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Review Article

After the ball is over: Reflections on Whistle blowing

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Abstract: The increasing emphasis on best-practice has meant that health care professionals are keenly encouraged to ensure delivery of the highest quality service provision. Where professionals are witness to serious professional misconduct 'whistleblowing' in considered as the last resort towards eliciting action and change. However, research suggests that the outcome for the whistleblower and in some cases, the services themselves, rarely exceeds, impacts or indeed even equals the benefit of exposing the problem. Researchers in the area concur that there requires a review of policy and procedure in this area. In considering the experiences of whistleblowers within healthcare services, this paper aims to pose a number of questions for service managers and policy makers to consider, in order to review existing whistleblowing guidelines, with the hope of improving an already prohibitive procedure and ultimately representing true, best practice across all levels of health care services.

Keywords: Whistleblowing outcomes, Whistleblowing policy, increased transparency in whistleblowing.

INTRO

The increasing emphasis on best-practice has meant that all health care professionals are keenly encouraged to ensure delivery of the highest quality service provision possible. Relatedly, there are clear, local and national guidelines for managing any failures in meeting standards set and extensive measures are taken to support services to work towards improvement. Furthermore, where clinical practice transgresses into the more concerning arena of covert, systematic, active, professional misconduct (be that by an individual or group), staff are encouraged to take up more formal complaints proceedings. Where even these actions fail to elicit an adequate response, professionals are encouraged to 'blow the whistle' in order to bring more serious attention to the problem. It is in this latter context that the reality of upholding standards of best practice truly emerges. In contrast to previously accessible safeguarding of patients and staff, the whistle-blower finds themselves isolated, exposed, advised and/or forced to take up the challenge of exposing problems quite independently and fight the 'good-fight' single-handedly with little or no defence. The reason for the process being a shared but silenced awareness of the reality of the consequences of whistle-blowing.

MacDougal [1] makes the point that whistle-blowing *should not be encouraged (per se), rather it should be prevented* by creating a structure that allows such concerns to be picked up at a much earlier stage of impact. Ideally, this should be the case but the fact that whistle-blowing is encouraged at all suggests some level of acknowledgement that existing procedures are not robust enough to capture all concerns. In recent years the UK health services have seen a number of public enquiry reports [2-5] encouraging whistle-blowing as a way to normalise the reporting and exposing of poor professional practice and encourage a culture of 'change not blame' across health care organisations [6]. Acknowledging the necessary importance of whistle-blowing - unfortunately, the reality is that in healthcare services the outcome for the whistle-blower and in some cases, the services themselves, rarely exceeds, impacts or indeed even equals the benefit of exposing the problem [6-8]. The significance of best practice is seemingly not considered valuable enough to support those individuals who uphold it under extreme circumstances and the whistle-blower is more often that not, both publicly and privately shunned - an action seemingly supported by both strangers and 'friends'- perhaps fearing a very possible 'dismissal-by-association'.

In considering research on the experiences of whistle-blowers *within healthcare services only*, this paper poses a number of questions for service managers and policy makers to consider based on and within in the context of a limited number of examples within existing literature, with the hope of improving an already prohibitive procedure and ultimately representing true, best practice across *all levels* of health care services.

NB: Whilst borrowing from a small body of generic research around whistle-blowing across professions, the issues raised here focus on health care settings only. The remit of the paper does not include debates around definitions or experiences of whistle-blowers outside of this setting and as such only a brief picture of the wider context is presented in order to offer context to the resulting questions.

Definition and context of whistle-blowing

Existing definitions of whistle-blowing are widely debated and varied in focus. To consider challenges specific to a healthcare context (and so related considerations), we may use the definition offered by Gooderham [8] in his work around whistle-blowing in the NHS as: *"The unauthorised disclosure of information that an employee reasonably believes evidences the contravention of law, rule or regulation, code of practice, or professional statement or that involves mismanagement, corruption, abuse of authority, or danger to public or worker health and safety."*

Bolsin [9] additionally sets out the *contexts* of whistle-blowing in UK healthcare services to include:

- Reporting on the systemic failure of a trust to provide adequate nursing resources
- Requesting review of the clinical outcomes of a whole department - Reviewing poor clinical outcomes involving a single individual over a period
- Anticipating and reporting a single catastrophic event

Whilst all basic definitions may share aspects of the above, further definitions attempt to capture more specific influences on whistle-blowing, allowing for individual differences in issues such as; motivation, understanding of dissent, moral justification, impact of organisational complaints structures, professional knowledge, workplace culture and effectiveness of current legal protection [2, 8, 10-16]. In combination, we can already see the complexity surrounding what appears to be an apparently straight-forward process.

Current outcomes

Research and case studies suggest that the effort of whistle-blowing remains inversely disproportionate to a successful outcome. There is a general consensus that there are a number of problems inherent within and related to the whistle-blowing guidelines and procedures themselves. In that context whistle-blowing results in a Pyrrhic victory - with the whistle-blower themselves far worse off - personally, professionally and financially [2, 6, 11-12, 16-23]. Research suggests that the burden of proof upon the whistle-blower to support the complaint is only one of many 'burdens' they must carry.

Reatedly, Near and Miceli [23] in a context of business ethics, make the point that encouraging whistle-blowing itself is a problem since in order to highlight issues at this very public level, the whistle-blower should necessarily be aware of a number of (perhaps previously unknown) influential variables, organisational structures, legalities and professional activities and standards as well as be in readiness for the personal/ professional consequences for the whistle-blower themselves [2, 9, 18].

Similarly, in spite of awareness and accessibility to all relevant information, Ashton [2] states that the whistle-blower can not necessarily rely on legal protection, in spite of Public Interest Disclosure Act (PIDA, 16) due to the wider issues such as a lack of organisational self-reflection - with even institutions following the ‘party line’ and the cultural reality of the workplace reactions and response once whistle-blowing occurs.

Lewis & Vandekerckhove [24] point out, the gathering of this information itself creates an initial dilemma/ hurdle; Whilst allowing for a much more pragmatic as opposed to emotional approach to an unpredictable situation, the necessary information gathering and personal consequences may cause the individual to withdraw without even taking any practical steps.

In spite of the pre-existing pressure of gathering information on their complaint, the whistle-blower is suddenly expected to gather information on wider organisational and even legal issues that they may have, rightly, expected would be a burden shared by the organisation promoting whistle-blowing itself.

Patrick and Lewis and Vandekerckhove [17, 24] highlight the fact that organisations themselves can be guilty of not being open to hearing the complaints of whistle-blowers, explaining this in part by an atmosphere of in/direct reminders of potential unemployment and loss of professional causing the whistle-blower to reconsider.

So, whilst both Ashton and Near and Miceli [22] rightly advocate increased levels of transparency across the procedure and professional roles, it appears that in certain cases, organisations claiming to support whistle-blowing can themselves be an obstacle to progress in the form of these unspoken yet predicted reactions.

In addition to distress experienced as a direct experience of the process itself, other research highlights the personal impact on the individual lifestyle, finances as well as mental health.

An early Australian study by Lenanne [23] showed the extent of personal impact on whistle-blowers in healthcare settings, examining the response of organisations and the effects on individuals. The study looked at professionals across different occupations who had exposed problems from a few months to over 20 years before. Results showed that all 35 participants suffered directly as a result of whistle-blowing. For 29 individuals, victimisation started immediately after their first, internal, complaint with 8 dismissals, 10 demotions and 11 professionals resigning or early retirement because of ill health related to victimisation. Only 10 had a full time job post whistle-blowing. Long-term relationships broke up in 7 cases, and 60 of the 77 children of 30 subjects were adversely affected. More concerning even than these figures were that 15 were prescribed with long term treatment with drugs which they had not been prescribed before and 17 had considered suicide. Income was reduced by three quarters or more for 14 subjects with a total financial loss estimated at hundreds of thousands of Australian dollars. Whistle-blowers received little or no help from statutory authorities and only a modest amount from workmates. In spite of all of the suffering experienced, to defend good practice, in most cases the corruption and malpractice continued unchanged.

The effect of this experience on the individual cannot be isolated from the wider view then of daring to blow the whistle and the related view of the whistle-blower. As Raktas [7] concludes, the problems of whistle-blowing (which he described as *a self-defeating act* given the consequences) far outweighs any benefit with rare victories for the individual and /or organisations involved. He added that whistle-blowing served only a social purpose and whilst society may benefit the whistle-blower did not. He concluded that given the suffering of the whistle-blower the value created is questionable and not easily measured. As such the process merely resulted in an ethical/moral dichotomy for both society at large and relatedly, the policy makers. This suggests that the responsibility of whistle-blowing is considered to be down to the individual alone, with wider organisations and services considering themselves removed from the process itself.

Mannion *et al*. [6] in their research with whistle-blowers concluded that a 'bottom up' approach where clinicians themselves alert management to concerns is not the most effective approach and too passive to result in action. Their research showed that that whistle-blowers advised increased training for staff across organisations on how to respond to such complaints stating that organisations need to be more active in the way they assess performance management and data collection on clinical outcomes as a way of better understanding reasons for whistle-blowing. Mannion *et al*. [5] concluded that their recommendations were made with the hope these initiatives would inform policy in this area. These steps in and of themselves would certainly improve overall service delivery and satisfaction for both patients and professionals, though the evidence remains largely absent to date.

We see clearly then, the quandary facing any professionals intending to blow the whistle. In spite of studies and recommendations made to change the process and so outcome of whistle-blowing - there appears to be little change at the coalface. It appears that the response to whistle-blowers, rather than representing justice and positive action, tends to reinforce the very climate of fear that services seek to change suggesting the basic reasoning to be flawed and the effort for the whistle-blower not worth the outcome. Perhaps even more concerning than this is the resultant defeated tolerance towards various levels of accepted malpractice and at best a waning allegiance to the best practice guidelines.

Facilitating whistle-blowing- improving services

At a glance we see that healthcare research repeats the theme of a necessary review of the process at all levels, as being essential to facilitate a good outcome. Findings repeatedly point to a marked disconnectedness between individuals who blow the whistle, local organisations and policy makers throughout.

In order to explore and understand the afore-mentioned discrepancies, following are a number of questions, built upon existing recommendations from previous cases of whistle-blowing. The questions are for the consideration of service managers and policy makers within healthcare services and aim is to facilitate the whistle blowing process; increasing transparency and supporting a more open- door management policy with the hope of reducing the existing conflicting messages around whistle-blowing guidance and to remind us of the ultimate intention- improving patient services.

Considerations and questions

1. Is the term and its associations, a help or a hindrance? Might we consider a term that more constructively reflects the positive action and impact taken to uphold professional standards? Although raised in the Francis report (4) this initial consideration remains-seemingly still attached to a negative connotation. Without this fundamental change little further debate can take place
2. Are the current pitfalls in the process seen by staff as oversights or 'obstacles' and what is the impact of each on staff actioning concerns? What is the resultant impact on patient services if organisations themselves are seen to be colluding with the idea that the whistle-blower becomes the problem and the problem itself is dismissed?
3. Is there a role for whistle-blowing to be incorporated into health care training by collaborating with academic institutions to ensure a pre-empting focus on best practice?
4. Similarly, can the action of whistle-blowing be refined in part, by incorporating a focus on best practice as part of one's professional role/ performance management and review rather than through a more formalised complaints procedure? That is, might the whistle-blowing criteria be incorporated into best practice guidelines?
5. Whilst research highlights the barriers for whistle-blowers, what do we know about the barriers to action by senior managers? If the problem of inaction is, in part, explained by personal fears and confidence to manage issues raised, can these be acknowledged, validated and addressed for all staff more clearly, emphasising that the issue is an organisational not individual responsibility
6. Can the problem of job insecurity be actively dealt with alongside the investigation, so that the individuals involved are motivated to stay with the process?
7. Do investigative teams have the correct skill mix and relevant knowledge of specific professions they investigate? For example, in investigating specialist clinical health psychology services, does the team have an experienced health psychologist on board? Do the investigating bodies have clear information and are they personally familiar with the exact standards each profession should be maintaining and working towards?
8. How many of the policy makers are whistle-blowers (for purpose of experience)? If there is an absence - how is this justified given the context and common use of patient representatives in other contexts?

Whilst the above questions are perhaps often discussed and put forward by teams locally and nationally, the fact that there remains little recognisable change in regard to the whistle-blowing process is disheartening. Perhaps it is by raising the questions in the *same public space* that whistle-blowers must enter that those oft -repeated concerns may be voiced with confidence and without fear of retaliation across healthcare services, thereby also acknowledging that the problems of the whistle-blower are problems for us all.

CONCLUSION

Whilst health care policy encourages whistle-blowing, the evidence suggests the outcome is far from successful at both an individual and organisational level. Existing research repeatedly concludes that policy review is required if there is to be any progress in managing this problem. By reflecting on problems within the existing procedure and asking related questions, it is hoped that relevant and necessary changes may be made. What remains clear is that responses to whistle-blowing ought necessarily to reflect the value and benefits that health care services will receive - by the action of those individuals- towards improving service provision. Ultimately, that is the aim we can all agree upon.

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