Three Australian whistleblowing sagas: lessons for internal and external regulation

Thomas A Faunce and Stephen N C Bolsin

ABSTRACT

- The protracted and costly investigations into Camden and Campbelltown hospitals (New South Wales), The Canberra Hospital (Australian Capital Territory), and King Edward Memorial Hospital (Western Australia) recently uncovered significant problems with quality and safety at these institutions.
- Each investigation arose after whistleblowers alerted politicians directly, having failed to resolve the problems using existing intra-institutional structures.
- None of the substantiated problems had been uncovered or previously resolved by extensive accreditation or national safety and quality processes; in each instance, the problems were exacerbated by a poor institutional culture of self-regulation, error reporting or investigation.
- Even after substantiation of their allegations, the whistleblowers, who included staff specialists, administrators and nurses, received little respect and support from their institutions or professions.
- Increasing legislative protections indicate the role of whistleblowers must now be formally acknowledged and incorporated as a "last resort" component in clinical-governance structures.
- Portable digital technology, if adequately funded and institutionally supported, may help to transform the conscience-based activity of whistleblowing into a culture of self-reporting, linked to personal and professional development.

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The public inquiry into paediatric cardiac surgery at the Bristol Royal Infirmary is widely regarded as a watershed in the regulation of the medical profession, both in the United Kingdom and elsewhere.[1] Many thought its recommended improvements in clinical governance pathways alone had the capacity to permanently enhance transparency and accountability in healthcare quality and safety.[2] The Bristol Inquiry was provoked by a whistleblower, whose actions caused him to be shunned and vilified by many senior colleagues, to the brink of resignation.[3] Yet, the dominant regulatory paradigm continues to be that whistleblowers are unnecessary in a system with overarching accreditation and regulatory councils, credentialling agencies, adequate peer review, adverse-events and mortality reviews, regular and thorough audits, risk-management strategies, and national data-based sentinel-event reporting.[4] The authoritative assumptions appear to be that individuals motivated by conscience should somehow "retire" their concerns once they have formally involved the clinical-governance system, regardless of how inadequately it performs, that its structures operate best without them, and that it would be best for everyone if whistleblowers simply calmed down. Analysis of the following three healthcare sagas suggests this is not true.

Whistleblowing's uncertain role in Australia

The Australian Council on Healthcare Standards (ACHS) is an institutional accreditation body established in 1974. Ninety per cent of the country's healthcare organisations are current members.[5] In 1995, the Quality in Australian Health Care Study retrospectively established that adverse events were still involved in 16.6% of hospital admissions, at a cost of over $1 billion annually.[6] In January 2000, the Australian Council for Safety and Quality in Health Care (ACSQ) was established to lead national efforts to minimise the likelihood and consequences of clinical error.

Both the ACHS and the ACSQ currently emphasise quality-control systems that are predicated on routine professional disclosure of adverse or sentinel events to intra-institutional structures embedded in clinical-governance pathways. Yet, three recent Australian whistleblowing sagas suggest these systems discourage notifiers with the "ticker" to forcefully seek results.

In July 2002, the ACSQ released key findings from the inquiry into obstetrics and gynaecology services at the King Edward Memorial Hospital ("KEM" Inquiry), Perth, Western Australia.[7] The inquiry found that major deficiencies had been uncovered by "whistleblowers", rather than "being identified, addressed or prevented through rigorous and routine safety and quality monitoring systems".[7]

Late in 2003, the New South Wales Health Care Complaints Commission (HCCC) handed down the report of its inquiry into safety and quality of care at Campbelltown and Camden hospitals, NSW. The inquiry was prompted by nurses at these hospitals contacting politicians because of a perceived inadequate institutional response to their concerns about patient safety.[8] The HCCC inquiry uncovered significant deficiencies in the standard of care. The investigation of the hospitals is ongoing, with the next report due this month.

Similarly, the report of the inquiry into neurosurgical services at The Canberra Hospital ("TCH" Inquiry) by the Australian Capital Territory Health Complaints Commissioner, released in December 2003, depicted another situation where the actions of a whistleblower, at acknowledged personal cost, were required to initiate a major quality and safety investigation.[9] This inquiry is also

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Australian National University, Canberra, ACT.
Thomas A Faunce, BA LLB(Hons), BMed, PhD, Senior Lecturer, Medical School, and Lecturer, Faculty of Law.
Geelong Hospital, Geelong, VIC.
Stephen N C Bolsin, MHCA, FRCA, FANZCA, MRACMA, Director of Perioperative Care.
Reprints will not be available from the authors. Correspondence: Dr Thomas A Faunce, Faculty of Law, ANU, Acton, Canberra, ACT 0200.
Thomas.Faunce@anu.edu.au

continuing, with external reviewers from the ACSQ scheduled to report late in 2004.

These three whistleblower-initiated inquiries raise important questions for healthcare regulators.

- Why does whistleblowing continue to play this significant role, despite a generalised reluctance among the profession, as well as accreditation and quality and safety bodies, to encourage or support it?
- Is there a link between this marginalisation of whistleblowers and poor institutional cultures of open disclosure, reporting, investigation and improvement?

Campbelltown and Camden hospitals inquiry

The HCCC Inquiry into Campbelltown and Camden Hospitals in the Macarthur Health Service (MHS) was initiated when nurses at these hospitals (including Nola Fraser, Yvonne Quinn, Vanessa Bragg, Sheree Martin and Valerie Owen) complained and later met with the NSW Minister for Health on 5 November 2002, after their and other nurses' intra-institutional attempts to improve patient care and safety were frustrated. The nurses' complaints related to a time when both hospitals had been partially accredited by ACHS.[5] The report of the Inquiry noted that "the nurse informants have paid a high personal price for their decisions to come forward. Some are no longer working as nurses or are not working at all. Those still working at the MHS report vilification and isolation by some of their colleagues because of the criticism of the health service brought about by the investigation."[8]

The most significant findings of the HCCC Inquiry were:

- Variability in staff reporting adverse events because of inappropriate culture and behaviour of different professional groups.
- Lack of positive feedback from management to staff who reported issues of quality and safety.
- Delay and failure by management in reviewing reports and implementing remedial action.
- Repeated challenge to the credibility of the whistleblowing nurses, which was not conducive to a culture that promotes safety through open discussion of adverse events.
- Failure by management to monitor and evaluate the implementation and effectiveness of any remedial action recommended.
- Inadequate resourcing of key quality and safety systems and personnel.[8]

The first five findings closely resembled those of the Kennedy Inquiry into Bristol paediatric cardiac services.[1]

Furthermore, public dissatisfaction with the results of the HCCC Inquiry led to the Minister establishing a Special Commission of Inquiry under the *Special Commissions of Inquiry Act* 1983 (NSW). The first report of this Inquiry, on 30 March 2004, found that the NSW HCCC improperly examined the 70 complaints made to them on this issue.[10] It also found that the HCCC failed to hold staff whose conduct was inadequate sufficiently accountable. A major lesson from the institutional response to the nurses' concerns may be that the expensive, ad-hoc, "catch-up" response involved in such inquiries does little to change institutional cultures and increase respect for the professional virtues that promote open disclosure. The HCCC Inquiry and subsequent related investigations came too late to transparently and efficiently balance public safety against the protection of organisational and professional reputation.[11]

King Edward Memorial Hospital inquiry

Throughout the 1990s, medical and nursing staff at King Edward Memorial (KEM) Hospital, in Western Australia, repeatedly and without result raised concerns with management about high error rates and a culture among consultants that minimised accountability and supervision of junior staff. During this period, the hospital regularly received ACHS accreditation focused on the nominal existence of structures and processes.[12] In 1999, a newly appointed Chief Executive Officer (CEO), Michael Moodie, wrote to the Metropolitan Health Service Board providing evidence of major quality and safety deficiencies. In doing so, as the investigation expressly recognised, the CEO was joining the ranks of whistleblowers. The deficiencies he highlighted included:

- Substandard patient care.
- Problems identifying and rectifying clinical issues by senior management.
- Inadequate systems to monitor and report adverse clinical incidents.
- Absence of a proper and transparent system to deal with patient complaints and claims.
- Lack of an overall clinical quality management system.
- Shortage of qualified clinical specialists, particularly after hours.
- Inadequate supervision of junior medical staff.[7]

The first three of these problems closely resembled inadequacies uncovered by the Bristol inquiry.[1]

The Health Service Board commissioned an investigation by an independent senior clinician, which was followed by a further 2-week review.[13] The CEO attempted to implement the resulting recommendations, but many senior clinicians questioned his own competence and refused to cooperate. One sought unsuccessfully to obtain a permanent injunction against release of the report.[7] The CEO was forced to resign.

The Minister for Health, in consultation with the WA Premier, finally established a formal KEM Inquiry lasting 2 years and costing $7 million. Its recommendations on quality and safety emphasised:

- The need for strong, sustained leadership supporting a culture of open disclosure, transparency and effective response to the performance problem.
- A rigorous third-party accreditation system that assured acceptable practice and performance standards.
- Practical and useful data collection systems for interhospital comparisons.
- Standardised credentialling systems that ensure clinicians have appropriate skills and training.
- Reliable and consistent incident and adverse-event reporting systems and follow-up processes.
- Clear and tenable statutory requirements and systems for mortality reporting and investigation.[7]

Active steps have been taken to implement these recommendations.[14]

The Canberra Hospital inquiry

In December 2000, a rehabilitation physician at The Canberra Hospital (TCH), Gerard McLaren, frustrated by his protracted unsuccessful efforts to address patient safety concerns, convinced the ACT Minister for Health to order the ACT Health Complaints Commissioner to conduct an inquiry into neurosurgical services at

Comparison of whistleblowing "sagas" at The Canberra Hospital, King Edward Memorial Hospital, and Camden and Campbelltown ("Cam") hospitals

Characteristics shared by all three:

- Problem not detected by sentinel-event reporting.
- Senior clinicians viewed clinical governance structures as adequate at time of complaint.
- Whistleblower(s) discouraged and criticised by the institution.
- Direct approach to politicians needed.
- Poor institutional culture proven.
- More than one inquiry held.

Characteristics shared by two:

- Attempt to suppress report (The Canberra Hospital and King Edward Memorial Hospital).
- Whistleblower(s) complaint(s) conclusively proven ("Cam" hospitals and King Edward Memorial Hospital); at The Canberra Hospital, the first inquiry was "critical of standard of care"; findings of second inquiry are pending.

Professions of whistleblower(s) differed:

- Staff specialist (The Canberra Hospital)
- Nurses ("Cam" hospitals)
- Administrator (King Edward Memorial Hospital).

the hospital. The Commissioner's report was completed 2 years later. Although critical of the standard of care, it acknowledged that the inquiry was so hampered by clinicians' reluctance to provide evidence as to render impractical a finding on the issue.[15] The report was not made public.

However, early in October 2003, the Commissioner summarised the major findings of the TCH Inquiry in his annual report.[15] He mentioned the extent to which a poor institutional environment of self-regulation had hindered his efforts. He noted in particular:

- The staff specialist complainant had acted appropriately in raising these issues, but found himself in an "uncomfortable and vulnerable" position.
- Some surgeons claimed not to be able to comment on another surgeon's patients, thus compromising peer review.
- Some health professionals failed to meet their statutory obligations to assist the Commissioner's investigation, thus further compromising peer review.
- The information made available to the Commissioner was insufficient to allow him to form a final view about the standard-of-practice issues.
- Further investigation would have been necessary if the changes had not occurred to make a definitive finding.[15]

The first two deficiencies were similar to those uncovered by the Bristol inquiry.[1] The "changes" referred to involved the voluntary agreement of a neurosurgeon to cease operating at the hospital. The hospital had been accredited by ACHS during this period.[5]

The staff-specialist whistleblower was chastised by colleagues and threatened with defamation proceedings when he attempted to present anonymised cases from the suppressed report in a hospital grand rounds (personal observation of the authors, who were present). Continuing community and academic pressure saw the Health Minister, on 9 December 2003, finally table the Inquiry's report in the ACT Legislative Assembly. Its findings raised sufficient concern to justify a further, external investigation, involving reconsideration of all cases initially examined, as well as review of all cases managed by a particular neurosurgeon over a selected 6-month period. It also prompted the establishment of a "hotline" for concerned patients, which received about 200 responses.[9]

Discussion

Each of these inquiries validated whistleblowers' claims of suboptimal clinical practice sufficient to cause significant patient harm or unnecessary deaths. However, these inquiries were *ad hoc* and failed to conform to many basic standards of qualitative methodology.[16] All arose after establishment of, but not as a result of, attempts by the ACHS to assist public safety through accreditation, and by the ACSQ to improve sentinel incident-reporting and clinical-governance systems.

Each Australian state now has legislation legitimising the persistence of whistleblowers by offering them protection[17] (although institutional reprisals can often be carefully disguised as challenges to competence). Many states are now also considering legislation obliging practitioners to report impaired colleagues.[18] Despite this, whistleblowers continue to suffer from the myth of being vindictive "informers" whenever they challenge the prevailing institutional and regulatory culture of secrecy and self-protectionism. Whistleblowing involving reasonable and not vexatious complaints, made in good faith and in the public interest, is firmly supported by law.[17] It is illogical and counterproductive for it to be excluded from clinical governance pathways and structures for adverse-event reporting.

It is unlikely that optimal clinical governance structures, including limited screening for adverse occurrences, would have detected and remedied the deficiencies in the cases discussed.[19] Limited screening involves screening hospital records that have a high probability of containing an adverse event.[20] The gap in consistently changing performance would remain.

Creating clinical-governance structures, such as committees for privileged review of mortality and adverse events, is manifestly important to healthcare quality and safety. However, these inquiries show that the function of these structures may be distorted by negative institutional and political cultures. In the UK National Health Service, half the healthcare professionals who had detected a colleague's error or incompetence remained inhibited about reporting it.[21] Common explanations were that they "feared retribution", "didn't want to cause trouble", "wouldn't have been listened to" and that "no one would support me".[21] An important lesson from these three Australian whistleblowing sagas may be that many of the current practices of Australian accreditation organisations, as well as quality and safety organisations, appear to deflect whistleblowers' criticism of the system and those in charge of it. Overemphasis on these practices may be actively suppressing the positive institutional culture of open disclosure that the organisations themselves report as crucial.

The task of transforming whistleblowing in modern healthcare systems into a national standards framework of self-reporting, open disclosure and continuous revalidation has become the responsibility of practitioners willing to systematically monitor and improve their own professional behaviour and the behaviour of those they supervise. Resident and registrar trainees can be rapidly trained (in under 6 weeks) to report 98% of critical incidents occurring in their practice (95% CI, 96.9%–100%), using performance indicators programmed into portable digital

technology.[22] Furthermore, 50% of the incidents so reported result in minor or no adverse outcomes for the patient and probably represent the "near miss" incident data that have been the "holy grail" of safety experts in healthcare for over a decade (unpublished data, available on request from SNB). This type of highly successful self-reporting (or personal whistleblowing) should, but currently does not, receive funding and support from the major Australian quality and safety organisations.[23] It could apply to all health professionals and students.[24] Constant peer and self-review are likely to be more efficient means of remedying impaired staff performance than delayed, retrospective evaluations from sentinel reporting and medical-record review.[25] The need is urgent. The time for change in the Australian healthcare quality and safety agenda is now.

Competing interests

None identified.

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