Patient safety, ethics and whistleblowing: a nursing response to the events at the Campbelltown and Camden Hospitals

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IN NOVEMBER 2002, in what stands as one of the most significant whistleblowing cases in the history of the Australian health care system, four nurses went public with concerns they had about the management of clinical incidents and patient safety at two hospitals in Sydney, New South Wales. The handling of this case and its aftermath raises important moral questions concerning the nature of whistleblowing in health care domains and the possible implications for the patient safety and quality of care movement in Australia. This paper presents an overview of the case, the moral risks associated with whistleblowing, and some lessons learned.

The International Council of Nurses (2000) Code of Ethics stipulates that nurses have a stringent responsibility to "take appropriate action to safeguard individuals when their care is endangered by a co-worker or any other person". Other local and international nursing codes of ethics and standards of professional conduct likewise obligate nurses to take appropriate action to safeguard individuals when placed at risk by the incompetent, unethical or illegal acts of others — including the system. Despite these coded moral prescriptions for responsible and accountable professional conduct, taking appropriate action when others are placed at risk (including making reports to appropriate authorities) is never an easy task nor is it free of risk for nurses. As has been amply demonstrated in the literature, taking a moral stance to protect patient safety and quality of care can be extremely hazardous to nurses (Johnstone 1994, 2002, 2004; Ahern & McDonald 2002). In situations where nurses report their concerns to an appropriate authority but nothing is done to either investigate or validate their claims, nurses are faced with the ethical dilemma and 'choice' of whether to: *do nothing* ('put up and shut up'); *leave their current place of employment* (and possibly even the profession); or *take the matter further* ('blow the whistle') by reporting their concerns to an external authority that they perceive as having the power to do something about their concerns.

It is rare for nurses to 'blow the whistle' in the public domain. When they do, it is usually because they perceive that something is terribly wrong and, as a matter of conscience, they cannot just look on as morally passive bystanders. For those nurses who do take a stand, the costs to them personally and professionally are almost always devastating, with no guarantees that the situation on which they have taken a public stance will be improved. Nurses who blow the whistle often end up with their careers and lives in tatters (see case studies in Johnstone 1994 & 2004).

The Campbelltown and Camden Hospitals case (discussed below) is a rare event. Publicity surrounding the case has had dire consequences for many people, including the nurses who went public with their concerns. However, the case has also provided an unprecedented opportunity to examine the relationship (some might say, tension) between whistleblowing and clinical risk

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management, and the processes that might be used by nurses and others to promote patient safety and quality of care in highly politicised environments.

This article focuses on the broader issues raised by this case, addressing what constitutes whistleblowing, the conditions under which nurses might decide to blow the whistle, the moral risks of whistleblowing, and why whistleblowing ought to be considered only as a last resort. The ultimate conclusion of this paper is that, contrary to some of the pessimistic views expressed about this case, it has provided a valuable opportunity for lessons to be learned and underscores the pressing moral imperative for establishing what Liang (2001) describes as a "non-punitive, cooperative environment that focuses on systems, not individuals, to reduce errors". In order to advance this discussion, however, some background information on the case is warranted.

Background to the case

In November 2002, four nurses reported to the then Minister for Health (NSW) concerns they had about the management of clinical incidents and patient safety at two main health care facilities of the Macarthur Health Service (MHS), notably the Campbelltown and Camden Hospitals, located within the South Western Sydney Area Health Service (SWSAHS). The nurses' concerns were echoed later by three more nurses who also came forward with allegations about mismanagement and patient neglect at the hospitals. As a result of these nurses' reports, a formal complaint involving 68 individual incidents was referred by the Director-General of NSW Health to the State's Health Care Complaints Commission (HCCC) for further investigation. Thirteen months later, in December 2003, the HCCC released the long-awaited report on its investigation (Health Care Complaints Commission 2003; Walker 2004a).

Of the total number (68) of incidents referred to the HCCC, only 48 clinical incidents that occurred between June 1999 and February 2003 were formally investigated (Walker 2004a). Nonetheless, the HCCC findings supported substantively the allegations made by the nurses regarding "the variable standards of patient care and safety at both hospitals" (Holland 2004). The HCCC report was highly critical of the MHS and SWSAHS, describing their responses to the HCCC investigation as "defensive" and as "indicative of the organisation's culture and the lack of openness in dealing with reported concerns about the safe care and treatment of patients" (Health Care Complaints Commission 2003, p.ii). The HCCC was particularly critical of the MHS response to the nurses, stating that:

> They [management] did not hear the message from the nurse informants about the safe care and treatment of patients. They did not hear the message from the nurse informants at the time of its original sending, at its first airing in the public media, nor during the course of most of this investigation (Health Care Complaints Commission 2003, p. ii).

The release of the HCCC report was not without controversy. Of particular concern to its critics was that the report "did not go far enough" in that it failed to find any individuals accountable for the incidents investigated and had failed to refer any doctors or nurses to the relevant regulating authorities (eg, the NSW Medical Board and NSW Nurses Board) for further investigation and possible disciplinary action. In response to this perceived failure (and in the aftermath of what could be described as a very public 'baying for blood' in the media) the NSW government terminated the employment of the Health Care Complaints Commissioner and set up an independent Special Commission of Inquiry (Commission) into Campbelltown and Camden Hospitals (Walker 2004a,b,c,d,e,f). Under its terms of reference, the Commission (headed by Bret Walker SC) was to investigate further the matters at hand and, where indicated by the Commission's findings, to also make "referral of any matter to any other person or body for prosecution or disciplinary or other investigative action" (Lawlink NSW 2004).

During the course of the Commission's hearings, eight 'informant nurses' were interviewed, with one of these nurses being interviewed over a number of sessions. At the time of the release of the first Interim Report of the Special Commission, 25 hours of interviews had been conducted with the nurses, generating over 500 pages of transcripts (Walker 2004a, p. 20). In the Commission's Second Interim Report, recommendations were made that in 24 incidents, 15 doctors and at least 11 nurses should be investigated by the HCCC, and that seven doctors should have their performance assessed by the NSW Medical Board (Walker 2004b, p. 4). It is anticipated that some nurses will also be referred to the NSW Nurses Board to have their performance assessed.

What is whistleblowing?

Whistleblowing broadly involves "the intersection of two phenomena: *principled organisational dissent*, and *public interest disclosure*" (Keyes 1993, p.26). Whistleblowing may be defined as:

> The voluntary release of non-public information, as a moral protest, by a member or former member of an organization outside the normal channels of communication to an appropriate audience about illegal and/or immoral conduct in the organization or conduct in the organization that is opposed in some significant way to the public interest (Boatright 1993, p. 133).

Although there are no universally agreed criteria of what constitutes an act of whistleblowing, there is some acceptance in the literature that the following conditions must be met:

- an individual performs an (unauthorised) action or series of actions intended to make information public;
- the information is made a matter of public record;
- the information is about possible or actual, non-trivial wrongdoing in an organization;
- the individual who performs the action is a member or former member of the organization (Vinten 1994, pp. 256-7).

Some contend that whistleblowing reports are also usually made to a person in a position of authority (ie, with the power to stop the wrong), or to some other entity which, if not having the direct power to stop the wrong, nevertheless is perceived to have the capacity to exert pressure on those who do have the power to stop the wrong — for example, the media (Rosen 1999).

As has been discussed elsewhere (Johnstone 2004), a key reason people resort to whistleblowing is to cause other people to pay attention and take action immediately. Like the siren or fire alarm, the sound of the 'whistleblower' seeks to alert people immediately to the fact "that something is either happening or is about to happen [and] there is a need to pay attention" (Erlen 1999, p. 67).

Processes influencing whistleblowing by nurses

As suggested earlier, it is rare for nurses to 'blow the whistle' outside of their employer organisations. Furthermore, there is some evidence to suggest that nurses generally are reluctant reporters. For example, in a recent report of a Scottish study on whistleblowing by nurses, it was revealed that 60% of the nurses surveyed "felt unable to report poor patient care, with 42% of these nurses fearing retribution if they did" (Nursing Standard 2004). North American studies on peer reporting of co-worker wrongdoing likewise suggest that nurses are reluctant to report (Lawton & Parker 2002; King & Hermodson 2000; King 2001). When 'pushed' beyond reasonable limits, however, nurses will take a stand — including reporting their concerns to a higher authority outside of their employer organisation (Johnstone 2002, 2004). According to one North American study, the processes most likely to influence a nurse's decision to report wrongdoing and risks include:

- individual characteristics (such as personal and professional ethics);
- situational factors (such as a the intentions of the wrongdoer and the severity of the wrongdoing);
- organisational issues (such as compliance or non-compliance with policy and procedures) (King & Hermodson 2000; King 2001).

There is no question that upon encountering a situation in which the safety of patients is at risk nurses and others ought to take appropriate action to have the situation remedied. The question here is not *whether* action should be taken, but rather what *kind* of action should be taken, and whether whistleblowing is an effective means of remedying the status quo.

Whistleblowing as a last resort

Whistleblowing aimed at protecting innocent others may be strongly warranted on moral grounds. Nonetheless, there is much to suggest that whistleblowing should only ever be considered after all other avenues have been exhausted in an attempt to remedy the situation (Johnstone 2004). There are at least two reasons for this. First, whistleblowing is never without risks — either to the whistleblower or, ironically, to the very people that a whistleblowing act was supposedly motivated to protect. This is because once a report has been made public the whistleblower has no control over how it will be interpreted or used in the public domain. Second, even though it draws needed public attention to a serious concern, an act of whistleblowing may still not result in the situation being improved. In summary, whistleblowing is not without significant moral costs that must be weighed up against the possible moral benefits. Thus, even when going public is morally justified, there are no guarantees that it will achieve morally desirable outcomes.

The risks of whistleblowing

Whistleblowing can be an extremely traumatic (and costly) method of putting to right a wrong. As has been argued elsewhere:

> Rather than seeing a whistleblower's report as an opportunity to improve the system and protect those whose interests have been placed at risk by questionable practices, an organisation whose conditions have been exposed may take a defensive stance and seek, instead, to protect itself (Johnstone 2004, p. 355).

Whistleblowing, by its very nature, upsets the status quo and accordingly is commonly perceived as 'rocking the boat' (Erlen 1999). In Australia, it might be viewed in the more colloquial terms of 'dobbing in a mate'. Thus, even though a nurse might have done the right thing, whistleblowing can nevertheless result in him or her being portrayed as a disloyal troublemaker and stigmatised and shunned accordingly (Erlen 1999; Rosen 1999). Employers and co-workers may retaliate by trying to discredit whistleblowing nurses, intimidating them by overly scrutinising the standards of their practice, threatening to terminate or actually terminating their jobs, and taking legal action against them for defamation (Johnstone 2004).

In the MHS case, in an attempt to discredit the nurses, one notable television current affairs program claimed that it had evidence that the "public had been duped" on account of it "never being told the whole story" by the nurses and that it would now "blow the whistle on the whistle blowers" (Davis 2004). During the program, allegations were levelled at one of the nurses that, contrary to her claims, she had failed to raise any issues of concern with a relevant clinical care committee of which she had been a member for four years (Davis 2004). In support of his allegations, the reporter cited the minutes of the committee in question, which he claimed contained no record of the nurse raising any concerns. The nurse contested the reporter's claims, explaining that the "minutes are not a true reflection of what happened at those meetings". The reporter did not accept this explanation, however, and characterised the nurse as being an unreliable member of the committee (Davis 2004).

Whistleblowing nurses can suffer serious health problems as a result of their experience. In a small

but important study on the physical and emotional effects of whistleblowing McDonald (2002) found that, as a result of blowing the whistle on misconduct in the workplace, the majority of the nurses surveyed suffered from significant physical and emotional health problems (70% and 94%, respectively), including lethargy, sleep disturbances, headaches, backaches, weight loss or gain, increased substance use (eg, drugs and alcohol intake, smoking), gastrointestinal problems, cardiac symptoms, anger, anxiety, depression, disillusionment, fear, poor self-esteem, and a breakdown of personal relationships (including separation and divorce).

It is important to acknowledge that whistleblowing nurses might not be the only casualties of their reports. Others might also be devastated by a whistleblowing act, and in ways not envisaged or desired by the whistleblowers. For example, following the release of the HCCC report, the entire SWSAHS Board was dismissed, the incumbent Health Care Complaints Commissioner was terminated from her position, the former general manager of the MHS was terminated from a new appointment which she had not yet taken up, and 15 doctors and 11 nurses were referred for further investigation (Holland 2004; Walker 2004a, 2004b). As well, staff who continued to work at the health service have reported verbal and physical abuse after reports were made public. In one report it was claimed that staff had been "spat at" and "treated like lepers" and that their children had been "treated appallingly" at school because it was known that their "parents [were] nurses and doctors" (Collins, in Davis 2004, p.9; see also Cassidy & Vale 2003).

There were also media reports claiming that medical negligence cases had "jumped over the past six months amid allegations of wrongful deaths in top Sydney hospitals", with one Sydney law firm claiming a fivefold increase in reports from clients (Morello 2004). Figures presented to the Commission, however, were more circumspect. One respondent indicated that for the 12 month period ending June 2002 there were just 42 statements of claims before the Supreme Court, and for the year ending June 2003 there were 62 cases and that these figures, while demonstrating an increase in claims, were "hardly a watershed of cases" (Reid, in Walker 2004f, p. 229).

Arguably one of the most undesirable risks associated with whistleblowing is the impact that its publicity might have on the public's trust in the health service on which it is otherwise dependent for care and from which it might turn away, even in moments that are life threatening. This risk is exemplified by the comments of Peter Bentley, whose wife died after surgery at Campbelltown Hospital (a case not part of the enquiry). Speaking before the Commission (forum held 8 June, 2004), Bentley responded:

> I live in Campbelltown with my daughter and my grand-daughter. I'm 65. It is quite possible I could have a heart attack tomorrow or next week. My daughter will not take me to Campbelltown Hospital. It might cost me my life, but I told her, "Don't take me over there." My grand-daughter was asked once — a friend of hers fell over and broke her arm. "You are going to have to go to hospital." My grand-daughter, who had just turned 11, said, "Don't go to Campbelltown Hospital. They killed my nanny" (Bentley, in Walker 2004f, p.254).

Lessons learned

There is fear among some in the health care sector that the handling of this case has set the quality agenda back many years, with one commentary published in the *Medical Journal of Australia* warning: "Be very afraid. The precedent is set — blame is back on the agenda" (Frankum et al. 2004). Others, however, have been more measured in their responses, with one commentator reflecting that an important lesson learned is that "for our hospitals, there is more to quality than rhetoric" (Van Der Weyden 2004a, p. 101). In a later commentary, this same author pleaded:

> Our public hospitals are 19th-century institutions at sea in the 21st century, and they need reform ... We desperately need an

> open, blameless and depoliticised environment which allows individuals to speak frankly about individual or systemic shortfalls and failures, and clear pathways for these to be addressed (Van Der Weyden 2004b, p. 365).

In her 1993 Clinton (Presidential) Inauguration poem *The rock cries out to us today*, the Black American writer Maya Angelou reminds us:

> History, despite its wrecking pain,
> Cannot be unlived, and if faced with courage,
> Need not be lived again. (Angelou 1993)

We cannot 'unlive' the NSW case, but we can face it with courage. It is understandable that some might feel that the events surrounding the MHS case have undermined the very good work that has been done in recent years to improve patient safety and quality of care in Australia. However, there are also considerable grounds for asserting that the case has, in fact, underscored rather than undermined the imperatives of effective clinical governance and clinical risk management in health care. More specifically, as stated earlier, it has emphasised the critical need and moral imperative for a non-punitive, cooperative environment that focuses on systems, not individuals, to reduce errors, and for such an approach to be supported not only in the health care arena but, importantly, in the political and legal arenas as well (Liang 2001).

Conclusion

Australia is currently experiencing what is probably one of the biggest cultural changes ever in its health care system and in the public arena where it is situated. This change involves a profound shift from a culture of blame to a culture of lessons learned, and from individual accountability to system accountability. Arguably, there is an even bigger cultural change still to come, notably in the political and legal cultures whose *modus operandi* is one of 'naming, blaming and shaming' and of seeking retribution, rather than restoration for the wrongs that have been done. Once these cultures begin to change, then the patient safety movement will have a real chance of succeeding. While changing these cultures may be difficult, it is not impossible. As the African restorative justice approach (commonly referred to as the 'third way') taken by the Truth and Reconciliation Commission of South Africa has so poignantly demonstrated to the world, it is possible to find out the truth, heal breaches, redress imbalances, restore broken relationships, and rehabilitate both victims and perpetrators injured by an offence without resorting to a system of retributive justice (Tutu 1999). Arguably, the MHS case has provided a timely opportunity for us all to reflect on this lesson.

As for the nurses (and others) who are still left wondering what they should do and where they should go when finding themselves in environments where patient safety is at risk, the message is clear: despite the risks involved, they must take a stance, since unless they do, things will not change. The system and those responsible for its management must ensure that a culture of safety is actively promulgated in health care domains, and that staff who have concerns have somewhere safe to go to have their concerns heard and redressed in a constructive manner.

The opportunity to 'make a difference' has, perhaps, never been greater. By working collectively, collaboratively and conscientiously to change the cultures of the systems in which we are all so embedded, and to operationalise effective quality and risk management programs in our hospitals (see Wilson in this issue, page 20), hopefully conscientious health care staff will have real opportunities to contribute to improving quality and safety in health care domains without resorting to blowing the whistle.

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