

Looking Back — A Personal Analysis of Whistleblowing

John Wright
Sydney, December 2005

Whistleblowing on health

In July 2005, a Sydney newspaper reported that one in every three anaesthetists reports a significant mishap every year. Of those matters, one in every five required legal action and /or financial settlement. That is three times as often as other doctors make reports.

In 1983 and 1986, senior surgical staff advised the top administration of a major Sydney hospital that death or serious complications during or after operation necessitated an urgent review of services. The reporter was threatened with dismissal.

In 1986, at the same hospital, two senior doctors had described themselves as having particular expertise in a certain specialty. Both had misrepresented their experience. Both had assumed exclusive responsibility for managing critically ill patients far beyond their capability. No action was taken by the hospital.

In 1990, a media report described the same hospital as having the “least efficient” patient turnover in NSW.

In 1995, the NSW Health Department received an evaluation of anaesthetic services at the same hospital in one surgical specialty area. Four anaesthetists were found to be two or three times more likely to have a serious complication than their peers elsewhere. No action was taken.

At the same hospital, surgeons and anaesthetists were questioned anonymously about their level of satisfaction with conditions in their operating rooms. More than 90% of them reported conditions as “bad or very bad“ over a long period. Three reported their experience as “terrible” and two as “tolerable”.

The victimisation of whistleblowers, therefore, also results in disadvantages to the community that relies on the performance of its services. Therein lies a major significance of whistleblowing. That is the justification for whistleblowing. Its acceptance should act as a legitimate source of essential management control.

Regardless of whistleblowing being a nuisance to bureaucracies, it remains the only reliable means of continuous monitoring of faulty or corrupt managerial procedures. The current state of health delivery in Australia reflects that the importance of whistleblowing has rarely been recognised and its lessons have usually been ignored.

A Profile of Whistleblowing

A definition

A whistleblower is a person who steps outside conventional techniques of warning in

order to expose what they consider a serious problem in an organisation. Usually, management has ignored accepted formulae for correction of problems. Complaints may be directed either within or outside the organisation.

Effects of whistleblowing

Management resents whistleblowing because it implies a criticism that is seen as a nuisance at best, or, at worst, a threat of exposure of fraud or incompetence. It destabilises routine administrative patterns. It threatens harmony and makes for untidiness and confusion in management.

It demands various levels of response, most if not all compounded of deception and threatened destruction of the offender's credibility, integrity, reliability and "soundness". Complaints are responded to by stereotyped, self-protective algorithms ranging from ignoring them up to dismissal or even psychological harm to the culprit.

Within that spectrum of responses are included ridicule, exaggerated placation, formal disciplining, threats to job security, instigation of rumours of misconduct and suggestions of psychological disorder.

Dissembling, counter-claims, false witness, misrepresentation of credentials, manipulation of evidence and destruction or suppression of records are customary responses. The objective is to isolate the threat, trivialise criticisms, exaggerate corporate concern and try to demonstrate a record of good governance at all cost.

Psychology of whistleblowers and whistleblowing

They are often described by one or more of the following adjectives: sensitive, loyal, naïve, unrealistic, unworldly, self righteous, incredulous, conscientious, obsessive or ambitious. They become increasingly fearful and affronted when their efforts are ignored or trivialised. Management labels them as conscience-stricken do-gooders ("shroud wavers" in common bureaucratic parlance). Some degree of psychological challenge follows their frustration at seeing wanton and deliberate ridicule of their complaints, exactly similar to the perceived derelictions of responsibility that led to those complaints.

Unfortunately, the vast majority of whistleblowers fail to accomplish what they hope for. Reliance on friends and colleagues is often unrewarded and trust in the integrity of people and institutions is diminished. Those who might have been supportive are often fearful of retaliation by management and may be coerced to testify against a whistleblowing colleague.

Associates are encouraged to be fatalistic team-players who can still express sympathy for the whistleblower's possibly irrational beliefs. They may be offered rewards for implying fault by counselling the offender: "you know you can't win"; "have a quiet life"; keep your pension safe"; "don't try to be a hero" etc.

Defences available to the threatened

Options range from passive acceptance up to legal contestation that is expensive, time consuming, unpredictable and useless if contract laws are involved with the employer's right to dismiss without existence of a reason. Never under-estimate an employer's fear, dishonesty, inertia, patience, deviousness, rigidity, resources, power, violence or hatred of being questioned.

The aim of all responses is to retain self-esteem and achieve “survival” — emotional, economic, intellectual, physical and personal. Survival requires self-reliance and the discovery of a personal power that, alone, may ensure a continuing sense of “viability”.

It is rare for a whistleblower to be restored to a comfortable form of past employment. Alternatives should be sought as a matter of urgency. Avoidance of a sense of “unemployability” is essential. Recourse might be directed towards assistance from unions, media, politicians, doctors’ certificates, family, friends and other aggrieved parties.

In combating the issue of failure in a pragmatic sense, it must be accepted that wide, urgent publicity offers the best hope of salvage of something worthwhile. Unfortunately, although the media have great power, their interest and value are transient, indiscriminate, often unprincipled, expedient and opportunistic. They can rarely help achieve significant restoration of position or prestige.

It is best to limit the seeking of sympathy, repetitiously discussing grievances or attempting to “get even” with the past employer. Corporations have infinite resources of finance and time, and experience no serious collective conscience. In each case of whistleblowing, there is usually a critical point beyond which full job recovery is impossible. Self-reconstruction must be set in train long before that moment arrives.

Adjustments necessary

The whistleblower should accept at the outset the likelihood of failing in primary expectations. Psychological insulation against a sense of failure is essential. A prior assessment of one’s position and area of influence may have to be sacrificed, even being prepared to lose face, influence and job.

Above all, the whistleblower should try to avoid the sense that a lost “position” equates with losing one’s personal value and “existence”. Compromise is the art of acceptance. New and different aims must be explored urgently. One has to be prepared to compromise somewhere, to feel, exercise and demonstrate independent thinking. To constructively immerse one’s self in a formal whistleblowers movement is often essential to understanding and a salvage of a sense of “wholeness”.

A Personal Case Report

In countering whistleblowing, there is usually a small nucleus of offended individuals who dominate the destructive drama. They enlist lesser figures to enhance and exaggerate the case against the offender.

It is instructive to examine briefly my experience when a major hospital suspended my services as departmental head of a major specialty immediately *after* I had rejected the offer of an alternative, “phoney” position (see Brian Martin’s website). Many features of the foregoing analysis are demonstrated in my understanding of the matter.

A hospital chairman, Dickinson, was the originally offended party, threatened by my implication of his Board’s managerial default. His initial response was to suggest my resignation but I rejected that step.

According to a departmental chief (Beveridge), Dickinson’s subsequent “hatred” for me was so great that Beveridge told me he would have to sacrifice me (his apparent friend and colleague for 20 years) if he were ever asked to take sides. Ultimately, he sacrificed me.

An anaesthetics director, Davidson, felt threatened when I questioned the quality of his service. Dickinson insisted that I withdraw my criticism or “pay the price”. I did not concur.

When I suggested the transfer of my surgical service to the Prince of Wales Hospital to get better support (a move Beveridge supported vigorously), Davidson advised both Dickinson and Beveridge that he would resist that move at any cost. Dickinson said that I would never succeed in such a move and I should forget it.

The fear and resentment induced in Dickinson, Davidson and Beveridge by my actions came to dominate the politics of my future. The remarkable degree to which their fear provoked resistance to me was revealed in the evolution of my history.

Soon after that exchange, a sudden, unexpected and total acquiescence to my wishes occurred, apparently based on a covert pact.

Beveridge invited me to head a new, senior post in his department (Beveridge later claimed that no such post had ever existed although the hospital had formally appointed me to it.); I would bring with me the surgical service that I had headed and controlled elsewhere for 20 years and which Beveridge coveted.

Davidson’s resistance would be concealed until such time as I had moved. My authority in the new post would be progressively eroded by Beveridge who, for 20 years, had falsely presented himself as an equal expert in my specialist field. (His confessed reason was commercial — he could develop a lucrative private practice in that false role. When asked, I advised him it was quite improper for him to persist with that pretence.)

The final component of my opponents’ strategy was the enlistment of criticism by other parties with direct, oblique or remote interest in my new enterprise. All were answerable only to Davidson or Beveridge.

None was an acknowledged specialist in the sphere of my work although such was

implied in their later criticisms of me. All were aware of Davidson's resistance to me but none revealed that until they testified against me. I knew nothing of Davidson's deal with the administration.

Crawford, of Davidson's anaesthetic department, was introduced to me by himself and others as having special training and substantial experience in areas pertaining to my new post. He was said to be the ideal colleague for me.

Later examination of Crawford's record showed no special knowledge of my specialty, as soon became apparent to me during my tenure in the new post. He had an unacceptable rate of failed vascular access procedures and of cardiac perforation from venous cannulation. He accepted but exhibited little understanding of conventional specialty techniques.

He later confessed, but only when challenged, that his primary anaesthetics interest and training had been in a different specialty altogether. Yet his violent criticism of me was accepted by the hospital without question.

The scenario leading to my destruction was ultimately exposed by my close colleagues, Beveridge and his surgical chief, Bowring, but only after my dismissal. Beveridge described his own behaviour to me as "Judas".

Bowring, whose office was adjacent to mine, was informed by Davidson of his inimical attitude to my new post but I was not advised.

Davidson had advised an executive officer of his attitude but the executive officer denied any knowledge of it.

The formal enquiry

An investigation showed the following stereotyped components of such enquiries:

- A junior assistant (Currie) stated that he was an unwillingly enlisted and uninformed critic. Another (Von Willer) regretted his involvement.
- Only two hospital medical officers were intrinsic to a statutory enquiry panel. One (Dwyer) did not attend in my presence, without given reason. The other (Murnaghan) attended without wanting to exercising his vote.
- Beveridge's involvement in the pact had included continuing gestures of support for me while concealing Davidson's resistance to my new appointment. He fabricated a post for me that he later said was non-existent. He pretended expertise he did not have and usurped my authority in patient management. Finally, he arranged the *coup de grace* by enlisting subservient critics from within his or Davidson's areas of control.
- While actively engaged in these deceptive roles, Beveridge twice accepted my financial support for travel with me to the Pacific Islands. He covertly diverted research funds from my department to his. He repeatedly invited me to install details of my financial affairs in his personal computer "for safe keeping".
- As an expression of ultimate obfuscation, when an *independent* expert advised the hospital of my competence but criticised hospital services, his report was concealed by the hospital until immediately *after* a decision was made to dismiss me.

- It took *five years* for the existence of the referee's report (favourable to me) to be acknowledged by a Minister for Health.
- *Four years* later, it could not be found in the Health Department.
- On request, I sent two registered copies but neither was traceable in the Department.
- The Minister then sent his personal driver to collect a copy from my home.
- *Three years* later, the Department could not find the report.
- Finally, it was discovered in a hospital where I had never worked.