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When Whistle-blowers Become the Story: The Problem of the ‘Third Victim’



Comment on “Cultures of Silence and Cultures of Voice: The Role of Whistleblowing in Healthcare Organisations”

Justin Waring*

Abstract

In the healthcare context, whistleblowing has come to the fore of political, professional and public attention in the wake of major service scandals and mounting evidence of the routine threats to safety that patients face in their care. This paper offers a commentary and wider contextualisation of Mannion and Davies, ‘Cultures of silence and cultures of voice: the role of whistleblowing in healthcare organisations.’ It argues that closer attention is needed to the way in which whistle-blowers can become the focus and victim of raising concerns and speaking up.

Keywords: Whistleblowing, Patient Safety, Speaking-up, Risk

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In recent years, whistleblowing and whistle-blowers have returned to prominence in political, media, and public discourse. This might be driven, in part, by the development of new technologies, especially digital communications technologies, that make it easier to identify and expose practices and behaviours that had previously been guarded or hidden. Where once print news transformed the relationship between the powerful and the public, today Twitter, Facebook, and WikiLeaks are offering new channels for casting light upon political and organisational standards. In parallel, we are seeing increased public expectation for transparency and openness in other areas of public life; that those who do things in our name or with our taxes should be more accountable for their behaviours. Societal interest in whistleblowing is exemplified by the recent experiences of Edward Snowden, the computer specialist and former Central Intelligence Agency (CIA) employee who leaked classified information from the U.S. National Security Agency (NSA). He showed how government agencies were working with various telecommunication companies and international governments to coordinate a mass surveillance system. This brought to light the possibility of state-sponsored infringements of civil liberties, which might have caused profound political scandal. What is also interesting about this and similar cases, however, is how the whistle-blower – Edward Snowden – became ‘the story’ as he fled from prosecution and sought refuge in different countries, rather than the issue of public surveillance.

In the healthcare context, whistleblowing has come to the fore of political, professional and public attention in the wake of major service scandals and mounting evidence of the routine threats to safety that patients face in their care. Over the last fifteen years, health policies have consistently called for a more open and transparent ‘safety culture’ in which staff can speak up about

their experiences of patient harm, thereby enabling learning and improvement.^{1,2} Given their role in precipitating the launch of several major public inquiries, whistle-blowers are increasingly described as positively contributing to service improvement through bringing to light the problems of healthcare quality and safety that too often remain hidden from public exposure. For example, the problems of paediatric cardiac surgery at Bristol Royal Infirmary were brought to light by anaesthetist Stephen Bolsin, which led to one of the largest public inquiries in UK history and major reforms in the governance of clinical quality and standards.³ Despite revealing the high mortality rates within this hospital and influencing clinical governance reforms within the United Kingdom and beyond, Bolsin put at risk his professional reputation and found it difficult to secure employment in the United Kingdom, leading him to relocate to Australia. This case further exemplifies the risks that whistle-blowers face in ‘speaking up’ especially the possibility that they will become ‘the story.’ In the patient safety field, the harmed patient is usually thought of as the (first) ‘victim,’ but there is growing recognition that clinicians directly involved in patient safety incidents can often become the ‘second victim’ as they experience emotional distress from the harm caused to patients and the sense of helplessness in dealing with wider system failings.⁴ Extending this line of thinking, those clinicians who speak up about patient safety events, risk becoming a further ‘third victim’ as they face public, professional or political reprisals and vilification, and potentially jeopardise their career or reputation.

Current interest in healthcare whistleblowing has been re-ignited following the publication of Robert Francis’ inquiries into the poor standards of care and patient mortality at Mid Staffordshire NHS Foundation Trust.⁵ A powerful finding of the inquiry was that healthcare professionals were too often

'doing the systems business' of meeting targets and complying with regulations, rather than providing compassionate and safe patient care. And where concerns were raised about substandard care these were too often disregarded or treated insensitively. Of its many recommendations was a call to encourage healthcare staff to raise concerns or 'blow the whistle' where concerns about patient safety were experienced. This recognised the need to create an environment that not only welcomed, but encouraged openness and transparency, and avoided focusing on or blaming the whistle-blower. Sir Robert Francis' subsequent report *Freedom to Speak up* published in 2015 further recognises the problems faced by whistle-blowers when raising concerns, including pressure from employers and co-workers, bullying, and personal suffering. The report identifies five areas where whistleblowing might be encouraged, including culture change, improvement handling of cases, measures to support good practices, particular measures for vulnerable groups, and extending legal protection. With regards to culture, for instance, this include creating a safety culture, a culture of raising concerns, a culture free from bullying, a culture of visible leadership, a culture of valuing staff, and a culture of reflexive practice.

To do this, the reports highlights the importance of visible leadership, the creation of reflective spaces and opportunities to raise concerns, the development of common policies and procedures, and legal-protection for those who come forward.² As healthcare organisations and leaders look to implement these recommendations, it is important that lessons from the past are learnt and that priority is not given to formal policies or reporting systems over and above the more informal aspects of visible leadership and the creation of reflective spaces. As the experience of Mid-Staffordshire show, an emphasis on regulatory or bureaucratic compliance – policies and procedures – can create a culture of compliance rather than compassion, and as such more attention might be given to the more informal aspects of culture change. It is also interesting to find that whistleblowing – defined as the disclosure by an individual to the public, or those in authority, of mismanagement, corruption, illegality, or some other form of wrong-doing in the marketplace – has been established in UK law through the Public Interest Disclosure Act since 1998, which protects whistle-blowers from victimisation or dismissal. This legislation has been in place throughout all of the major UK patient safety reforms, suggesting that legal protection might not be sufficient in encouraging clinicians to speak up and instead the problem might rest with how co-workers, managers, service leaders and the public respond to whistle-blowers.

Mannion and Davies' recent paper makes a timely and important contribution to the current debates on the role of and support for healthcare whistleblowing.⁶ Their article introduces the worrying statistics from the 2012 NHS staff survey that although 90% of staff know how to report any concerns, only 72% would feel safe to do so, and 55% felt confident their organisations would address them. They highlight the difficult position faced by whistle-blowers and the perception that they can be both heroes and villains. Echoing the new policy trajectory, they highlight the very real possibility for whistle-blowers to be victimised and bullied for raising concerns, and the need for strategies to create a safer environment for speaking up, especially to overcome the potential for 'organisational

deafness.' In other words, organisational leaders need to do more to listen and hear the concerns of their staff, without seeing such concerns as necessarily threatening the legitimacy or reputation of their organisation. Moreover, organisational leaders should refrain from making the whistle-blower the problem or the story, but rather should focus on the concerns they raise.

Mannion and Davies make the powerful argument that it is too simplistic to see whistleblowing as an individual choice, but rather it must be seen as a social interaction – a process of sense-making and story-telling – that is framed by the underlying dynamics of organisational and occupational power. When experiencing some form of risk or safety incident, clinicians will interact with co-workers and supervisors as they struggle to make sense of ambiguous circumstances, and work through their own emotional involvement, to determine the best course of remedial action or speaking up. This suggests that the decision to speak up is framed by the relationships, norms and customs of the clinical workplace. Moreover, and following the work of Mary Douglas,⁷ the social meanings of risk are co-constructed through these relationships and in light of shared norms and value systems, so that the decision to 'blow the whistle' is inherently more social and cultural, than it is individual. A further theme developed through their article is the idea that local power relationships inherently frame, not only whether someone will speak up, but more fundamentally how they will make sense of and give meaning to their risks or concerns. Through interacting with colleagues clinicians will give meaning to their experiences but the possibility exists that the views and interests of other, more influential actors, will override or reshape the narrative or story as original developed by the clinician. Mannion and Davies elaborate this point through highlighting how local power relationships are integral to speaking up, not simply from the overt threats of discipline or bullying, but more insidiously through the ability of some actors to assert one narrative over another.

My own work on the social construction of patient safety incidents shows, for example, how meaning is made (and remade) through interaction with both colleagues and formal incident reporting systems, and where the meanings of clinicians are re-fashioned to suit the needs of management systems.⁸ This theme is addressed in Jones and Kelly's recent work of whistleblowing, which reveals a common tension between clinical and managerial perspectives.⁹ Given the proclivity of managers to see those who speak out as trouble-makers, their study found clinicians often used informal and circumlocutory means of communication. Although not meeting the expectations of formal whistleblowing, these local practices help clinicians to maintain a commitment to their shared professional customs, but also to challenge co-workers behaviours where standards were concerning.

Reflecting upon these ideas, I am reminded of Goffman's¹⁰ dramaturgical approach to everyday interactions. In particular his notion of the front- and back-stages of everyday life, where the backstage, hidden from the audiences' view, provides a safe place to plan front-stage activities and discuss concerns that might threaten the legitimacy or integrity of the front-stage performance. Goffman talks of the backstage being home to 'secrets' that are rarely disclosed outside the backstage because of the potential to disrupt or undermine the performance. However, such secrets, and the interactions through which

they are addressed, both reflect and recreate the shared identity and sense of community of ‘the crew.’ In the healthcare context, for example, deeply embedded professional cultures around collegiality, the shared inevitability of error, and the complex sorrow of patient harm are integral to understanding how clinicians make sense of and respond to safety events.¹¹ This might suggest that the negative response to whistle-blowers can, in some cases, stem from them contravening the established collegial norms of the profession, not necessarily because of the potential to expose professional wrong-doing. This chimes with Ehrlich’s¹² discussion of ‘cultural censorship’ whereby a conspiracy of silence can prevail because of the established norms of not criticising colleagues, despite compelling evidence of their wrong-doing. I do not want to suggest that whistleblowing should not be encouraged or that a new approach is needed to support whistle-blowers, but the decision to speak up is located, as Mannion and Davies suggestion, with a more complex set of social relationships and norms.

This reveals an aspect of workplace culture that might not be so well-understood in current policy, or indeed reconciled with the ambition of creating culture change. On the one hand, these backstage cultures can be positive through providing a basis for sense-making, a ‘circumlocutory’ means of communication, an opportunity for rapid improvements, and reinforcing group solidarity.¹³ On the other hand, these backstage cultures have the potential to hoard and conceal knowledge about performance issues that might better be addressed through working in the front-stage or indeed with the audience. In the current climate of change, it seems that the former scenario is increasingly untenable, especially as it is increasingly argued that service improvements should be co-produced with patient and that patients should be involved in patient safety. Returning to Goffman’s metaphor, we might argue that the audience should have greater exposure to and influence upon the mechanics of the performance. However, exposing patients and the public to these backstage secrets requires further thought. It is not simply about tackling organisational deafness or ensuring whistle-blowers are protected, but it also involves helping the audience – patients and the public – to come to terms with the concerns being raised, to deal with their anger and outrage, and to find ways for them to participate in learning and safety improvement. Supporting whistleblowing is not only an organisational issue, but it is also a societal issue.

In conclusion, the problem might not be the shortage of whistle-blowers but rather how policy-makers, services leaders and public groups respond to those who speak up and share in the responsibility to bring about change. Nurturing a culture of openness or whistleblowing might not only be a matter of promoting legal protections, introducing more transparent communication, nor encouraging leaders to be more responsive. Rather we need to think about who controls the narrative or the story, and how all stakeholders both inside and outside the organisation respond to and seek to re-write stories that might be uncomfortable. Contemporary communication channels might make whistleblowing easier, but the reception of relevant audiences, often in the light of other news media and cultural beliefs, can still make the whistle-blower, rather than the underlying problems, the focus of the story. If we look to whistle-blowers in other fields, we see that all too

often they become the story, over and above the issues they raise. It also appears there is public appetite to focus on the whistle-blower, the snitch or the ‘super-grass’ because they have ‘insider’ knowledge, because they break the implicit rules, because they are persecuted or troubled – and in doing so they become the story. This can be seen with aforementioned case of Edward Snowden, but also with Mark Felt or ‘deep throat’ who became the focus of Woodward and Bernstein’s reporting of the Watergate scandal; Frank Serpico who became infamous for exposing corruption amongst the New York City Police Department (NYPD); and Jeffrey Wigand who became the story after exposing how cigarette companies enhanced the addictive properties of their products. These whistle-blowers have become just as famous as the stories they exposed, and also victims of the response of the wider audience. In healthcare we must avoid making those who speak up the story, because such infamy distracts from the real need for learning and makes the whistle-blower the third victim.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author’s contribution

JW is the single author of the manuscript.

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