The inquiry into NHS governance and whistle-blowing announced by the Holyrood Health Committee is welcome, likewise the previous belated acknowledgement of problems by Paul Gray (CEO of NHS Scotland). These however are clearly enmeshed in a much broader NHS managerial and socio-political context.

Supporting staff in speaking out is vitally important for quality and safety of services, cost-effectiveness, staff morale, well-being, recruitment and retention - all major problems currently. Despite rhetoric and 'policies and procedures' it is clear from staff surveys the majority have no confidence in doing so. Those who dare suffer damage and 'consequences' - certainly if concerns threaten 'reputational damage' to Health Boards, management, or those responsible for the NHS. Meanwhile there is nowhere independent for staff to go. The current 'help-line' is recognised as risible, typically referring staff back to the very system they have raised concerns about and where they may be victimised for so doing.

These 'consequences', including the systemic and psychological aspects of whistle-blowing like scape-goating, mobbing, smearing, covering-up, are now widely appreciated (see e.g. the Private Eye 'Shoot The Messenger' supplement or the recent BBC 'File on 4' feature on whistle-blowing). But not it seems, in the NHS in Scotland.

Currently Health Boards are 'allowed' to operate essentially like medieval fiefdoms accountable only to themselves, and, mostly, to investigate and cover up their own mistakes or wrong-doing, often through internally-commissioned and managed 'inquiries'. When serious concerns are raised, civil servants, politicians and members of the judiciary routinely accept their 'reassurances'. Senior management or executives responsible for wrong-doing or 'wilful blindness' are never held accountable. This is simply not credible in the 21st century.

Meantime front-line staff work under a 'duty of candour', threats of sanctions (e.g. spurious referral to GMC or NMC), they are scrutinised, 'appraised' (a process whose effectiveness is questioned), and held accountable (even jailed). And despite 'boiler-plate' denials and reassurances from successive governments, costly service failures in the NHS, both financial and patient-related, are reported daily, much of it due to remediable mismanagement.

A so-called 'New Public Management' approach, whose effectiveness is widely questioned, now prevails with its recognised 'toxic managerialism'. This is a top-down, harshly-authoritarian ('sticks not carrots'), Soviet-style system (see Brian Jarman), without meaningful checks or balances, misleadingly obsessed with 'outputs' and 'targets', rather than quality of care. Health care, and staff, are increasingly treated as commodities in a quasi-commercialised model of care. This has resulted in various scandals e.g. around waiting lists in NHS Lothian. In a rare external review Bowles reported a culture of 'bullying, harassment and covering up' -
with no evidence of change since. However managers now (often under considerable pressure themselves) may have little clinical expertise, and commonly do not collaborate with front-line workers, far less listen to concerns.

This culture is partly a reaction to inadequacies of previously clinician-led services and has also apparently partial roots in Thatcherite anti-professionalism. This damaging management culture (for managers too) has also fitted easily into our broader historic authoritarian culture in Scotland. This is characterised by deference to an establishment that 'knows best', and which one should not complain about. It has also fitted easily, in our small country, into a widespread establishment 'interconnectedness' (i.e. cronyism) in managerial, political, legal, and even media circles. This results in many of the same, or interconnected, people ('old pals') doing interconnected jobs (including 'independent' inquiries and 'regulation'!). This is a whole socio-political issue in itself, but at the least needs to be acknowledged and should be addressed. This culture is well-recognised south of the border by clinical colleagues, to whom it is a serious disincentive to moving. But public deference to this culture does appear to be shifting and may well be an important factor ultimately in insisting on change in the culture of our public services.

Staff commitment, morale, care and compassion are fundamental to good, safe health care. These are qualities most staff bring initially, but they are now being crushed in a defensive, demoralised work force (including GPs) who are voting with their feet. As a psychiatrist working in NHS mental health services, my colleagues and I see and treat increasing numbers of staff. The atmosphere for most is frankly toxic. This is documented by the Paterson report, by reports from the BMA, unions and nursing organisations. But it appears successive political stewards of the NHS do not accept these, or refuse to listen ('wilful deafness').

It is imperative this parliamentary inquiry looks to the broader managerial and socio-political culture of the NHS, and is also not undermined by vested establishment and party political interests. Serious change will require a genuinely-independent, 'root and branch' review, with evidence from a multi-disciplinary group of experts, especially from outwith Scotland, (including management 'gurus', and experts such as Robert Francis QC, safety expert Margaret Heffernan, whistle-blower Dr Kim Holt), and including 'experts by experience'. Ultimately a genuinely-independent regulatory body with rigorous investigatory and disciplinary powers is needed, and a judicial culture of accountability for all. Such a body does not exist at present and current fatal accident inquiry (FAI) type procedures are simply not 'fit for purpose' with regard to wrongdoing or incompetence at any level of the NHS. The role of any regulatory body should include support, protection and justice for those being victimised for attempting to speak out in the face of wrong-doing. Within the NHS itself, it is clear that training initiatives for all around the systemic and psychological aspects of whistle blowing
are urgently required, analogous to those now routinely delivered around ‘equality and diversity’.

With real cross-party commitment our NHS could be transformed into a more cost-effective, genuinely ‘person-centred’ service characterised by genuine - not simply rhetorical, - participatory democratic processes. An NHS ‘of the people, by the people, for the people’ - certainly not what it appears at present, and to its considerable detriment.

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