
(5) If management/HR make a mistake, "…it's OK or plausible!"
(6) Pressure is good and produces hard work and commitment
(7) The NHS is there for the patients
(8) All NHS staff are dedicated
(9) Cultures take a long time to change
(10) Public assumption; NHS there "…solely to make them better"
(11) Increasing number of safety incidents reports is a good thing
(12) Nothing can be done

Analysis and Discussion

The actual event when the directors unexpectedly left the room was probably about 'silence breaking' (Zerubavel 2006). They knew, but they had chosen to ignore, and they did not want to know. They had chosen not to see and to know (Heffernan 2011).

The Higher Level Classes of data analysis for the scenario are the metaphorical terms of: The Elephant in the room; Ostriches with heads in the sand; No airing of dirty linen; Shooting of the messengers and Sticking fingers in my ears, humming loudly—it is not happening. All of these Classes relate to the protection of image, denial of reality, wilful blindness (Brown 1997; Zerubavel 2006; Heffernan 2011) and leadership blindness (Vincent 2014). There is an active rejection and suppression of negative information and "bad news".

The situation was also about the expression of power and authority, power bases and personal agendas (Blaug 2014). There is also the dynamics of group behaviour and of having to fit in with 'the club' and "…singing from the same hymn sheet". Individual and group rationalisations are identified.

> …in relation to this story. I said they would have had a rationalisation, they would have constructed amongst themselves a rationalisation for the way they were behaving, which will be convincing to them as a group

Participants considered that people also do not care, and are not interested. Some senior personnel see themselves as "…untouchable". There is an inability to learn. One person referred to the scenario as "…a form of collective stupidity" where there is "…fear, protectionism, trench mentality, ignorance, self preservation".

In the proposed model of organisational dysfunction (Pope and Burnes 2013), the three concepts of organisational silence, normalised corruption and protection of image reflect three aspects and perspectives of the NHS culture. The mechanisms of selective moral disengagement enable the persistence of this dysfunctional culture.

The research findings not only support the original proposed model but also extend and develop it (Table 1). The model is now discussed under the specific concept headings. There is much overlap between the three concepts. They are completely interlinked, entwining and reinforcing each other.

Organisational Silence

The findings reflect many of the factors and characteristics of the model of organisation silence (Morrison and Milliken 2000, p. 709). There is indeed a "…centralisation of decision making" (p. 709) with the "top down driven", "authoritarian", "command and control", "hierarchical" structure and system of the NHS. Their model, however, appears somewhat benign compared to the experiences of some staff within the NHS. The findings indicate a far more negative situation. Two participants used the word "malign". One person used it to describe the NHS itself, and the effect of management. The other related it to the influence of NHS management. Several participants used the word "oppressive" to describe the culture.

The participants made many references to fear. The presence of fear appears to be a major factor in the NHS, regarding being a driver of behaviour. There should be a reference in the organisational silence model to the presence of fear as one of the factors affecting employee interaction and also as an effect/outcome of organisational silence.

In the Morrison and Milliken model, there are also the implicit managerial beliefs that "…employees are self interested"; "…management knows best" and "…unity is good and dissent is bad" (p. 709). This research study identified assumptions/beliefs that the "Manager is always right", they "…always tell the truth", "…know best" and "…staff are liars". The implicit conclusions from these statements are that managers are honest and staff are dishonest. These are particularly corrosive and clearly erroneous assumptions to have in a workplace. There are also other possible assumptions such as: A manager serves the purpose/best interests of the organisation; If management/HR make a mistake "…it's OK or plausible!", therefore justified; Pressure is good and produces hard work and commitment and "…nothing can be done". These assumptions could all have an extremely detrimental impact.

Table 1 A developed model of organisational dysfunction with the specific characteristics of the NHS

Organisational silence Resistance to, active suppression of voice; Do not want to listen—"They're deaf"; Hiding of negative information—cover up; Lies and spin; Assumptions/beliefs, e.g. managers are "…always right","…always tell the truth","…know best"/"…staff are liars"/If management or HR make a mistake "…it's OK or plausible!"; Silence "…driven by fear"; Silence produces fear; Failure to voice - "…sea of silence", "…silent majority"; Do not "…put their heads above the parapet"; Imbalance of power; Intimidation/victimisation of person raising concerns/'truth telling'; Shoot the messenger; "…endemic top-down bullying culture…suppresses constructive dissent"; Witch hunts, "…set the trap", "…trying to dig dirt", "…savaged by a mob of wild dogs…baying for blood"; "The system will eliminate" people; Kafkaesque experiences; Loss of jobs and careers; Detriment to health and wellbeing; Organisational inability to learn/improve
Normalised organisational corruption Collective tolerance to negative behaviour—normalisation; Systemic culture of disrespect; "…arrogant and elitist at the top"; Bullying from the top; Culture of fear and blame; Lack of accountability; Intimidation of people who raise concerns; Dishonesty/lying; "Institutionalised dishonesty"—"…fiddle waiting lists times, targets…finances"; Pressure to cheat; Manipulation of data; Suppression of information important for improving staff/patient welfare; Desire for power, status and position; Self-interest/ambition put before patient/staff welfare; Misuse of position for personal gain; "Money speaks"/money, awards, honours, buying silence; "Kiss up, kick down", "…kiss their arses", "…'yes', written on their foreheads"—appoint puppets; Protection of managers/people at the top; Reward for failure/dysfunctional behaviour; "Survival of the unfittest"; "Self perpetuating dysfunctional system"; CEOs as a "…free good" to other organisations; Misuse of public funds/fraud; Recycling of "…bad managers"; Self-serving relationships; Powerful and protective alliances—"You pat my back"; Incestuous, nepotism, cronyism, cliques, favouritism; "The end justifies the means"; Lack of moral/ethical values—"…ethical fading"/moral vacuum; Focus on organisational needs; "…learned helplessness"; "…slippery slope"; Misuse of policy/process
Protection of image Organisational narcissistic/ego-defensive behaviour; Resistance to 'knowing'; Denial, pretence, wilful blindness; Turning a 'blind eye'; "Truth suppression"; Perversity; "…good news factory"; Avoidance of 'bad news'; No washing, exposing, or airing of dirty linen in public; Problems "…swept under the carpet"; Concerns "…brushed aside"; Secrecy; Concealment; Culture of fear and denial; Rhetoric not reality—"…empty words", "…lip service", "…spin", "…maximum gloss", "…veneer", "…fabrication", "…lies", "…whitewash", "…rosy picture", "…false front", "…charade"; Need to be seen "…whiter than white"; Live in "…La La Land"; "Iced cake syndrome"; Protecting image/self-esteem is more important than patient/staff welfare; "…disattending"; "If I stick my fingers in my ears and hum loudly, then it's not happening"; "…hear nothing, they see nothing and they say nothing"; Reports can "…get the three wise monkeys treatment"; Ostriches with heads in the sand ("Ostrich effect"); The Elephant in the Room; The Emperors Clothes; Chameleons, to gain advantage—just take on the next thing; Distorted morality and perversity (Good becomes bad and bad becomes good); Painful to think/do not want to think; Adaption of behaviour; Inability to learn/improve
Selective moral disengagement; Rationalisations and justifications; Denial; Redefinition/reframing of reality; Acronyms and mantras (cultural language)

The findings also identify the perceived lack of autonomy and powerlessness of many in the NHS. Certain groups and people are described as powerful and "…power matters". Power is such a strong driver of social behaviour that "…the power imbalance inherent in organizational roles is perhaps *the* most important factor that makes employee silence such a common experience" (Morrison and Rothman 2009, p. 112).

There are some high profile publically recognised whistleblowers in the NHS (Heffernan 2011; Pink 2013; Drew 2014). One of the participants considered that high profile whistleblowers are simply the 'tip of the iceberg'. These are the ones who refuse to be 'gagged' and continue to speak out. Beneath are those who are formally 'gagged'. Then there are the people who try to speak out, are intimidated and bullied and go quiet, or leave their work situations because of the difficulties. The 'messenger is shot', and many problems are covered up and hidden. At the bottom are those who see what is happening and stay silent. They are the "…silent majority" and the "…sea of silence".

The term 'whistleblower' is not used in the developed model (Table 1) as it is considered limiting in its application. The researcher prefers the broader term of 'raising concerns' which is happening within the NHS at all levels. Pink (2013) prefers the term of 'truth teller'. 'Silence breaking' is used by Zerubavel (2006) to denote revealing of "…open "secrets" of which we are aware yet unwilling to publically acknowledge" (p. 65). This is in contrast to whistleblowing with the revealing of "…ordinary secrets" where people are not aware. Silence breakers help "…uncover "elephants" rather than "skeletons" a whistleblower might bring to light" (p. 65). 'Background' information is publicised rather than 'backstage' information. Glazer and Glazer (1989) use the term 'ethical resistance' in the context of whistleblowing and Beardshaw describes "Conscientious objectors at work" (Beardshaw 1981, p. 1).

It is clear that any problem or major concern or anything that is contrary to the latest directive is difficult to raise and will often have negative repercussions. Anything negative or any "bad news", which puts anyone or the organisation in a "bad light", is also difficult. One participant described the NHS as being "deaf". The NHS does not appear to like 'truth telling' or 'ethical resistance' in any form.

Normalised Organisational Corruption

The original model (Fig. 1) identified negative behaviour as normalised organisational corruption as described by Ashforth and Anand (2003). This aspect of the model has been developed considerably as many aspects of corruption in the NHS are identified.

The findings identify the toleration of negative behaviour and intimidation of people who raise concerns, as well as the poor and inadequate management of negative behaviour. There appears to be a systemic culture of disrespect, as well as a culture of fear and blame. There is particularly a lack of respect for those at the lower, and more clinical end of the NHS, but also lack of respect between the different groups.

In a troubled organisation, staff are not always treated with respect or as individuals, or made to feel that they matter (Fevre et al. 2012). "One clinical indicator for corruption by power is the systematic devaluation of subordinates capacities" (Blaug 2014, p. 113). Dixon-Woods et al. (2014) found that "Lack of support, appreciation and respect and not being consulted and listened to were seen as endemic problems by staff in some organisations" (p. 7).

The management of bullying could be viewed as "..a serious and corrupt activity" (Hutchinson et al. 2009, p. 213). All of their five aspects of "…bullying as organizational corruption" (p. 217) are reflected in this research study. Relationships are also key to maintaining the dysfunctional behaviour. Their statement that "The worse you behave, the more you seem, to be rewarded" is supported (p. 213). The findings identified that certain people and groups can be protected, particularly at the top of organisations.

One of the participants said that sadly, when there are genuine whistleblowers raising concerns about standards of care, HR was "…always on the *opposite side of the line"*. The findings suggest that most responses from HR to negative behaviour are inadequate reflecting the work of Harrington (2010) and Harrington et al. (2012). There was evidence of reframing of behaviour. The HR professionals appeared to support and protect managers and the organisation "…with considerable negative implications for employees and…the employee voice appears denied" (2012, p. 405). It does appear that HR can be "…embroiled in organisational failure".

In the view of some of the participants, there has been a proliferation of managers in the NHS (Goddard 2008; Riddington Young et al. 2008; Traynor et al. 2014; Drew 2014). It is the view of Goddard (2008) that when the original administrators who "…saw themselves as facilitators" became managers, they embraced the government driven changes. "Presumably this is because power corrupts" (p. 204).

In the King's Fund report (The King's Fund 2014), the views of leadership in the NHS have improved since 2013, but "…a majority still believe the quality of leadership is poor or very poor" (p. 10). Dixon-Woods et al. (2014) found "…substantial variation in the quality of management" (p. 7). The interesting description "…sleek suited" is used of leaders of big teaching hospitals (McLellan 2013,

p. 3). Drew (2014) describes that his chief executive and chair of the trust were icons of a "…new corporate ethos. Sartorially elegant and immaculately groomed" seeming distant and "…somehow unreachable" (p. 167). This same chief executive was living "…in her own hermetically sealed world. She was dangerously blind to what was happening on the ground" (p. 162). Many of the participants in this thesis study viewed management behaviour and practice as poor and of senior staff being detached and remote. There are examples of mismanagement and abuse (Hodson 2001; Traynor et al. 2014). The culture could be viewed as toxic (Ballatt and Campling 2011).

There appears to be misuse of position and a "…misuse of entrusted power" to fulfil self-interests and personal gain. For some, perhaps many at senior levels, self-interest and advancement is their primary aim. The findings identify that relationships are a major factor in the advancement of self-interest and reward. Words such as "incestuous", "nepotism", "cronyism", "clique", "coterie" and "favouritism" are used.

Participants identified a huge pressure to deliver; a culture of bullying performance management which can have unintended dysfunctional consequences (Mannion and Braithwaite, 2012; Newdick and Danbury, 2013). "Institutionalised dishonesty" where people "…fiddle waiting lists times, targets or the finances" is described. Chief executives are being given as a "…free good" to other organisations paid for by the NHS. There is also the practice of "…bad managers" going on to lead and work in other trusts. The words "…ethical fading" are used to describe what is happening. Some people see organisations as a "…moral vacuum". The NHS does appear to have "…deviated from the core goal of delivering health" seeming to be 'ailing' and 'rotten' to a significant degree (Ibrahim and Majoor 2002, p. 20).

Not only are individuals being seen as corrupt, but organisations themselves "…are increasingly being construed as corrupt entities" (Ashforth et al. 2008, p. 670). Due to the widespread, persistent and top down nature of the problems in the NHS and the destructive impact of them, it is suggested the NHS could be described as both an organisation where a significant number of its individuals act in a corrupt manner and a corrupt organisation (Pinto et al. 2008). There does appear to be "…a general failure to orient to the common good, a crisis of moral judgement and an aggrandised and *hubristic* distortion of individual thinking" (Blaug 2014, p. 2). There is "…a failure of *virtue* that has impoverished…thought and judgement" (p. 2) and "…a disorder of meaning" (p. 7).

The NHS appears to be a coercive bureaucracy rather than facilitative (Hodson et al. 2006). Participants describe some characteristics in the NHS which could be viewed as Kafkaesque. These are according to Hodson et al. (2013) inherent in a bureaucracy.

There is a power imbalance in the NHS. Some people/groups have a lot of power and many are powerless. Under certain conditions "…wielding institutional power changes the power holders in ways that is conducive to dehumanization" (Bandura 1999, p. 200). Having power can result in the devaluing of those we control. "When power corrupts, dominants are unable to empathise with subordinates, and so are more likely to harm them with moral impunity" (Blaug, p. 52).

When people are under authority within a bureaucracy there can be appalling examples of a lack of humanity and destructive behaviour and "…responsibility is essentially 'unpinnable'" (Bauman 1989). A lack of accountability is identified in the findings particularly at more senior levels (Goddard 2008). Power is held by managers, but responsibility and blame has been shifted down and devolved.

The term "…learned helplessness" was used by a participant to describe the responses of staff in the Mid Staffordshire situation where patients were neglected. Some participants asked questions such as "Why does nobody ever push back up and say I am sorry, but this is not good?" and "Why don't people say no?" This reflects the writing of Blaug (2014) regarding corruption by power and the impact on subordinates. The "…common symptoms are dependence, apathy and blind obedience" (p. 4). Learned helplessness is one of the costs of "…hierarchic relations of power" (p. 105).

Protection of Image

The data very much support the aspect of the proposed model regarding protection of image. It appears to be a very powerful driving force and focus, which seems to override all other considerations, including the needs of the patients or the staff. The protection of the organisational image and the image and self-esteem of the individual appears to be the dominant influence.

People individually and collectively can retreat and hide from reality. Individuals fail to address problems indicating an inability to learn. There is evidence of the three wise monkeys, ostriches with their heads in the sand and of turning a blind eye; a wilful blindness. There is an avoidance of 'bad news', secrecy and concealment, and a culture of fear and denial. Reality is redefined and reframed. The NHS is described as a "…good news factory", or as one person preferred, a "…stopping bad news factory".

Orwell's 'Nineteen Eighteen Four' is given as an example of how supposed reality is declared at the top of an organisation which is very different to the reality perceived at the bottom. Power holders have a tendency towards having a very positive view of themselves (Morrison and Rothman, 2009). The different perceptions of reality are also seen in the King's Fund report (2014).

No one is allowed to expose any 'dirty linen'. The Emperor's New Clothes story is given as an explanation of what is happening in the NHS and there is a creation of a positive reality. There is much rhetoric, rather than reality. There is "empty words", "spin", "maximum gloss", "veneer", "fabrication", "whitewash", "lies", a "charade", "false front" and a "rosy picture".

The findings indicate such widespread ego-defensive behaviour, and resistance to 'knowing' which "…is at the core of the 'pull towards perversion'" (Ballatt and Campling 2011, p. 141), that the NHS could also be described as a perverse organisation. Perversity underpins the more obvious conscious corruption (Long, 2008).

Perversion is also about "…seeking individual gain and pleasure at the expense of the common good, often to the extent of not recognising the existence of others or their rights" (Ballatt and Campling 2011, p. 139). The result of this perversion in the NHS appears to be a distorted and 'upside down' morality, and a loss of correct and morally acceptable priorities. Good can become bad and bad can become good, and be rewarded. Harmful practices have to be vindicated and "…they have to make out that what's harmful is, in fact, good" (Bandura interview in Heffernan 2011, p. 259).

Participants also identified the alteration of behaviour that can take place. People can be chameleons to gain advantage and "…just take on the next thing that is required". The cardigan can be discarded for the cocktail dress, heels and jacket. Values and principles can be discarded and lost; "They sacrifice them on...the altar of maintaining or developing their careers".

The findings identify the organisational forces of wilful blindness (Heffernan 2011). "…obedience, conformity, bystander effects, distance and division of labour—combine to obscure the moral, human face of work". "…then money is the final incentive to keep looking away" (p. 257). "To paraphrase Burke, all that evil needs to flourish is for good people to see nothing—and get paid for it" (p. 258).

Pink (2013) described how in 1990 he learned that "…it was the publicity rather than the quality of care that exercised members' minds." (p. 99). Sadly, the research data confirms this mindset. This attitude and overriding concern with image appears to have changed little in the intervening years in the NHS. The situation has probably got worse with the increased pressure in the NHS and the constant changes.

"Self-interest is always a strong driving force of behaviour, as is the tendency to justify its pursuit" (Gabor 1994, p. 336). It may be that self-interest is the driving force behind the dysfunctional behaviours in the NHS. The apparent focus on protecting the reputation/image of the organisation may simply be part of the rationalisation process to justify self-interest and the protection of peoples own self-image and self-esteem. These factors may also, however, be linked with our sense of identity and how we meet our needs for self-esteem through being part of a particular organisation (Schwartz 1987a; Brown and Starkey 2000, p. 103; Blaug 2014).

The NHS appears to have a strong tendency to 'comfort-seeking' rather than 'problem-sensing' (Dixon-Woods et al. 2014). Such is the apparent level of ego-defensive behaviour with the resistance to 'bad news' and desire for 'good news'; with the resulting dishonesty, it is suggested the NHS is perhaps literally incapable of assessing itself honestly, or truly learning. If organisations are incapable of recognising their failures and learning, they are "…pathologically unable to improve" (Bailey 2012, p. 295).

When organisations

> …become clogged by corruption. Stuck hierarchies, inflated leaders and disengaged subordinates serve to shut down the knowledge-processing engine and render the organisation ineffective…The corrupting organisation starts to turn inward; it fails to interact with its environment. As a consequence, it stops learning (Blaug, p. 112).

Conclusions and Implications

Conclusions

Although some participants described positive characteristics, most of the data identifies negative aspects of the NHS. Many people expressed their concern at what they saw and experienced, and wanted change.

There is a lack of humanity within the vast, hierarchical, "top down driven" NHS. The NHS is an enclosed "system", a "machine" and an "…insensitive bureaucracy" where there is great complexity and great pressure to deliver with limited resources. There is constant change and there can also be disorder, chaos and paralysis. There can be a lack of care, concern and compassion for both patients and staff. A culture of disrespect is described and many staff do not feel valued. Negative behaviour appears to have become tolerated and normalised and responses to such behaviour are often inadequate. There is a strong resistance to voicing concerns and any information which puts individuals or the organisation into a 'negative light'. People who raise concerns can be victimised. The "…endemic top-down bullying culture…suppresses constructive dissent".

There appears to be a culture of elitism, fear, blame, bullying and a lack of accountability; a culture where power, self-interest and status matters. Good practice/behaviour can be punished, and bad rewarded, as can failure;

a distorted and irrational upside-down morality. The NHS may well reflect the general British culture and the "Structures of impunity" as described by Whyte (2015).

There seem to be "islands" and "pockets" with a positive culture; however, the generalised evidence suggests the NHS is systemically and institutionally deaf (with its fingers stuck in its ears, humming loudly), bullying, defensive and dishonest, exhibiting a resistance to 'knowing', denial and "wilful blindness"; a dysfunctional, perverse and troubled organisation. Corrupt and unethical behaviour has been identified as have totalitarian and Kafkaesque characteristics. The NHS could also be described as a coercive bureaucracy and under certain definitions, a corrupt entity. The NHS appears to be an organisation with a *heart of darkness;* a "…self perpetuating dysfunctional system" where there is the perverse dynamic of "…survival of the unfittest". There may be widespread "learned helplessness". Overall, the needs of the NHS and the protection of image appear more important than the welfare of staff or patients. It does seem to be a "…good news factory"; rejecting and hiding any "bad news"; retreating from reality. The NHS appears to have "lost its way" and its focus/purpose as an institution. Negative behaviour is one of many 'Elephants in the room' in the NHS.

Implications for Practice/The Organisation

There are implications for a range of people such as senior leaders/managers including HR professionals, regulatory bodies, trade unions as well as those at a political level and interested parties external to the NHS. There are particularly implications for the government as the body with overall responsibility and accountability for the UK National Health Service. This is especially relevant in the light of the many politically driven policy and structural changes that have taken place over a number of years.

There are also implications for every person employed within the NHS. Every person has a responsibility to not be part of the "…sea of silence" and "…learned helplessness". The care of the patient and the welfare of the staff have to be at the core of everything that is done. There needs to be a facing up to reality and a "…cleaning up" of the NHS. All employees in the NHS must choose to see, listen, hear, know, acknowledge, think, challenge, speak and act for the benefit of the patient and other staff. The 'undiscussable' needs to become 'discussable'. The NHS must reorientate its focus and choose to care and exhibit 'intelligent kindness'. There needs to be a culture of respect (Leape et al. 2012a, b, Parts 1 and 2), where every role is valued.

There also needs to be recognition within the NHS that the degree of dysfunctional behaviours described in this article and the responses to such behaviour are not normal or acceptable. The behaviours can be extremely destructive and dangerous. This is particularly seen in situations such as the Mid Staffordshire trust. Both patients and staff can be extremely damaged. Everything possible should be done to address these problems to protect the welfare of patients and staff. There is an urgent need to very consciously and determinedly move counter culturally. There has got to be a healthy level of individual and collective ego-defences and narcissism. The NHS needs to embrace the identity of being a listening, learning and honest organisation.

Let us hope the NHS is going to take its fingers out of its ears and stop humming.

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