COMMENTARY

Thoughts before whistling

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Abstract

Whistleblowing is a public alert by an insider of an organisation to a practice or concerning potential they observe in the organisation. This paper proposes that the risk, values at stake, timeliness and manner of complaint be considered before a whistle is blown. It also notes education and monitoring mechanisms.

Whistleblowing

'Whistleblowing' is a term that has a particular usage in professional vigilance and is increasingly being discussed in an institutional and social context. To 'blow on a whistle' has had a different meaning in the past. It has meant the whistle to stop work for a break (a smoko) or a sounding of an alarm, an alert to danger. Nowadays, whistleblowing is an alert as well. It is an alert to dangerous behaviour, or potential danger, by an organisation or a person. It is an alert to have the practice stopped, when other internal alerts have failed. It is an alert to the world outside the organisation, a public discussion of concern by an insider to the organisation, and is often associated with public servants speaking out against public agency or government practices. The alert is made in the public interest. One definition is:

> *The unauthorised disclosure of information that an employee reasonably believes evidences the contravention of any 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* (Vinten 1994, p 257).

Other definitions, post the development of whistleblowing legislation, are gaining in popularity. The Australian legislation, which is enacted at the State level, concentrates more on the public interest in investigating and protecting the whistleblower (as described in Fox 1993). There is now a trend, particularly in the United States, to assess the bone fides of the claims, and the motive for complaining. The fear is that false and unworthy claims may be made out of vindictiveness. There is little representative research on how often real concerns are voiced by whistleblowers in the spirit of the public interest, nor detailed research on the outcome of whistleblowing. The evidence is more by way of personal accounts of difficulties in speaking out, or the need for whistleblowing, or of institutional suppression of dissent (D'Isidori 1997; Martin 1997).

Importance of professional limits and professional vigilance

It is vital in all professional practice to be aware of proper professional conduct and of limits which should not be exceeded. Professionals should not only be skilled. They should also carry out their practices ethically. This is particularly the case in health care.

We need to be vigilant in respect of our own standard of care and behaviour and vigilant in respect of the standard of care offered by others and the behaviour of others around us. We have a responsibility to work ethically, and to think about the broader ethics of the organisation to which we lend our professional support. For instance, an ethic of medical and health professionals is expressed in the principle of non-maleficence, which is routinely discussed as fundamental: *At least do no harm*. If professionals were to intentionally cause harm, they would be regarded as unethical. If professionals work with organisations which justify harm in some way, and ask their members to participate in harm (or collude in it), the organisation demand does not make the practice ethical. A case study of this is found in systematic torture and the role of health professionals in stopping the torture of prisoners and witnesses in war time or apparent peace (Anon. 1995).

The codes of ethics which are available to us all have an element for one's own behaviour, and for that of others. There are reporting requirements (internal reporting requirements) so that disturbing practices can be investigated. Members have a responsibility to be alert to proper professional practice, and to form part of their profession's vigilance so that their own and others' practice is acceptable.

The codes of ethics are sometimes specific enough to be practical guides for individual decisions, as in the case of torture. To quote from the recently released Australian Medical Association's *Code of Ethics* (1996), a member professional must:

> *2.1 (c) Report to the appropriate body of peers any unethical, or unprofessional conduct by a colleague* (p 6).

And in respect of societal or organisation practice, the professional is advised:

> *3 (g) Regardless of society's attitudes, do not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman, or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or convicted* (p 8).

Torture is a fairly straightforward example, while difficult for those in an organisation which condones it. It is the more subtle harms, or potential harms, that are more commonly the focus of whistleblowing. And it is the more subtle harms that are often not directly addressed in codes. It is the general principles of the codes which must be reflected on, to decide whether behaviour is acceptable or not. The individual is strongly guided by professional codes to make their concerns known to relevant internal or professional authorities. That internal process could take some time. And it is when the internal alerts have failed that the individual has the difficult decision to make about whether the potential or actual harm is so important that the whistle has to be blown.

Recent whistles blown

A recent example of professional practice challenging the limits can be examined to consider what opportunities exist for alerts to be made internally and externally. The example is of two practitioners apparently using a public facility after hours to investigate and treat a clinical problem in a pet dog belonging to one of the practitioners (TNC9 1996). TCN9 reported on *A Current Affair* that ultrasound equipment was used and infected fluid was drained from the dog. The subsequent reaction, also documented in the program, involved government, the profession, the hospital and the community. The professional limits of caring have clearly been challenged. One could well argue that it is natural to care for one's own pet animals, and the practitioner understandably wanted to use his skills to help and care. However, the blurring of lines of proper care is why it is recommended that clinicians do not treat their own family. The harm may not be so much in the infection danger, as in the less tangible: the unavailability of the ultrasound facility for that period of time, and the shaken reputation of the medical profession in the public's eye.

At an individual level, the second practitioner had an opportunity to monitor and alert the first practitioner to more appropriate behaviour. At an individual level, a decision could have been made not to participate or collude in the behaviour. This, in a collective way, would change the behaviour. An individual could also try to educate and change their peers in an advisory way. Even after hours, there is a peer safety net of other professionals in the institution who may be able to discuss more acceptable means of seeking treatment for the dog. An ex-matron interviewed by the Channel 9 journalists reportedly said that she would have politely told them to take their animal elsewhere. It seems that persons inside the institution concerned blew a public whistle. Either they were not able to use internal alerts, or they felt that the alert processes were too threatening for them.

Generally, the trend nowadays is to enhance education and monitoring, and to promote peer discussion and reflection, so that potential or actual whistleblowers' concerns are acknowledged and harnessed to improve the organisation or professional behaviour. Internal ombudsmen are more common, available to investigate concerns impartially. This is consistent with the trend to encourage both negative and positive incident reporting in the health context (Williamson & Mackay 1991). Individual and institutional limits and foibles are recognised, and constructive change aimed for. These internal mechanisms are yet to be assessed in detail for their effective dealing with problematic conduct.

There has been a recent example of a health worker dilemma in the team, morgue setting. Groups of workers apparently colluded to act in their own interest, by:

> *ratting bodies of jewellery and other valuables, without police knowledge; and arranging with certain funeral services to refer relatives on, for a small personal benefit* (Ellicott 1996, p 5).

The whistle was blown to the New South Wales Independent Commission Against Corruption, which investigated. If teams were in fact involved, then it is an institutionalised behaviour. What we can learn from this is that the ethics of the institution lie with the workers. It is up to each worker to uphold the good repute of their profession and of their organisation. When the issue was made public, there was swift reaction. At all levels in the morgue, structuring and work practice safety nets were imposed, such as forced rotation to different teams after specified periods of time. With rotation comes new faces for observation of existing practices, and challenges both to the current ethics and the quality of work undertaken.

Irena Blonder (1996) has written an overview of whistleblowing. Blonder describes the New Zealand cervical cancer research by Professor Herbert Green as a case of whistleblowing. There is a difference of opinion about whether it was, in fact, whistleblowing. It has been described elsewhere as journalistic enterprise (Coney 1988). The medical profession stood behind Green for some time, for his judgment that pre-cancerous cervical cells could be 'watched' to see if they developed to cancer in women attending the National Women's Hospital in Auckland. At some point, the colposcopist became unsettled about the health risk to participants, despite the scientific value, and published an open finding in an American journal with a co-worker. Their intention was to promote discussion. Journalists pursued the matter. There was a subsequent inquiry (McNeill 1989). The reaction in New Zealand was to encourage more accessible and less judgmental or hierarchical avenues for internal complaint and greater accountability at all levels of organisations.

Concerns for whistleblowers

The conduct and character of whistleblowers routinely comes under scrutiny (Vinten 1994). People wonder why they are speaking out, and outside the normal procedures of the organisation or profession. While being named gives apparent credence to the complaint, it may deflect energy from investigation of the practice concerned. Many of the whistleblowers who responded to Lennane's survey (1993) (through Whistleblowers Australia) had lost their job, and had had social problems and illnesses. They reported extreme levels of stress. It is worth noting that all 'had started by making a complaint internally, through what they considered were the proper channels' (Lennane 1993, p 667).

Lennane makes the assertion that prevention of the problem at the workplace is preferable, to have educated managers is preferable. I would add, to have dynamic and educatable organisations and professions is ideal. The advice of Vinten (1994) is that while there is probably a lot of material for the budding whistleblower, it is better to be selective if one does not wish to be a full-time whistleblower. A person may only be in a position to blow the whistle once. Vinten has called this the bee-sting phenomenon – one sting and then die. My own added advice is that there are many more opportunities for an educator and adviser. There are continual opportunities to be involved in the gradual evolution of a profession, in influencing the dynamic norm of an organisation from within. A voice is heard all the better if it is well-reasoned, calm and selective.

The long-term outcome of a public alert could also be considered. As Vinten (1994, p 259) says:

> *Even assuming near saintliness, and a caste-iron psychological constitution to withstand the considerable pressures on self and family, there remains the question as to exactly what a successful outcome amounts to.*

A public body which has the power to make a difference to the practice can be useful. A public forum which does not have that power may not be as useful. Nor may the reaction by the public immediately change the problem. The whistleblower may feel as frustrated at inaction or slow reaction as they did when making an internal complaint. The resources involved in this process are also considerable and could be considered against any resource or care issue which is complained about.

A sociological analysis of whistleblowing situations points out the intense difficulty those in relatively less powerful positions have when they encounter a troubling dilemma. *The Nursing Standard* (a nursing journal) has had a series of articles recently about the nursing dilemma. The sheer institutional and professional strength (which is usually harnessed for the public good) can be resistance to any challenge. Deciding how and when to make that challenge is crucial to an effective outcome of an alert. There is ongoing debate about the encouragement of alerts in the public interest and the offering of some protection to the whistleblower. Individual States as well as the Commonwealth could legislate (Senate Select Committee on Public Interest Whistleblowing 1994). There are monitoring provisions to guard against backlash and victimisation in the legislation (Fox 1993).

Deciding to blow

I would suggest the following checklist of considerations which could be used to make the difficult decision of whether to 'whistle'. These could also be used as a checklist for internal complaint and explanation of an individual concern.

Checklist

- Likelihood of risk or harm which is faced
- Seriousness of harm
- Value at stake
- Timeliness
- Likely outcome with manner of complaint action

Deciding whether to blow the whistle could then depend on ethical significance as well as practical issues. Ethics are part of proper standards; skill and appropriate ethical application of skill are defined by peers, and can be checked in professional conduct guidelines and codes of ethics. The concern should be considered in its own context, as outlined in a recent article in the *Australian Health Review* (Berglund 1997). The key part of any assessment is reflection on standards and the context to which they are applied.

Hypothetically assessing likelihood and seriousness of risk is difficult, but it is part of our health practice and everyday life to assess likely outcome prior to action. We are therefore in a good position to assess the likely outcome of other people's actions, even though the assessment of likelihood of risk or harm, and seriousness of that risk or harm, is quite subjective.

Assessing a value which is apparently threatened requires some internal reflection and some external reflection on peer norms and ethics standards. It is an objective measure of how 'bad' the behaviour or structure is. Whether a good outcome could be achieved in an internal manner and how soon action or change is required could be practical elements of deciding whether to step outside the organisational and professional structure and blow the whistle. Deciding who to complain to or alert may depend on the seriousness and imminence of the risk. Some situations may be amenable to education, in others there may not be time, or the potential harm or ongoing harm may be so extreme that the observer of the practice may feel little choice but to breathe in and whistle hard.

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