A model of organisational dysfunction in the NHS

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Abstract

Purpose – This paper explores the reasons for the sometimes seemingly irrational and dysfunctional organisational behaviour within the NHS. It seeks to provide possible answers to the persistent historical problem of intimidating and negative behaviour between staff, and the sometimes inadequate organisational responses. The aim is to develop a model to explain and increase understanding of such behaviour in the NHS.

Design/methodology/approach – This paper is conceptual in nature based upon a systematic literature review. The concepts of organisational silence, normalised organisational corruption, and protection of image, provide some possible answers for these dysfunctional responses, as does the theory of selective moral disengagement.

Findings – The NHS exhibits too high a level of collective ego defences and protection of its image and self-esteem, which distorts its ability to address problems and to learn. Organisations and the individuals within them can hide and retreat from reality and exhibit denial; there is a resistance to voice and to "knowing". The persistence and tolerance of negative behaviour is a corruption and is not healthy or desirable. Organisations need to embrace the identity of a listening and learning organisation; a "wise" organisation. The "Elephant in the room" of persistent negative behaviour has to be acknowledged; the silence must be broken. There is a need for cultures of "respect", exhibiting "intelligent kindness".

Originality/value – A model has been developed to increase understanding of dysfunctional organisational behaviour in the NHS primarily for leaders/managers of health services, health service regulators and health researchers/academics. Research, with ethical approval, is currently being undertaken to test and develop the conceptual model to further reflect the complexities of the NHS culture.

Keywords National Health Service, Corruption, Denial, Ego-defences, Image, Negative behaviour, Organizational silence

Paper type Conceptual paper

Introduction

In any health service the behaviour of staff and their interactions have a huge impact on the quality of care provided, as well as affecting the health and well-being of individual employees. In 2005 following ethical approval from the NHS research ethics committee, research on negative behaviour between staff was undertaken in two primary care trusts in the UK National Health Service (NHS) (Burnes and Pope, 2007; Pope and Burnes, 2009). The scenario detailed in the following quote identifies some of the organisational responses to that research (Pope, 2012):

> It had been arranged that research findings on negative behaviour would be presented to a range of staff from two NHS trusts. As the equipment was prepared for the presentation, to the stunned shock and amazement of all, the directors/senior managers walked out of the room, saying they were busy and had other things to do. The presentation continued without them.
>
> A staff member wanted to write a short article about the research for the Trust News; this was blocked. There was resistance to a brief summary being placed on the research section of

the Trust's website. A letter critical of the research was sent to the researcher by a senior
manager. A year later, an offer was made to share the research findings with the Board; the offer
was refused.

This experience described in the previous quotes leaves us with many questions. Why
are senior NHS managers who are supposed to be interested in the welfare of staff and
the patients, behaving in such a seemingly irrational manner? Despite negative
behaviour being so costly to the individual, the patient and the organisation, why was
there such resistance to hearing evidence of a problem and taking effective action?
What was the underlying motivation for their actions?

This article is conceptual in nature. It is attempting to explore the reasons for the
sometimes seemingly irrational and dysfunctional organisational behaviour within the
NHS. The literature provides possible answers to the persistent historical problem of
intimidating and negative behaviour between staff, and the sometimes inadequate
organisational responses. The aim is to develop a model to explain and increase
understanding of such behaviour.

Though the main focus in this article is on the NHS and some specific events, it is
recognised that negative behaviour is a problem for health organisations
internationally and globally (Zapf *et al.*, 2003; Johnson, 2009; Leape *et al.*, 2012a, b).
There is therefore a wider application regarding other health organisations. There is
also relevance for other persistent problems within the NHS, and implications for
organisations external to the health sector.

Methodology of the literature review
Following the experiences and observations outlined in the above quotes, a systematic
investigative literature review was conducted drawing material from different
academic disciplines. From consideration of the reference list at the end of this article
there are contributions from nursing and medicine, management, organisational
behaviour, safety and risk, psychology, sociology and anthropology. This indicates a
broad awareness of the problems of dysfunctional behaviour, but this has not yet been
translated into the reality of change for the NHS. Databases such as Web of
Knowledge, Google and Google Scholar were used. The review predominately took
place in 2009-2011, although it is ongoing. Only English language documents were
considered.

Cooper (1988) suggests a taxonomy of literature reviews which offers the key
characteristics of reviews, including the central foci and goals. The taxonomy includes
six characteristics, which are the focus, goal, perspective, coverage, organisation and
audience. A review can focus on research outcomes, methods, theories, and practices. A
goal of the review can be to integrate past literature, critically analyse literature, or
identify central issues. The reviewer can present literature neutrally, or the review can
be based on a reviewer's point-of-view. Coverage of the review can be exhaustive.
However, including every available source can be difficult. Alternatively, the review
can cover literature selectively. In addition, the review can concentrate on works which
are pivotal or representative. The organisation of the review can be historical,
conceptual, and methodological. Last, the review can target specialised or general
scholars, practitioners, policy makers, or members of the general public.

Based on Cooper's taxonomy, first, the focus of this review was previous research
outcomes, practices and behaviours in the workplace. Second, the goal of the review

was to identify central and key issues to find possible answers to the real life scenario that appeared, at the time, to be inexplicable to those directly involved. Third, the perspective was that of neutrality in the quest to find those answers. Fourth, an attempt was made to be exhaustive, while recognising that some important works may have been missed. However, some key literature such as Brodsky (1976) and Leape *et al.* (2012a, b) are cited selectively. Initially, the focus was upon the topic of negative behaviour within the NHS and workplace negative behaviour literature more generally. This included different types of articles, journals, minor and major survey data, Department of Health documents and academic literature. This review was then broadened, and ultimately focused around the theory of selective moral disengagement, and the concepts of organisational silence, normalised organisational corruption and protection of image. This literature was considered to provide possible explanations for the described dysfunctional behaviour and formed the basis for the research questions and the proposed model.

Keywords used to search included: organisational silence, deafness, blindness, mindlessness, corruption, abuse, image; suppression/denial of voice; moral blindness, deafness; protection/restoration of image; rationalisations, denial and selective moral disengagement; destructive/*laissez-faire* leadership; workplace bullying and other words to describe any negative behaviour such as incivility, aggression, harassment and intimidation. The number of articles and books generated from the search was in excess of 400.

Fifth, the organisation of this article is conceptual, rather than historical or methodological. Last, this article targets primarily leaders/managers of health services, health service regulators and health researchers/academics. There is also relevance for scholars of organisational behaviour generally and particularly in the light of recent health disasters in the NHS, interested members of the public.

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; Pope and Burnes, 2009). It includes incivility, aggression, bullying, harassment or abuse.

The article covers the following:

- Section 1. Negative behaviour in the workplace. A literature review is detailed on negative behaviour between staff in the NHS and some key texts relating to negative behaviour in the general workplace.

- Section 2. Making sense of negative behaviour and the organisational responses. This literature review considers the work on selective moral disengagement and the concepts of organisational silence, normalised organisational corruption and protection of image, which forms the basis of the conceptual model.

- Section 3. Towards a conceptual model/framework. Based upon the literature detailed in section 1 and 2, a model is proposed to explain organisational dysfunction in the NHS.

- Section 4. Conclusion and recommendations. There is a call for NHS organisations to exhibit a healthy level of ego-defences and honest self-reflection and to embrace the identity of being a learning and wise organisation. There has to be a culture of "respect" and "intelligent kindness".

Negative behaviour in the workplace

Section 1 provides a review of a broad range of literature relating to the NHS. This is supported by some key literature concerning negative behaviour in the general workplace.

Adams (1992) did much to raise the profile of bullying in the workplace, identified problems within the nursing profession. Four years later Ball wrote that "Bullying is thought to be a significant problem within the National Health Service", asking the question "So why is so little being done about it?" (Ball, 1996, p. 114).

In 1998 it was stated that "Harassment and bullying in the health service is a wide spread and serious problem" and that recent research findings provide ". . .a glimpse of the darker side of organisational life" (Oakley, 1998, p. 18). Brennan considers it particularly concerning that ". . .bullying is tacitly and even overtly condoned" (Brennan, 1999, p. 20) and that "Some organisations promote a culture that almost rewards bullying" (Brennan, 1999, p. 17).

Quine (1999) researching within an NHS Community Trust, asked staff to indicate the behaviours they had experienced, rather than self-label as bullying. It was stated that 38 per cent of staff had been subjected to one or more forms of bullying behaviour in the previous year and 42 per cent had witnessed such behaviours.

Describing the experiences of doctors, "Bullying remains a familiar part of the health professional culture, despite the caring nature of doctors' work" (Hicks, 2000, p. 428) and "These are serious issues for quality assurance and clinical governance" (Hicks, 2000, p. 431). Cusack writes in the Lancet, "Of concern is the evidence that is accumulating of bullying among health-care workers and of its effect on them" and that "Health care organisations ought to recognise that bullying is an issue for them and place themselves in the vanguard of cultural reform" (Cusack, 2000, p. 2118).

The Bullying Culture, written by two midwives (Hadikin and O'Driscoll, 2000), describes a bullying culture that is deeply entrenched in the NHS as a whole and is extremely damaging to both staff and patients. In the *British Medical Journal* an anonymous junior doctor details being intimidated and traumatised by the behaviour of their surgical consultant. They describe themselves as disillusioned and wrote "I do not know why bullying still has to be part of medical training" (*BMJ*, 2001, p. 60). The "Opinion" section of the *Nursing Times* asked the question "Why is bullying in the workplace such an intractable problem in the 'caring' professions?" (Chan, 2002, p. 18).

The Amicus MSF research work (CPHVA/MHNA, 2003) involved health visitors, school nurses and community nurses across the UK, and showed that 45 per cent considered they had been bullied under a set definition, in their current workplace by other staff.

A three-year longitudinal study of a cohort of pre-registration students was conducted in England primarily looking at the self-esteem of students. "Bullying emerged as an important theme in the qualitative interviews conducted" (Randle, 2003, p. 395). There was the view that bullying was commonplace, and that students witnessed bullying of patients by qualified nurses, that qualified nurses bully them and as a result, students bullied others. A link was identified between the behaviour of staff and negative behaviour towards patients. A link with ill treatment of patients is also detailed in Hadikin and O'Driscoll (2000), Hume *et al.* (2006) and Randle *et al.* (2007).

In the Triple Helix it was stated that bullying is "…alive and well, an integral part of NHS culture" and expresses the view that "…it's high time we confronted it" (Cheesman, 2004, p. 8). The Royal College of Nursing (RCN) undertook surveys in 2000 and 2005 of 6,000 members across England, Wales, Scotland and Northern Ireland. Nurses were asked whether they had been "bullied/harassed by a member of staff in the last 12 months" (RCN, 2006, App. 4, p. 111) against two set definitions for "bullying" and "harassment". Most of the respondents worked in the NHS (82 per cent). The results showed an increase of negative behaviour from 17 per cent in 2000 to 23 per cent in 2005 (RCN, 2002, 2006). Another question is asked within the title of a short article "Why is bullying still rife? The opinion was that "…it is clear that, despite years of initiatives and zero tolerance policies, that the NHS and nursing – the caring profession – still has a serious problem" (Paton, 2006, p. 20). These statements are supported by a survey at an HR in the NHS conference by Consult GEE (2006).

The literature also highlights the less than positive responses to the problem of negative behaviour within the NHS. The qualitative research work of Lewis (2006a, p. 42) describes a much darker side of the problem. There is a permeating climate of silence and fear and of keeping "…bullying quiet and low profile, of it being nebulous and hidden". People were fearful of retribution, particularly in cases where an individual highlights examples of poor clinical practice and patient care. There is pretence that negative behaviour is not taking place, a reluctance to admit, and "Bullying is openly justified by some managers" (Lewis, (2006a, p. 40). Managers know what is happening, but prefer to ignore the issue. "Bullying is embedded in the act of 'management'" (Lewis, 2006a, p. 40). The need for getting work done is seen as justification and the more "…senior you are the more appropriate it may be to use such an option" (Lewis, 2006a, p. 39).

A quote from one interviewee (Mary) particularly resonated with the researcher.

> We give no support to the bullied. We have a policy, which nobody hopes will be used … I think it's a paper exercise. It's tick in the box. Trusts don't want the confrontation of it unless it gets into the union bracket. Unless it's actively pushed into their face and it has to be dealt with, they would rather people on the ground floor deal with it and it doesn't get through to the top so we can shield the Board from these issues (Lewis, 2006a, p. 42).

It was also the view of Lewis (2006b) that human resource departments often failed to support targets and that if people try to get redress they can be made more of a target. The overall perception "…is that management as a whole handles bullying situations very poorly" (Lewis, 2006a, p. 42).

Randle *et al.* (2006) support these findings, stating that environments can be created where bullying is allowed and seen as acceptable, behaviours are not challenged and "…staff pretend that bullying is not taking place" (Randle *et al.*, 2007, p. 53). Also, many individuals, managers and NHS Trusts are choosing to ignore bullying or deny that it happens, "…hoping it will go away" (Randle, 2006, p. 1). Randle considers this has repercussions for individual health and the functioning of teams, systems and structures. She considers that "Bullying does not only affect the individual, but it goes to the heart and purpose of the NHS" (Randle, 2006, p. 1).

"Bullying is rife in the health care sector …" (Edwards and O'Connell, 2007, p. 27) and there are also difficulties for educators, which they consider has been transferred into the health educational sector from the NHS. Another anonymous person, in a senior NHS position described being bullied by people at the top of the organisation

and again of bullying being "…rife in the health service" (*BMJ*, 2009, p. 177). They considered that human resource personnel were implicated in that process and used the phrase "institutional bullying".

The research in two primary care trusts in 2005 (Burnes and Pope, 2007; Pope and Burnes, 2009) showed that 63 and 52.8 per cent of the respondents had experienced and/or witnessed negative behaviour from staff in the previous year. The findings showed that behaviour perceived as incivility (whether or not it was classed as bullying by the individual) and aggression (this was always described as bullying and had higher levels of effect than incivility) was damaging to the individual and the organisation.

In an online survey in 2007/2008 trainee doctors were asked whether they had been subjected to persistent behaviour in their post that undermined their professional confidence and self-esteem, and 9.7 per cent responded "yes". This was linked to an increased reporting of making medical errors. It was considered that "…bullying is a patient safety issue, and should be taken seriously" (Paice and Smith, 2009, p. 17).

A website survey of 5,428 RCN members was conducted in 2009 looking at attitudes towards reporting worries about patient safety. A press release (11 May 2009) indicated that 78 per cent of nurses responded "…they would be concerned about victimisation, personal reprisals or a negative effect on their career if they were to report concerns to their employers".

The Health and Wellbeing Review refers to the need to address "…some of the deep rooted cultural issues that are endemic in the NHS, such as a culture of long hours and high levels of bullying and harassment" (DoH, 2009, p. 23). From over 11,000 responses 13 per cent of staff considered they had been bullied/harassed by a manager and over 17 per cent by "Other colleagues" in the previous 12 months.

On retirement from the Health Care Commission Sir Ian Kennedy gave "… a sombre warning about the 'corrosive' impact of bullying among NHS staff" and stated it was "permeating the delivery of care", (Santry, 2009a, April 23). That bullying is "one of the biggest untalked about problems in the delivery of good care to patients" (Santry, 2009b, April 1). Santry asks the question, "…but why is bullying so widespread in an institution devoted to caring?" (Santry, 2009a, April 23).

In the book *Intelligent Kindness: Reforming the Culture of Healthcare* Ballatt and Campling (2011) make comments about leadership behaviour in the NHS. "There are many anxious, ambitious and reactive managers and leaders, some of whom are simply ineffectual, some of whom place healthcare secondary to organisational and personal success, and some of whom attempt to drive their staff towards achieving targets in ways that often include silencing or bullying them" (Ballatt and Campling, 2011, p. 183).

A recent national study of ill treatment in the workplace included a case study within a large NHS trust with some 30,000 staff. Fevre *et al.* (2011) observed that "The working environment of much of the organisation seemed to function as a 'pressure cooker' where tempers fray, insults are traded and intimidation is practiced. Employees of all ages and backgrounds appeared to be on the receiving end of ill-treatment with aggressive behaviour being seen as commonplace" (Fevre *et al.*, 2011, p. 27).

In 2012 allegations of waiting list manipulation and distortions and innapropriate managerial behaviour were made about a Health Board in Scotland. An independent report described "…an organisation where being bullied, whilst not representing the

daily experiences of the majority of staff, is common at certain levels... staff feel intimidated and anecdotes of bullying behaviour are common... This has pervaded the culture of the organisation so that staff feel under-valued and they have little faith that the organisation will handle them in a fair manner, should they need to raise an issue about bullying by a senior manager" (Bowles & Associates, 2012, p. 22).

There was "...a fairly consistent theme from all parts of the workforce and at all levels of either an inability to challenge inappropriate behaviour or an apparent acceptance or 'developed' tolerance of these behaviours" (Bowles & Associates, 2012, p. 26).

The public inquiry report into the appalling care provided by Mid-Staffordshire hospital, where so many people died unnecessarily, was published on 6 February 2013 (Francis, 2013). It describes a negative workplace culture of bullying, target-driven priorities, disengagement from management, low staff morale, isolation, lack of candour, acceptance of poor behaviours, reliance on external assessments and denial. It is considered that "these negative aspects of culturally driven behaviours are not restricted to Stafford", and that "Unfortunately, echoes of the cultural issues found in Stafford can be found throughout the NHS system. It is not possible to say that such deficiencies permeate to all organisations, all of the time, but aspects of this negative culture have emerged throughout the system" (Francis, 2013, p. 1361).

To conclude this literature review on negative behaviour in the NHS, we consider the results of the UK staff attitude/employee surveys.

The first English NHS Staff Survey in 2003 gave the overall figure as 7 per cent from a manager, and 11 per cent from a colleague for bullying and harassment between staff in the previous year. This was 16 per cent of the total number of staff (Care Quality Commission, 2004). The latest figure for 2011 is around 15 per cent (National NHS Staff Survey Coordination Centre, 2012). Over the intervening years the figures changed little.

The surveys and questions in Scotland are not comparable, but in the NHSScotland Staff Survey report for 2010, 22 per cent of staff considered they had experienced bullying and harassment from various sources in the previous 12 months. Of that 22 per cent, 43 per cent stated a manager/team leader as a source and 60 per cent "other colleagues" (Bacon and Hoque, n.d.). In Northern Ireland in 2009, 8 per cent said that they had experienced harassment, bullying or abuse from their manager/team leader and 11 per cent from other colleagues in the previous 12 months (Business Services Organisations, n.d).

No comparable figures for the NHS in Wales could be found. However, the 1000 Lives Plus online survey in spring 2011 showed that in response to the statement "I am treated with dignity and respect in this organisation", 19 per cent strongly disagreed/tended to disagree; 57 per cent agreed (Opinion Research Services, 2011).

The above literature relating to the NHS is supported by some key texts on negative behaviour in the general workplace.

A very key work is by Brodsky (1976) who considered that "...harassment is a basic mechanism in human interaction", a "...social instinct" and "...an informal mechanism for achieving change". What was striking was that harassment was described as a privilege and a benefit, that "Harassment signifies status..." , coming down through all levels of an organisation. He assumes that organisations could tackle such behaviour if they chose to do so, implying that behaviour is only there if "...permission to harass" is given (Brodsky, 1976, p. 84).

Harlos and Pinder (1999) when researching organisatonal injustice write that "... an implicit, if not explicit, sense of entitlement to mistreat others pervaded participants' descriptions of unjust treatment by bosses" (Harlos and Pinder, 1999, p. 111).

The sense of benefit is also seen in a paper by Salin (2003, p. 35) which argues that "...workplace bullying can in some cases be a form of organisational politics, that is, a deliberate competitive strategy". One of the items on the organisational politics scale is "Some build up themselves by tearing others down" (Salin, 2003, p. 46).

Two important articles have been published by Leape *et al.* (2012a, b). These relate to the widespread culture of disrespectful behaviour within healthcare generally and its extremely detrimental impact on individuals and patient care. They consider that "A culture of respect is a 'precondition' for the changes needed to make healthcare safe" (Leape *et al.*, 2012b, p. 1).

This review on negative behaviour in the workplace has identified some key themes:

- The NHS appears to have a widespread and persistent problem with negative behaviour between staff. This is despite various initiatives over the years such as Improving Working Lives and guidelines around bullying and harassment issued from the Department of Health.
- 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.

We now move into section 2 which attempts to make some sense of negative behaviour and the organisational responses within the NHS.

## Making sense of negative behaviour and the organisational responses

This literature review in section 2 considers the work on selective moral disengagement, and the concepts of organisational silence, normalised organisational corruption and protection of image, which forms the basis of the conceptual model.

Selective moral disengagement

The theory of selective moral disengagement (Bandura, 2002, p. 101) assists in explaining the process and psychological mechanisms by which "...moral self-sanctions are selectively disengaged from inhumane conduct". In other words, how we can all do bad things more comfortably.

Mechanisms are described that cognitively redefine our actions to lessen and remove feelings of guilt and self-censure (e.g. Bandura, 1991, 2002; White *et al.*, 2009). This includes moral justification, palliative/advantageous comparisons, euphemistic language, displaced and diffused responsibility, minimising, ignoring, or misconstruing the consequences of actions, denial, and dehumanisation of, and blaming the victim for our damaging actions (Figure 1). There is also the possibility of collective pretence and people choosing to remain uniformed (Bandura, 1991).
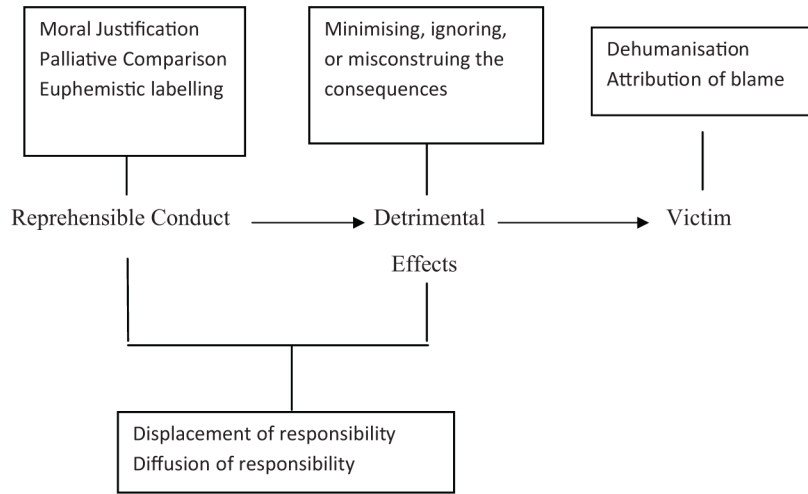
Source: Bandura (1986) in Bandura (2002)

It is proposed that the mechanisms of selective moral disengagement enable the persistence of a dysfunctional culture within the NHS described in the following concepts of organisational silence, normalised organisational corruption and protection of image. It is an integral part of the proposed model of organisational dysfunction (Figure 2).

The review is now broken into three further areas of literature.

Organisational silence
A letter written by a staff nurse in New Jersey was discovered entitled "Organisational silence: the threat to nurse empowerment" (Hascup, 2003, p. 562). She writes "We have more power than ever . . . , yet the fear of nurses to speak out and stand up for patient
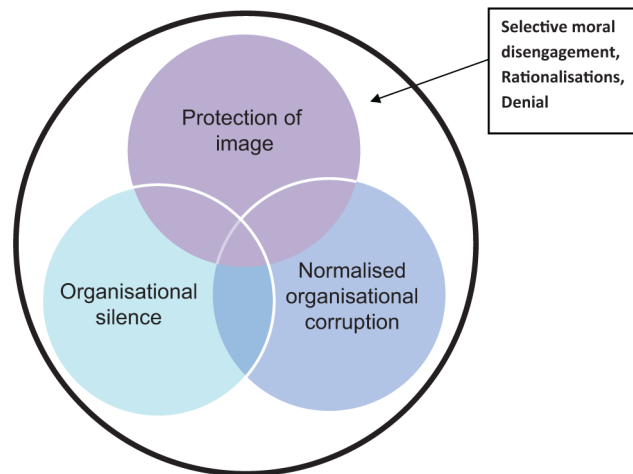
care and nursing standards is as strong as ever before. Why? Because nurses who do are labelled and punished. This is organisational silence: most organisations do not want nor do they value nurses who speak out". She refers to the article by Perlow and Williams (2003), who ask the question "Is silence killing your organisation?".

A comprehensive model has been detailed by Morrison and Milliken (2000, p. 706) 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 ". 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" (Morrison and Milliken, 2000, 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 (Morrison and Milliken, 2000, p. 718). The organisational outcome is less effective organisational decision-making and decreased error detection and correction.

In the staff survey findings in England for 2011, only a third of NHS staff (32 per cent) were satisfied with the extent their trust values their work. Only 26 per cent said that communication between senior managers and staff was effective and less than a third (30 per cent) said that senior managers act on their feedback (National NHS Staff Survey Coordination Centre, 2012). In the Welsh 1000 Lives Plus survey (Opinion Research Services, 2011) the response to the statement "This organisation's leaders listen to me and care about my concerns" was that only 35 per cent strongly agreed/tended to agree, and 38 per cent disagreed. The NHS Scotland survey (Bacon and Hoque n.d.) identified that only 27 per cent considered they were always consulted about changes at work, and only 40 per cent were confident that their ideas or suggestions would be listened to.

In Northern Ireland in 2009 (Business Services Organisations, n.d.) only 38 per cent of staff agreed that communication between senior managers and staff was effective and 45 per cent disagreed.

Only a third of staff (33 per cent) agreed that senior managers acted on staff feedback.

The public inquiry report into the disaster at Mid Staffordshire hospital (Francis, 2013) identified that some people did try to raise concerns about the poor patient care. One nurse in particular was a whistle blower in 2007, regarding the accident and emergency services. The management of the trust did not respond positively to those concerns, or to the many concerns that were raised by the patients and their families, over a number of years.

A number of academics have reviewed the impact of the Bristol Royal Infirmary (BRI) tragedy. Kennedy (2001), Alaszewski (2002), Weick and Sutcliffe (2003), and Kewell (2006) identified a culture where there was a resistance to the raising of concerns and identification of problems, as well as a culture of fear. "Most frontline staff conceal their concerns from key decision makers because of fears of victimisation" (Alaszewski, 2002, p. 372). Warnings were persistently disregarded and those who did raise concerns were viewed as trouble makers and marginalised.

Referring to the NHS, "Individuals raising concerns – or ideas – face high anxiety and vulnerabilty to being ignored, or even punished" (Ballatt and Campling, 2011, p. 186). Cultures of silence and cultural censorship in the NHS are considered by Hart and Hazelgrove (2001, p. 261). They describe the parodox of "...a characteristic feature of cultural censorship – that adverse events can be widely known about yet simultaneously concealed".

Denial of voice is also perceived as bullying (Mackenzie *et al.*, 2003), and Henriksen and Dayton (2006) consider organisational silence and the hidden threats to patient safety. Another item on the already mentioned organisational politics scale is "Don't speak up for fear of retaliation" (Salin, 2003, p. 46).

The concept of organisational silence with the resistance to, and suppression of voice and upward feedback forms one of the aspects of the NHS culture. It provides some possible reasons for lack of action and response to problems, forming part of the proposed model of organisational dysfunction in the NHS (Figure 2).

Normalised organisational corruption
The literature around the process of normalising organisational corruption identifies how corrupt behaviour can become engrained into organisations. Corrupt behaviour is defined as "...aggregate wrongdoing...", which is explicitly or implicitly "...officially sanctioned" (Brief *et al.*, 2001, p. 472). The "...misuse of authority for personal, subunit and/or organisational gain" (Ashforth and Anand, 2003, p. 2) and "...illegal, unethical, or socially irresponsible" behaviour (Palmer, 2008, p. 107).

Ashforth and Anand (2003) describe a theoretical model of institutionalisation, rationalisation and socialisation, producing normalised corruption.

Institutionalisation is where an initial corrupt decision or act becomes embedded and routine. A permissive ethical climate and leadership are key to the intitiation and the behaviour, once routine, becomes normative. Rationalisation is where justifications are made to serve self interests. Behaviours are described such as, denial of the victim and denial of injury and responsibilty, which are very similar to those of selective moral disengagement. Socialisation is where new employees are induced by rewards to view corruption as "...permissable if not desirable" (Ashforth and Anand, 2003, p. 1) leading to a gradual excalation.

Using different terminolgy Maclean (2001), outlines the mechanisms of diffusion and facilitation embedded in the relationships between managers and employees resulting in widespread rule breaking. Qualitative research had been conducted with former employees of a large mutinational life insurance company where there had been corrupt practices. In this model the rule breaking produced an increase in productivity or "benefit", which promoted more bad behaviour. People were then rewarded by being promoted. They in turn assist in perpetuating bad behaviour, including affecting new employees.

The link between corrupt behaviour and selective moral disengagement is discussed by Moore (2008). It is proposed that moral disengagement plays an important role in the intitiation, facilitation and perpetuation of corruption in organisations. If the corruption is to the benefit of the organisation, she also suggests that the promotion and advancement of individuals who practice some form of corruption assists in the perpetuation of the behaviour.

Ballatt and Campling (2011, p. 187) consider that "There is a strong argument that there are worrying perverse incentives operating within the NHS that undermine its ethical intention. These are known about on many levels, but a blind eye is deliberately turned".

From narrative qualitative research conducted in two Australian public sector health organisations (Hutchinson *et al.*, 2009, p. 213) a link is made between bullying and corruption in organisations. They consider that the study offers "…implications for the management of bullying as a serious and corrupt activity". There are five aspects of "…bullying as organisational corruption" (Hutchinson *et al.*, 2009, p. 217). First, there is the "institutional backdrop" of silence, of "..secrecy and cover up in which corrupt conduct was able to flourish". There are also networks of "predatory alliances" of established informal networks, "corrupting legitimate routines and processes" for personal gain, "reward and promotion" where career prospects were advanced within the alliances, and the "protection from detection" within these groups. It is the view that "The worse you behave, the more you seem, to be rewarded" (Hutchinson *et al.*, 2009, p. 213).

The concept of normalised organisational corruption where there is a persistent engrained high tolerance of negative behaviour forms a second aspect of the NHS culture. It provides further possible reasons for lack of action and response to problems, forming part of the proposed model of organisational dysfunctional in the NHS (Figure 2).

Protection of image
The anthropologist Douglas (1986, p. 112) writes that institutions promote their "…righteous image", and "…they endow themselves with rightness…" (Douglas, 1986, p. 92) as well as "…create shadowed places in which nothing can be seen and no questions asked" (Douglas, 1986, p. 69).

Brown (1997, p. 649) interprets the shadowed places as relating to the pervasiveness of rationalisations. He argues that groups and organisations, "…literally have needs for self-esteem that are regulated narcissistically". "Just as individuals seek to regulate their self-esteem through such ego-defence mechanisms as denial, rationalisation, attributional egotism, sense of entitlement, and ego aggrandizement, which ameliorate anxiety, so too do groups and organisations" (Brown, 1997, p. 643). Idealisation and fantasy are other collective ego defences (Brown and Starkey, 2000).

People are extremely sensitive to their organisation's external image and promoting a positive 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). They contend that organisations fail to learn, due to the ego defences that maintain collective self-esteem.

There is a healthy level of ego defences and self-esteem in any individual or organisation. However, there are extremes in either direction, of either too low or, too high defence of self-esteem and image, which is pathological (Brown and Starkey, 2000). In the organisation that over protects its self-esteem there is a retreat from reality and an inability to learn and change.

Brown (1999, p. 669) suggests a number of questions that could be used to assess an organisations level of denial. "Do people admit responsibility for their errors? Are

important issues dodged around here? Does the organisation refuse to acknowledge problems?". It is suggested that ego-defenses can be mitigated by embracing the identity of a learning organisation of becoming a "wise" organisation (Brown and Starkey, 2000).

In the first inquiry report on Mid-Staffordshire hospital, there is a section on denial (Francis, 2010, pp. 179-184). In the final comments it is written "This culture is characterised by introspection, lack of insight or sufficient self-criticism, rejection of external criticism, reliance on external praise and above all, fear" (Francis, 2010, p. 184).

These findings are further reinforced in the latest report (Francis, 2013, p. 4). There was "An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern". A lack of openness to criticism, lack of consideration for patients, and defensiveness. A culture of "...self-promotion rather than critical analysis" (Francis, 2013, p. 44).

Again linked with the BRI tragedy, it is important to note that Weick and Sutcliffe (2003) identified socially acceptable rationalisations and justifications as critical to reinforcing and confirming the actions of a failing health system. They identify a health system which was unable to learn, describing this as "cultural entrapment". Where "Cultural blind spots can lead an organisation down the wrong path, sometimes with dire performance consequences" (Weick and Sutcliffe, 2003, p. 73).

Kewell (2006, p. 365) brings an interesting qualitative focus to the BRI events, of what themes of discourse and "language games" were used within that situation. They identify from the original transcripts seven main language games. The third is "...about staff bullying and whistle blowing" the seventh, however, is said to underpin all other themes and "...functioned at a deeper level than all the others" (Kewell, 2006, p. 365); that of "reputation". "...with the exception of victim's parents and carers, most witnesses spoke from a defensive position and sought to shield their reputation, the reputation of colleagues, or the image of an organisation to which they felt some degree of loyalty" (Kewell, 2006, p. 365).

Reviewing failures within international health systems Walshe and Shortell (2004, p. 103) identify that "The culture of secrecy, professional protectionism, defensiveness, and deference to authority is central to such major failures". They consider that "...some health care organisation leaders act defensively to protect the institution rather than its patients" (Walshe and Shortell, 2004, p. 107). "...the capacity of individuals and organisations for self-deception and *post hoc* rationalisation in the face of unwelcome information often plays a part in their inaction" (Walshe and Shortell, 2004, p. 107).

The report on the Scottish Health Board (Bowles & Associates, 2012, p. 24) identified a culture of a requirement for "gloss" and positive "spin", where "A generally consistent pattern emerged of a reluctance to pass bad news too far up the management chain". And "...at times, creating the right image or gloss was just as, if not more important than, seeking to obtain a full understanding of some of the substantive issues or risks".

A range of behaviours within the NHS are discussed by Ballat and Campling (2011). These behaviours include the presence of denial driven by the need to dispel anxiety, which they consider is common in healthcare. They describe denial as "... a step on from repression and involves active distortion of the truth and consequent distortion of relationships. Denial frequently involves omnipotence, grandiosity and triumphalism"

(Ballatt and Campling, 2011, p. 75). Problems are ignored or "…rationalised away" (Ballatt and Campling, 2011, p. 76). They also describe the "Pull towards to perversion" (Ballatt and Campling, 2011, p. 139) based upon the work of Susan Long in "The perverse organisation and its deadly sins" (Long, 2008). "Perversion is 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). They identify that "A fundamental aspect of perversion is the process of turning a blind eye and, with this, the development of perverse certainty, the denial of a reality that continues to be encountered and the consequent self-deception that seduces accomplices and breeds corruption" (Ballatt and Campling, 2011, p. 140). They believe that resistance to "knowing" "…is at the core of the 'pull towards perversion'" (Ballatt and Campling, 2011, p. 141).

They recognise that the situation at the Mid Staffordshire hospital was extreme, however they consider that the dynamics that produced it "…are everywhere in the NHS, and there is the risk that they could tip into such outcomes at anytime, anywhere" (Ballatt and Campling, 2011, p. 176).

To conclude this literature review we bring to your attention "The elephant in the room: silence and denial in everyday life" (Zerubavel, 2006), and "Wilful blindness: why we ignore the obvious at our peril" (Heffernan, 2011):

> Like silence, denial involves active avoidance. Rather than simply failing to notice something, it entails a deliberate effort to refrain from noticing it. Furthermore, it usually involves refusing to acknowledge the presence of things that actually beg for attention, thereby reminding us that conspiracies of silence revolve not around those largely unnoticeable matters we simply overlook but, on the contrary, around those highly conspicuous matters we deliberately try to avoid (Zerubavel, 2006, p. 9).

We choose not to see and to know (Heffernan, 2011).

Denial itself is also denied. "In other words, the very act of avoiding the elephant is itself an elephant!" (Zerubavel, 2006, p. 53). The concept of "silence breaking" and the negative responses to the breaking of silence are identified. Silence breakers are not received positively.

The concept of protection of image where there are high levels of ego defences, denial and rationalisations and an unhealthy focus on the image of organisation or individuals form the third aspect of the NHS culture. It provides further possible reasons for lack of action and response to problems, forming part of the proposed model of organisational dysfunctional in the NHS (Figure 2).

In the following section 3 a conceptual model of organisational dysfunction in the NHS is proposed based upon the literature review.

Towards a conceptual model/framework

From the evidence in the literature review the NHS appears to have a persistent, engrained problem with negative behaviour between its staff, in its different forms. It is behaviour that ostensibly has become tolerated and "normalised".

The concepts of organisational silence, normalised corruption and protection of image reflect three aspects and perspectives of the NHS culture (Figure 2), providing some possible reasons for lack of action and response to problems. This reflects a "darker side" to the NHS than perhaps many would wish to consider (Vaughan, 1999).

These concepts are also seen as being entwined/interlocked, each reinforcing the other. Encompassing and integral to this is our tendency to rationalise/morally disengage and to exhibit denial. These adaptations to our thinking enabling us to do bad things more comfortably, so that we can avoid self-censure, keep our self-esteem and avoid anxiety.

Underpinning these concepts is the human requirement for benefits and reward. There is the benefit and privilege of negative behaviour described by Brodsky (1976), rewards for corrupt behaviour, as well as the preservation of self-esteem and avoidance of anxiety with individual or collective narcissistic behaviour.

In the scenario described in the first quotes, there was a resistance to receiving information. The behaviour appeared not to be rational and there were no signs of any care, or concern for the staff, or ultimately the patient. It could be viewed as an extreme form of organisational silence.

We suggest however, that the protection of the organisational image and also their own image and self-esteem, was probably the dominant influence. It may be that this is always the case in organisational life. The information was perhaps perceived as a threat. Over time some NHS colleagues were asked to give their opinion on the possible reasons for this experience. One said "fear", another, "they didn't want to know" and they were "scared". Other responses included "protecting their image" and "you were showing them a mirror". All of these link with the writing on organisational narcissism, which includes the emphasis on denial. Other people have suggested it was about exerting control, power and showing their authority (Clegg *et al.*, 2006).

The actual event when the directors/senior managers walked out of the room was probably about silence breaking (Zerubavel, 2006). They knew, but they had chosen to ignore, and they didn't want to know. Negative behaviour is one of the "elephants in the room" for the NHS. Perhaps it would not matter if there wasn't so much at stake. The NHS however, cannot afford to have extreme levels of narcissistic behaviour, protecting image and self-esteem; patient care is at stake, as well as the welfare of its staff.

In the literature review on negative behaviour in the NHS questions are asked and calls for action are present, but there is little evidence of NHS organisations taking effective action.

In section 4 we now draw together some conclusions and offer some recommendations based upon the literature review.

Conclusion and recommendations

A model has been developed to explain and increase understanding of dysfunctional organisational behaviour in the NHS (Figure 2). Qualitative research in the form of interviews and focus groups is currently being undertaken across the UK to test and develop the conceptual model, to further reflect the complexities of the NHS culture. This will hopefully contribute to academic knowledge and impact on practice within the NHS. The combination of the behaviours outlined in this model can have an extremely damaging impact on staff health and well-being and the delivery of patient care. We have only to look at the Mid Staffordshire situation to see the direct devastating impact of dysfunctional behaviours, and the dire consequences of avoiding facing reality, upon the patients.

We conclude that organisational behaviour in the NHS can be dysfunctional, not always rational, and perverse. The mechanisms of selective moral disengagement enable the persistence of this dysfunctional culture. We propose that the NHS exhibits too high a level of collective ego defences and protection of its image and self-esteem, which distorts its ability to address problems and to learn. 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.

Some possible characteristics of an organisation retreating/hiding from reality are proposed based upon the literature review, as well as from direct observation within NHS organisations:

- centralised decision making/authoritarian leadership;
- suggestions for improvements not received well/active resistance to upward feedback;
- managers choosing to remain uninformed;
- important issues/problems are avoided/deflected;
- organisations refuse to acknowledge/deny problems;
- not admitting responsibility for errors;
- pretence that things are ok when they are not/lack of honest self-assessment;
- people who raise concerns are marginalised/intimidated;
- organisation acutely sensitive to outside interest by the press/other interested parties/staff talking to the press;
- staff access to non-executives strongly controlled/restricted;
- patient complaints are deflected; and
- the presence of fear.

Regarding negative behaviour:

- denial that negative behaviour exists in the organisation;
- extreme reluctance to class/label any behaviour as "bullying"; and
- staff/managers who intimidate people can be protected/promoted.

This list of characteristics could be used to encourage honest self-reflection at all levels of the NHS, but particularly at the senior and middle management layers, regarding the behaviour in their own organisation. It could also assist in helping them to gather feedback from employees and to respond more positively to that feedback. There is also a place for discussion around the justifications and rationalisations that are used to excuse such negative and dysfunctional behaviour. There could also be utilisation as a diagnostic tool at a regulatory level, and there is an intention to develop such a tool as part of the current research project. The serious implications of not taking these dysfunctional behaviours seriously are repeated failures across the UK NHS, possibly repeated on the scale of Mid Staffordshire.

There needs to be recognition within the NHS that the dysfunctional behaviours described in this article are not "normal" or acceptable, and everything possible should

be done to address these problems. There has got to be a healthy level of individual and collective ego defences and narcissism. From the literature already reviewed, there are recommendations regarding actions. Again, these recommendations have implications for a range of people such as senior leaders/managers including HR professionals, regulatory bodies, as well as those at a political level.

Brodsky (1976, p. 156), regarding workplace harassment, is the most traditional in thinking with broad public policy measures from four directions: "...research, legislation, enforcement, and on-the-job programs to change attitudes". He recognised that strong public pressure was needed.

Within the work on organisational corruption, Ashforth and Anand (2003) consider that "Given the self-sustaining nature of normalised corruption, overcoming it typically requires the administration of a strong shock – typically from external sources. A common form of shock is media exposure. Significant negative exposure creates a socially undesirable image, often galvanising change" (Ashforth and Anand, 2003, p. 38). It requires a significant organisational effort to remove the normalised corruption.

The huge challenges of addressing organisational silence are also recognised by Morrison and Milliken (2000, p. 721). "Everyone understands that it is risky to speak the truth, but this fact itself is undiscussable", and few people know how to bring about change". Revolutionary change may be needed but "...achieving such system-wide change is unusual in the absence of a strong external force" (Morrison and Milliken, 2000, p. 722). Top management change will be required, and it also might be necessary to have changes of personnel at multiple levels throughout the organisation.

It is suggested that ego-defenses can be mitigated by embracing the identity of a learning organisation (Brown and Starkey, 2000). They consider that organisations can learn, but that the process can be extremely difficult and take time. The characteristics of a learning organisation are: critical self-reflexivity, the promotion of dialogue about future identity as an integral feature of strategic management, and the attainment of an attitude of wisdom (Brown and Starkey, 2000, p. 108). The wise individual or organisation is one who/which is willing to explore ego-threatening matters and be willing to undergo challenging and honest self-assessment.

Two main lessons for hospitals are identified by Weick and Sutcliffe (2003). "First, be certain that the socially acceptable reasons that are available as content for justifications centre on a learning orientation that values communication, openness, mutual aid, and mindfull attention to patient care. Second, "...hospitals should try to weaken the committing context that surrounds adverse events so that people are not forced to justify inadequate performance" (Weick and Sutcliffe, 2003, p. 82). They call for a greater recognition of interdependence and awareness of collective responsibility.

"Ultimately, the most effective actions we take to prevent future major failures will be those that help to create a more open, transparent, equitable, and accountable health care culture (Walshe and Shortell, 2004, p. 110). A call is made to build "open learning organisations" by Bowles and Associates (2012, p. 34) where an emphasis is on organisations learning from their mistakes. The Mid Staffordshire report calls for a fundamental change of culture and identifies the need to "Ensure openness, transparency and candour throughout the system about matters of concern" (Francis, 2013, p. 4).

Leape *et al.* (2012b, p. 1) consider that "Safe organisations are 'learning organisations' that build shared visions, use systems thinking, and respond to

untoward events as opportunities for improvement rather than with denial and cover up. They achieve high levels of mutual trust, collaboration, and accountability, both personal and institutional. . . Respect is core to all of these behaviours".

Many proposals for improvements are made by Ballatt and Campling (2011, p. 175) as they encourage us to see the central place and extreme importance of "kinship and kindness in healthcare". We need "A change of mind" and ". . .a radical change of direction", which will need ". . .courage and imagination". Their contribution needs to be read in entirety and we will only briefly mention one area, that of leadership. They consider that "The culture and values of NHS leadership need scrutiny – from top to bottom" (Ballatt and Campling, 2011, p. 182). There has to be acceptance of the psychosocial aspect of the organisation and managers at all levels have to live out "intelligent kindness" in reality, as well as manage their own anxiety. "In the end how leaders behave, whatever role they play, will make the biggest difference". "They need to be able to resist the urge to minimise genuine complexity and to denigrate or turn a blind eye to staff who either raise problems or fail to meet impractical, even impossible demands" (Ballatt and Campling, 2011, p. 182):

> Leaders need to be emotionally capable of trusting staff, brave enough to put supporting front-line practice at the centre of their thoughts, and alive and attentive enough to notice where things are going wrong. They need to resist the temptation to rule by fear and procedure and instead promote and model openness, participation and collective creativity and problem-solving (Ballatt and Campling, 2011, p. 182-183).

Safeguards have to be ". . .built into social systems that uphold compassionate behaviour" (Bandura, 2002, p. 101). There must also be safeguards against the misuse of institutional power, ensuring that it is made difficult to remove humanity from our conduct.

The silence must be broken. Silence ". . . is consent. By remaining silent about improper behaviour we help to normalise it" (Zerubavel, 2006, p. 85). "Silence is also morally corrosive, as it inevitably opens the door to abuse". "'Elephants' rarely go away just because we pretend not to notice them" (Zerubavel, 2006, p. 86) and it is only ". . .when we no longer collude to ignore it, can we finally get the proverbial elephant out of the room" (Zerubavel, 2006, p. 87).

Bringing the recommendations to a close, Heffernan quotes Colm O'Gormand. "We make ourselves powerless by pretending we don't know" (Heffernan, 2011, p. 51). Heffernan develops this and concludes her book with, "We make ourselves powerless when we choose not to know. But we give ourselves hope when we insist on looking. The very act that wilful blindness is willed. . . is what gives us the capacity to change it" (Heffernan, 2011, p. 331).

We must all insist on looking and knowing. There is hope for change.

References

Adams, A. (1992), "The standard guide to. . .confronting bullying at work", *Nursing Standard*, Vol. 7 No. 10, pp. 44-46.

Alaszewski, A. (2002), "The impact of the Bristol Royal Infirmary disaster and inquiry on public services in the UK", *Journal of Interprofessional Care*, Vol. 16 No. 4, pp. 371-378.

Ashforth, B.E. and Anand, V. (2003), "The normalization of corruption in organizations", *Research in Organizational Behavior*, Vol. 25, pp. 1-52.

Bacon, N. and Hoque, K. (n.d.), *NHS Scotland 2010 Staff Survey: Highlights Report*, NHS Scotland, Scotland.

Ball, H.C. (1996), "Management of bullying and bullying in management", *Accident and Emergency Nursing*, Vol. 4, pp. 114-118.

Ballatt, J. and Campling, P. (2011), *Intelligent Kindness: Reforming the Culture of Healthcare*, RCPsych Publications, London.

Bandura, A. (1991), "Social cognitive theory of moral thought and action", in Kurtines, W.M. and Gewitz, J.L. (Eds), *Handbook of Moral Behaviour and Development*, Erlbaum, Hillsdale, NJ, pp. 45-103.

Bandura, A. (2002), "Selective moral disengagement in the exercise of moral agency", *Journal of Moral Education*, Vol. 31 No. 2, pp. 101-119.

BMJ (2001), "Bullying in medicine", *British Medical Journal*, Vol. 323 No. 7324, p. 1314.

BMJ (2009), "What do you do if your bosses are bullies?", *British Medical Journal*, Vol. 338, p. 177.

Bowles & Associates (2012), *Investigation in to Management Culture in NHS Lothian*, Bowles & Associates, Gretna, LA.

Brennan, W. (1999), "I'm talking to you!", *Emergency Nurse*, Vol. 7 No. 2, pp. 16-20.

Brief, A.P., Buttram, R.T. and Dukerich, J.M. (2001), "Collective corruption in the corporate world: toward a process model", in Turner, M.E. (Ed.), *Groups at Work: Advances in Theory and Research*, Lawrence Erlbaum & Associates, Hillsdale, NJ, pp. 471-499.

Brodsky, C. (1976), *The Harassed Worker*, Lexington Books, Toronto.

Brown, A.D. (1997), "Narcissism, identity, and legitimacy", *Academy of Management Review*, Vol. 22 No. 3, pp. 643-686.

Brown, A.D. and Starkey, K. (2000), "Organizational identity and learning: a psychodynamic perspective", *Academy of Management Review*, Vol. 25 No. 1, pp. 102-120.

Burnes, B. and Pope, R. (2007), "Negative behaviours in the workplace: a study of two primary care trusts in the NHS", *The International Journal of Public Sector Management*, Vol. 20 No. 4, pp. 285-303.

Care Quality Commission (CQC) (2004), available at: www.cqc.org.uk/ (accessed July 6, 2011).

Chan, P. (2002), "Pull no punches with serial bullies", *Nursing Times*, Vol. 98 No. 32, p. 18.

Cheesman, M. (2004), "Bullying in the NHS", *Triple Helix*, Winter, pp. 8-9.

Clegg, S.R., Courpasson, D. and Philips, N.P. (2006), *Power and Organizations*, Sage, London.

Consult GEE (2006), *Tackling Bullying in the NHS: Is It on Your Agenda?*, NHS Employers, London.

Cooper, H.M. (1988), "Organizing knowledge syntheses: a taxonomy of literature reviews", *Knowledge in Society*, Vol. 1 No. 1, pp. 104-126.

CPHVA/MHNA (2003), *Bullying in the NHS*, Amicus, London.

Cusack, S. (2000), "Workplace bullying: icebergs in sight, soundings needed", *The Lancet*, Vol. 356, December 23/30, p. 2118.

DoH (2009), *Health and Well-being Review*, COI, London.

Douglas, M. (1986), *How Institutions Think*, Syracuse University Press, London.

Edwards, S.L. and O'Connell, C.F. (2007), "Exploring bullying: implications for nurse educators", *Nurse Education in Practice*, Vol. 7, pp. 26-35.

Fevre, R., Lewis, D., Robinson, A. and Jones, T. (2011), *Insight into Ill-treatment in the Workplace: Patterns, Causes and Solutions*, Cardiff School of Social Sciences, Cardiff.

Francis, R. (2010), *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust*, The Stationery Office, London.

Francis, R. (2013), *Report of the Mid Staffordshire NHS FoundationTrust Public Inquiry*, The Stationery Office, London.

Hadikin, R. and O'Driscoll, M. (2000), *The Bullying Culture*, Books for Midwives, Oxford.

Harlos, K.P. and Pinder, C.C. (1999), "Patterns of organizational injustice: a taxonomy of what employees regard as unjust", *Advances in Qualitative Research*, Vol. 2, pp. 97-125.

Hart, E. and Hazelgrove, J. (2001), "Understanding the organisational context for adverse events in the health services: the role of cultural censorship", *Quality in Health Care*, Vol. 10, pp. 257-262.

Hascup, V.A. (2003), "Organizational silence: the threat to nurse empowerment", *Journal of Nursing Administration*, Vol. 30 No. 11, p. 562.

Heffernan, M. (2011), *Wilful Blindness: Why We Ignore the Obvious at Our Peril*, Simon & Schuster, London.

Henriksen, K. and Dayton, E. (2006), "Organizational silence and hidden threats to patient safety", *Health Services Research*, pp. 1539-1554.

Hicks, B. (2000), "Time to stop bullying and intimidation", *Hospital Medicine*, Vol. 61 No. 6, pp. 428-431.

Hume, C., Randle, J. and Stevenson, K. (2006), "Student nurses exerience of workplace relationships", in Randle, J. (Ed.), *Workplace Bullying in the NHS*, Radcliffe, Abington, pp. 63-75.

Hutchinson, M., Vickers, M.H., Wilkes, L. and Jackson, D. (2009), "The worse you behave, the more you seem, to be rewarded: bullying in nursing as organizational corruption", *Employee Responsibilities and Rights Journal*, Vol. 21, pp. 213-229.

Johnson, S.L. (2009), "International perspectives on workplace bullying among nurses", *International Nursing Review*, Vol. 56, pp. 34-40.

Kennedy, I. (2001), "Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995", CM 5207(I), HMSO, London, July.

Kewell, B.J. (2006), "Language games and tragedy: The Bristol Royal Infirmary disaster revisited", *Health, Risk & Society*, Vol. 8 No. 4, pp. 359-377.

Leape, L.L., Shore, M.F., Dienstag, J.L., Mayer, R.J., Edgman-Levitan, S. and Meyer, G.S. (2012a), "A culture of respect, Part 1: the nature and causes of disrepectful behavior", *Academic Medicine*, Vol. 87 No. 7, pp. 1-8.

Leape, L.L., Shore, M.F., Dienstag, J.L., Mayer, R.J., Edgman-Levitan, S. and Meyer, G.S. (2012b), "A culture of respect, Part 2: creating a culture of respect", *Academic Medicine*, Vol. 87 No. 7, pp. 1-6.

Lewis, M. (2006a), "Organisational accounts of bullying: an interactive approach", in Randle, J. (Ed.), *Workplace Bullying in the NHS*, Radcliffe Publishing, Abingdon, pp. 25-45.

Lewis, M. (2006b), "Nurse bullying: organisational considerations in the maintenance and perpetration of health care bullying cultures", *Journal of Nursing Management*, Vol. 14, pp. 52-58.

Long, S. (2008), *The Perverse Organisation and its Deadly Sins*, Karnac Books, London.

Mackenzie Davey, K. and Liefhooghe, A.P. (2003), "Voice and power: a critical investigation of accounts of bullying in organizations", in Schorr, A., Campbell, W. and Schenk, M. (Eds), *Communication Research and Media Science in Europe*, DeGruyter, Berlin, pp. 441-457.

Maclean, T.L. (2001), "Thick as thieves: a social embeddedness model of rule breaking in organizations", *Business & Society*, Vol. 40 No. 2, pp. 167-196.

Moore, C. (2008), "Moral disengagement in processes of organizational corruption", *Journal of Business Ethics*, Vol. 80, pp. 129-139.

Morrison, E.W. and Milliken, F.J. (2000), "Organizational silence: a barrier to change and development in a pluralistic world", *Academy of Management Review*, Vol. 25 No. 4, pp. 706-725.

National NHS Staff Survey Coordination Centre (2012), available at: www.nhsstaffsurveys.com/cms/ (accessed July 30, 2012).

Oakley, P. (1998), "Harassment and bullying in the NHS", *Health Service Report*, Summer, pp. 15-19.

Opinion Research Services (2011), *1000 Lives Plus Quality & Safety Survey (Staff Survey): Summary Report*, Opinion Research Services, Wales.

Paice, E. and Smith, D. (2009), "Bullying of trainee doctors is a patient safety issue", *The Clinical Teacher*, Vol. 6, pp. 13-17.

Palmer, D. (2008), "Extending the process model of collective corruption", *Research in Organizational Behavior*, Vol. 28, pp. 107-135.

Paton, N. (2006), "Why is bullying still rife?", *Nursing Times*, Vol. 102 No. 48, pp. 20-21.

Perlow, I. and Williams, S. (2003), "Is silence killing your company?", *Harvard Business Review*, Vol. 81, pp. 52-58.

Pope, R. and Burnes, B. (2009), "Looking beyond bullying to assess the impact of negative behaviours on healthcare staff", *Nursing Times*, Vol. 105 No. 39, pp. 20-24.

Pope, R.A. (2012), "Organisational dysfunction in the NHS", Organisational Behaviour in Healthcare Conference, Dublin.

Quine, L. (1999), "Workplace bullying in an NHS community trust: staff questionnaire survey", *British Medical Journal*, Vol. 318, pp. 228-232.

Randle, J. (2003), "Bullying in the nursing profession", *Journal of Advanced Nursing*, Vol. 43 No. 4, pp. 395-401.

Randle, J. (2006), *Workplace Bullying in the NHS*, Radcliffe Publishing, Abingdon.

Randle, J., Stevenson, K. and Grayling, I. (2007), "Reducing workplace bullying in healthcare organisations", *Nursing Standard*, Vol. 21 No. 23, pp. 49-56.

Royal College of Nursing (2002), "Working well? Results from the RCN working well survey into the wellbeing and working lives of nurses", Royal College of Nursing, London.

Royal College of Nursing (2006), "At breaking point? A survey of the wellbeing and working lives of nurses in 2005", Royal College of Nursing, London.

Salin, D. (2003), "Bullying and organisational politics in competitive and rapidly changing work environments", *International Journal of Management and Decision Making*, Vol. 4 No. 1, pp. 35-46.

Santry, C. (2009a), *Health Service Journal*, April 1, available at: www.hsj.co.uk/news/workforce/bullying-permeating-patient-care-warns-healthcare-commission/2 (accessed April 28, 2009).

Santry, C. (2009b), *Health Service Journal*, April 23, available at: www.hsj.co.uk/5000577.article (accessed April 28, 2009).

Vaughan, D. (1999), "The dark side of organizations: mistake, misconduct, and disaster", *Annual Review of Sociology*, Vol. 25 No. 1, pp. 271-305.

Walshe, K. and Shortall, S.M. (2004), "When things go wrong: how health care organizations deal with major failures", *Health Affairs*, Vol. 23 No. 3, pp. 103-111.

Weick, k.E. and Sutcliffe, K.M. (2003), "Hospitals as cultures of entrapment: a re-analysis of the Bristol Royal Infirmary", *California Management Review*, Vol. 45 No. 2, pp. 73-84.

White, J., Bandura, A. and Bero, L.A. (2009), "Moral disengagement in the corporate world", *Accountability in Research*, Vol. 16, pp. 41-74.

Zapf, D., Einarsen, S., Hoel, H. and Vartia, M. (2003), "Empirical findings on bullying in the workplace", in Einarsen, S., Hoel, H., Zapf, D. and Cooper, C.L. (Eds), *Bullying and Emotional Abuse in the Workplace*, Taylor & Francis, London, pp. 103-126.

Zerubavel, E. (2006), *The Elephant in the Room: Silence and Denial in Everyday Life*, Oxford University Press, Oxford.

Further reading

Bandura, A. (1986), *Social Foundations of Thought and Action: Social Cognitive Theory*, Prentice Hall, Englewoods Cliffs, NJ.

Business Service Organisations (n.d.), *Health & Social Care Staff Survey*, Business Service Organisations, Northern Ireland.

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