NURSE WHISTLEBLOWERS IN AUSTRALIAN HOSPITALS: A CRITICAL CASE STUDY

by
Sonja Cleary
MHlthSc, GradCertTertEdn, BN, RN, DipApSc

Submitted in fulfilment of the requirements for the degree of
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Deakin University

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This research would not have been possible if the nurse whistleblowers had not spoken out and their actions setting in motion a series of events that culminated into Commissions of Inquiry.

ABSTRACT

Background

Between 2002 and 2005, two high-profile Australian cases of whistleblowing by nurses received widespread media attention: the Macarthur Health Service in New South Wales, and the Bundaberg Base Hospital in Queensland. The nurses in these cases 'blew the whistle' after their attempts to have patient safety concerns raised with appropriate personnel within their employer organisation failed. Despite the widespread attention that the above two cases attracted, whistleblowing by nurses is a rare event. Little is known about the contextual processes that might influence a nurse to engage in whistleblowing behaviour or the aftermath of engaging in such behaviour. In light of the lessons learned from Bundaberg Base Hospital and Macarthur Health Service cases and their implications in regard to the codified obligation that nurses have to 'take appropriate action' when patient safety and quality care are placed at risk, a critical investigation of the social phenomena of nurse whistleblowing is warranted.

Aims of the study

The key aims of this study are three-fold:

1. To provide a comprehensive account of the social phenomenon of nurse whistleblowing of substandard practice, unprofessional and unethical conduct in healthcare contexts.
2. To explain the contextual effects of power, information dissemination and ethics on the reporting behaviours of nurses.
3. To describe the ethical issues nurses face when witnessing substandard practice, unprofessional and unethical conduct in acute health services and their sequelae.

Research questions

The research questions which this study aims to address are:

- What is the nature of the social phenomenon of whistleblowing of substandard practice, unprofessional and unethical conduct in healthcare contexts?
- What are the contextual effects of power, information dissemination and ethics on the reporting behaviours of nurses?
- What ethical issues do nurses face when witnessing substandard practice, unprofessional and unethical conduct in acute health services?

Method/approach

The study was undertaken as a critical case study using Fay's Critical Social Theory as an interpretive frame and progressed as an unobtrusive research inquiry. Existing data generated by the respective Commissions of Inquiry held into Bundaberg Base Hospital in Queensland and Macarthur Health Service in New South Wales were accessed and analysed. Data were analysed using content and thematic analysis strategies commonly used in qualitative case study research.

Findings

The nurse whistleblowing in the cases studied occurred in response to a fundamental breakdown in clinical governance and incident reporting processes. When the nurses at Bundaberg Base Hospital and Macarthur Health Service first reported their concerns they wrongly assumed that 'something would be done' and that their concerns would be addressed. Instead, the respective organisational responses were retaliatory leading to a 'social crisis' in the organisations involved. Four structural bases contributed to this crisis: the need to assign blame, the exercise of wilful blindness on the part of hospital administrators, the presence of a

network of hierarchical gaze and discipline and, finally, the use of confidentiality as a mechanism to silence dissent and prevent external disclosures. A key driver motivating the nurses to take the action they did was the need to find internal psychological peace, which they believed would come from standing up for a personal non-negotiable principle: patient safety.

Conclusions

Failures in clinical governance can set the context for whistleblowing. When managers fail to give due attention to reports of possible and actual risks to patient safety, the ability to capture and learn from such reports and to take remedial action is undermined, leaving patients and the hospital vulnerable to preventable harm. In such circumstances nurses may reason that they have little choice but to raise their concerns to an authority external to their employer organisation. Whistleblowing need never occur if effective clinical governance processes are in place and contain provisions for ensuring that those responsible for receiving and acting on reports of patient safety concerns (including senior managers) take appropriate and timely action to address the concerns reported.

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LIST OF ABBREVIATIONS

ABC	Australian Broadcasting Corporation
ACEM	Australasian College for Emergency Medicine
ACSQHC	Australian Council for Safety and Quality in Health Care
ACT	Australian Capital Territory
ADNAS	Acting Director of Nursing and Acute Services
AHNM	After Hours Nurse Manager
AHPRA	Australian Health Practitioner Regulation Agency
ANMC	Australian Nursing and Midwifery Council
ASIC	Australian Securities and Investments Commission
ASPIC	Anaesthetic, Surgical, Pre-Admission and Intensive Care Forum
ATNA	Australasian Trained Nurses Association
BBC	British Broadcasting Corporation
BBH	Bundaberg Base Hospital
BHCI	Bundaberg Hospital Commission of Inquiry
BHSD	Bundaberg Health Service District
CCC	Critical Care Committee
CCRC	Critical Care Review Committee
CEO	Chief Executive Officer
CDA	Critical discourse analysis
CMO	Consultant Medical Officer
CNS	Clinical Nurse Specialist
CST	Critical Social Theory
CT	Computed tomography
CTA	Content Thematic Analysis
CV	Curriculum Vitae
DA	Documentary Analysis
DG	Director General
DoH	Department of Health
DoMS	Director of Medical Services
DoN	Director of Nursing
DM	District Manager
DQDSU	District Quality Division Support Unit
DRG	Diagnostic Related Groupings
EAS	Employee Assistance Scheme
ED	Emergency Department
EN	Enrolled Nurse
EASA	European Aviation Safety Agency

FHS	Fairfield Health Service
HCCC	Health Care Complaints Commission
ICAC	Independent Commission against Corruption
ICN	International Council of Nurses
ICU	Intensive Care Unit
LHS	Liverpool Health Service
MET	Medical Emergency Team
MHS	Macarthur Health Service
MP	Member of Parliament
NHS	National Health Service
NMBA	Nursing and Midwifery Board of Australia
NMC	Nursing and Midwifery Council
NSW	New South Wales
NT	Northern Territory
NUM	Nurse Unit Manager
OT	Operating Theatre
OED	Oxford English Dictionary
PCaW	Public Concern at Work
Pdf	portable document file
PI	Philosophical Inquiry
POB	Prosocial Organizational Behaviour
PM	Propaganda Model
QM	Quality Manager
QNU	Queensland Nurses Union
QPHCI	Queensland Public Hospitals Commission of Inquiry
RCN	Royal College of Nursing
RN	Registered Nurse
SA	South Australia
SCICCH	Special Commission of Inquiry into Campbelltown and Camden Hospitals
SMO	Senior Medical Officer
SWSAHS	South Western Sydney Area Health Services
TMB	Texas Medical Board
TNA	Texas Nurses Association
UK	United Kingdom
UN	United Nations
US	United States
USA	United States of America
VMO	Visiting Medical Officer
WA	Western Australia
WHO	World Health Organisation

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CHAPTER 1

INTRODUCTION

1.1 Introduction

This thesis provides a critical examination of the social phenomenon of nurse whistleblowing. This, the first chapter of this thesis, outlines the focus of the study, the research questions and key aims guiding the inquiry. A working definition of whistleblowing is given and clarification provided of other key terms used in the study. Finally, a synopsis of the chapters constituting this thesis is presented.

1.2 Focus of inquiry

The notion 'nurse whistleblower' has been defined in the nursing literature as a nurse who 'identifies an incompetent, unethical, or illegal situation in the workplace [then] reports it to someone who may have the power to stop the wrong'(McDonald & Ahern, 2002, p. 16). Reports in this instance are usually made to an authority outside a healthcare organisation in the hope that the perceived wrongdoing will be remedied by that authority. This action is normally taken as a last resort.

Nurse whistleblowing is a rare event. When it does occur however, its effects can reverberate through the health service, affecting not only the personal and professional wellbeing of the whistleblower but others within the organisation (Johnstone, 2004b; Peters *et al.*, 2011). It can also result in

unwanted public exposure of an organisation's failure to act, which in turn can result in attempts by management to discredit the whistleblower in an effort to protect the organisation's perceived 'best interests' (McDonald & Ahern, 2000).

Hospital care is delivered by regulated health professionals working within imperfect systems, constrained by heavy workloads, inadequate resources and increasing public expectations (Braithwaite & Travaglia, 2008; Mohr & Horton-Deutsch, 2001; Pugh, 2011; Runciman, Merry, & Walton, 2007). Due to these conditions the risk of failing to meet a standard of practice ensuring patient safety is always present. When things go wrong, frontline healthcare staff, including nurses are expected to capture the event in an incident reporting system, or raise concerns via verbal reports to their line manager (Wachter, 2012b).

Incident reporting forms part of an organisation's internal quality assurance process. The primary role of reporting is to 'enhance patient safety by learning from failures of the healthcare system'(World Health Organisation, 2005, p. 3). Reporting and the provision of feedback is a cornerstone for the establishment of trust and essential for the identification of gaps and weaknesses in the system (Shaw & Coles, 2001; WHO, 2005). However, the capacity for reporting systems to improve patient safety is reliant on those making reports being given a constructive response to the reports made. In the first instance, this requires feedback related to the analysis of the incident being

provided and, if required, recommendations being made for a change in the processes or systems that contributed to the event (WHO, 2005). When no action is taken, or when retaliation occurs in response to a report, a dilemmatic situation arises, in that the healthcare staff member is faced with the decision of whether to remain silent or escalate their concern to a higher authority within the organisation. This situation is compounded if, after escalation, there still remains no action. It is here that the healthcare staff must whether to take the matter further, that is outside the organisation.

1.3 Research questions

The infrequent nature of nurse whistleblowing has left, unanswered, questions, about the contextual effects of power, information dissemination and ethics on the reporting behaviours of nurses. In the last decade, two Australian cases of nurse whistleblowers, which resulted in the establishment of Commissions of Inquiry[1] have a provided a unique opportunity to redress these unanswered questions. To this end, this thesis has sought to address the following questions:

- What is the nature of the social phenomenon of whistleblowing of substandard practice, and/or unprofessional and unethical conduct in acute health services?

[1] A Commission of Inquiry is a non -permanent body (usually with members drawn outside the government) appointed by the executive government who are charged with investigating an issue or a number of issues identified. The Inquiry will have clear terms of reference and are funded by the government. A report with recommendations is submitted back to the executive government and is usually made public (unless there are security issues of concern)(Prasser, 2005).

- What are the contextual effects of power, information dissemination and ethics on the reporting behaviours of nurses?
- What ethical issues do nurses face when witnessing substandard practice, unprofessional and/or unethical conduct in acute health services?

1.4 Aims of the study

This research aims to provide a comprehensive account of the social phenomenon and surrounding social context of whistleblowing and reporting of adverse clinical events by nurses. This study will seek:

1. To provide a comprehensive account of the social phenomenon of nurse whistleblowing of substandard practice, unprofessional and unethical conduct in healthcare contexts.
2. To explain the contextual effects of power, information dissemination and ethics on the reporting behaviours of nurses.
3. To describe the ethical issues nurses face when witnessing substandard practice, unprofessional and unethical conduct in acute health services and their sequelae.

The cases chosen are the whistleblowing events that occurred at Bundaberg Base Hospital (BBH) and at MacArthur Health Service (MHS).[2] In each of these cases, nurses first raised concerns of substandard clinical practice

[2] Which included Campbelltown and Camden Hospitals

and unprofessional conduct (some leading to patient death) with appropriate authorities within their organisations. When their allegations were not acted on, the nurses 'blew the whistle', taking their concerns to elected representative members of parliament. This action led to The Bundaberg Hospital Commission of Inquiry (BHCI)[3] and the Special Commission of Inquiry into Campbelltown and Camden Hospitals (SCICCH).

1.5 Clarification of key terms

Conceptual confusion is problematic in research, particularly if concepts are applied inconsistently. A lack of clear definition affects the coherence and interpretation of findings (Collier, Hidalgo, & Maciuceanu, 2006). Terms such as whistleblowing, substandard practice, unprofessional conduct, professional misconduct and unethical conduct could all be considered what Gallie (1956) refers to as 'essentially contested concepts' (p.167).[4] Essentially contested concepts occur when there are multiple definitions in general use and a potential for dispute about their proper use. Since these terms are contested, a jurisprudential definition of whistleblowing, substandard practice, unprofessional conduct, professional misconduct and unethical conduct will be used to guide this study.

[3] Later to become the Queensland Public Hospitals Commission of Inquiry (QPHCI).
[4] The contested notion of the term whistleblowing is further examined in Chapter 2.

1.5.1 The whistleblowing definition used for this study

Although nurse whistleblowing has been defined in the nursing literature by McDonald and Ahern (2002) as:

> a nurse who identifies an incompetent, unethical, or illegal situation in the workplace and reports it to someone who may have the power to stop the wrong.
>
> (p. 16)

for the purposes of this inquiry, the following jurisprudential definition will be used:

> a deliberate non-obligatory act of disclosure, which gets onto public record and is made by a person who has or had privileged access to data or information of an organisation, about non-trivial illegality or other wrongdoing whether actual, suspected or anticipated which implicates and is under control of that organisation, to an external entity having potential to rectify the wrongdoing.
>
> (Jubb, 1999, p. 83)

This definition recognises the clear distinction between whistleblowing and internal authorised' reporting, such that whistleblowing requires the act of going outside the organisation (Jubb, 1999). Internal reporting, in contrast, is a 'normal' organisational process that is not recognised as involving breaches of confidentiality as such, at least not in the sense associated with reporting to an unauthorised external authority (Firtko & Jackson, 2005). This research distinguishes internal reporting from whistleblowing. Prior to reporting externally, the would-be whistleblower should have exhausted all the internal reporting structures in order to effect action that brings an end to the offending practice.

1.5.2 Substandard practice

Substandard practice is defined here as the actions of a health practitioner that fail to meet, or fall short of, the agreed standards of practice outlined by a peak professional body. In Australia, the *Health Practitioner Regulation National Law Act 2009* employs the term 'unsatisfactory professional performance' in the manner in which this thesis uses the term substandard practice. Unsatisfactory professional performance in the Act reflects:

> the knowledge, skills or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of the health practitioner of an equivalent level of training or experience.
>
> (AHPRA, 2010)

By this view substandard practice represents a lack in the practitioner's abilities rather than a deliberate attempt to subvert recommended and acceptable practice.

1.5.3 Unprofessional conduct

Within the context of healthcare, unprofessional conduct refers to action undertaken by a health professional that violates the transparent principles and standards outlined formally in the codes, guidelines and registration standards endorsed by their professional and registering authorities (AHPRA, 2010; Pugh, 2011; Staunton & Chiarella, 2013). The professional conduct of health practitioners is moderated and controlled by a range of external obligations and governance structures such as legislative and registration requirements, as well as by professional standards, codes of practice and guidelines developed by

peak professional organisations (Johnstone, in press; O'Rourke & Davidson, 2004). In keeping with these processes, professional conduct implies a clear obligation on the part of health professionals that they be responsible for the provision of quality care by monitoring their own standards of practice against these regulatory requirements, codes of practice and guidelines.

The Australian Health Practitioner Regulation Agency (AHPRA, 2010) includes each of the following as examples of unprofessional conduct by health practitioners:

- a breach the legal requirements set by the Health Practitioner Regulation National Law Act (the National Law);
- a breach of a 'registration condition or undertaking' set by the registration authority e.g., the Nursing and Midwifery Board of Australia;
- a 'conviction for an offence that may affect their suitability to continue practice';
- providing health services that are considered 'excessive, unnecessary or not reasonably required';
- influencing, or attempting 'to influence, the conduct of another registered health practitioner that may compromise patient care';
- accepting 'a benefit as inducement, consideration or reward, for referrals or recommendations to use a health service provider';
- offering or giving a patient 'a benefit, consideration or reward, in return for providing referrals or recommendations to use a health service provider'; or
- referring a patient to, or recommending 'another health service provider, health service or health product, if there is a financial interest, unless the interest is disclosed'.

(AHPRA, 2010; Staunton & Chiarella, 2013, p. 280)

In its broadest sense, then, unprofessional conduct is any *deliberate* action or behaviour that diverges from the agreed and accepted practices of the respective profession (Johnstone & Kanitsaki, 2001; Pugh, 2009).[5]

Prior to the introduction of the *Health Practitioner Regulation National Law Act 2009*, the nomenclature pertaining to unprofessional conduct and/or professional misconduct in Australia varied considerably between different health professions and across state and territory jurisdictions (Forrester & Griffiths, 2010; Kerridge, Lowe, & Stewart, 2013; Staunton & Chiarella, 2013). A comprehensive critique of the differences lies beyond the scope of this thesis. However, common to all nomenclature is the requirement that professional perform at a level that upholds *public protection and patient safety* (Staunton & Chiarella, 2013).

1.5.4 Professional misconduct

The *Health Practitioner Regulation National Law Act 2009* regards professional misconduct as a form of unprofessional conduct, but with additional characteristics. Specifically, professional misconduct is conduct considered 'substantially *below* the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience' [emphasis

[5] In the legal case of Versteegh v The Nurses Board of South Australia (1992) the Supreme Court of South Australia ruled against the appellant and supported the Nurses Board of South Australia's finding of unprofessional conduct on the grounds that the appellant's conduct breached the standards outlined in the Australasian Nurse Registering Authorities Conference (ANRAC) competencies and contravened the International Code of Nursing Ethics. Further, his Honour Judge Mullighan stated 'It may be accepted that those standards are well recognised and accepted in the nursing profession.'

added]. It also can be 'more than one instance of unprofessional conduct' or conduct 'that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession' (part 1, section 5).

1.5.5 Unethical conduct

Unethical conduct is defined as any act performed by a health professional that intentionally and deliberately violates the accepted, agreed and professionally endorsed ethical codes of conduct (1998, 2009, in press; Morreim, 1993). This definition derives from other terms used such as *moral turpitude* and *immoral conduct*. The notion of moral turpitude has its origins in United States case law, where it was used as grounds for the denial or revocation of professional licenses. In 1938, the United States Supreme Court considered grounds for the disbarment of Gavin W. Craig, an Attorney and Counsellor-at-Law, who had been charged with a felony. In this case, moral turpitude was defined as

> an act of baseness, vileness or depravity in the private and social duties which a man owes to his fellowmen, or to society in general, contrary to the accepted and customary rule of right and duty between man and man.
> (In re Craig, 12 Cal. 2d 93 - Cal: Supreme Court 1938)

United States law has also defined the offence of immoral conduct. In the case of *Searcy v. State Bar of Texas,* moral turpitude is defined as 'anything done knowingly contrary to justice, honesty, principle, or good morals'. While immoral conduct occurs when an action is deemed: 'wilful, flagrant, or shameless and which shows a moral indifference to the opinion of the good and respectable members of the community' (Tex: Court of Civil Appeals, 4th Dist.

1980). Freckelton (1996) and Johnstone (1998; 2009; in press) apply these two definitions of moral turpitude and immoral conduct to the conventional definition of unethical conduct with which this section opened.

Professional codes of ethics outline the standards that shape and guide health professionals' behaviours and represent normative applications of those beliefs and values that are morally acceptable to the profession (Butts, 2008). So, any determination as to whether or not an incident of unethical conduct has occurred, first, requires evidence that the practitioner in question had prior knowledge of the code of ethics, and, then, that the actions were a deliberate and knowing violation of that code (Johnstone, 2009, in press). For nursing in Australia, unethical conduct would arise from an intentional breach of the *International Council of Nurses code of ethics for nurses* (ICN, 2012), and/or the *Code of Ethics for Nurses in Australia* (Nursing and Midwifery Board of Australia (NMBA), 2008a).

It is important to note that a wilful breach of extant ethical codes can, at times, be seen not only to be proper and required, but paradoxically, may also be ethically justifiable. This is an acknowledgment of the impossibility of providing 'exact directives for moral reasoning and action in all situations' (Butts, 2008, p. 83), since no codified system of ethics is capable of providing (nor should it aim to provide) absolute judgements immune to change. Ethical decision-making requires that sound justifications be made when making value judgements (Fry & Johnstone, 2002; Johnstone, 2009). Moreover, there may be

occasions when a health professional's conduct will not reflect or align with the requirements set forth in their particular code of ethics. Thus conduct that contravenes that code may be justified by the presence of stronger moral considerations (Johnstone, 2009, in press). Therefore, a nurse, functioning under professional ethical requirements to keep all patient personal details confidential, may judge that threats to patient safety are of such gravity that there exists a stronger moral obligation to report them.

It is equally important to note here that even strict adherence to a code of ethics may not necessarily protect a health professional should they be called to justify their conduct in a court of law or at a disciplinary hearing (Johnstone, 1994, 2009). The changing face of the healthcare sector, the advent of multidisciplinary practice and ever growing uncertainty regarding scopes of practice in multidisciplinary teams, as well as the impost of economic realities, challenges the ability of nurses and other healthcare professionals to function and conduct themselves consistently according to the expectations of particular codes of ethics (Meulenbergs, Verpeet, Schotsmans, & Gastmans, 2004).

Although unethical conduct is not specifically referred to in the current *Health Practitioner Regulation National Law Act 2009*, the term is to be found in some repealed legislation. For example, in the *New South Wales Nurses and Midwives Act (1991)* and the *South Australia Nurses Act (1999)*, the notion of 'improper or unethical conduct' was originally listed as a constituent of 'unsatisfactory professional conduct' or 'unprofessional conduct', which goes

some way towards indicating the intricate semantic, ethical and legal web connecting these terms and concepts.

1.6 Synopsis of chapters

This thesis is presented in eight chapters, this, first chapter outlines the focus of the inquiry, the research questions and aims guiding the study. A clarification of key terms used in the study is also provided.

Chapter Two focuses on the background of the study beginning with the etymology and contested definitions of the term 'whistleblowing'. This is followed by an examination of both historical and contemporary cases of nurse whistleblowers. A review is then made of various influential developments that have had an impact on the safety and quality of patient care, beginning with the patient rights movement, the emergence of the field of bioethics and, finally, the development of professional codes of practice.

In Chapter Three a review of contemporary research literature provides insight into the factors that are perceived to contribute to the decisions associated with both internal reporting and whistleblowing as well as the perils associated with such actions. Drawing on this literature, contextual gaps in knowledge of the field are identified.

Chapter Four details and justifies the study's methodological approach. Critical Social Theory is examined and the reasons for selecting Fay's (1987) Critical Social Theory as an interpretive frame to guide the study are explained. Power and justice were considered to be important analytical frames to guide

the textual analysis of the documents sampled in the case studies. As such a critical examination is made of the various theoretical underpinnings of power and justice. Attention is then directed to outlining the case study research processes, such as sample selection, data collection and data analysis techniques, the processes used to ensure rigor, identifying the strengths and weaknesses of the study, and ethical considerations.

Chapter Five examines two important macro level contexts central to this inquiry: whistleblowing legislation, and clinical governance in healthcare organisations. It begins with a brief discussion of the international and national status of whistleblowing law, before examining the movement towards, and development of, legislative provisions designed to protect whistleblowers. A specific focus of this examination includes whistleblowing legislation in the jurisdictions of New South Wales (NSW) and Queensland, where the two case studies occurred. The focus then turns to clinical governance and pertinent contemporary patient safety literature, isolating the systemic and human factors that might contribute to a failure of clinical governance.

In Chapters and Six and Seven, the two cases of nurse whistleblowing in Australia: the Macarthur Health Service (MHS) in New South Wales (NSW) and the Bundaberg Base Hospital (BBH) in Queensland are presented. It is here that the voices of the nurses are heard via excerpts from their exhibits and transcripts of testimony at the respective commissions of inquiry. The cases reflect the cultural, political and organisational context and circumstances that

led to the nurses' decisions to blow the whistle on unsafe practice. Historical accounts of the development of the ensuing crises are presented.

In Chapter Eight the study's key findings framed by Fay's theories of *false consciousness*, *crisis*, *education* and *transformative action* are analysed and discussed. The chapter begins with an examination of the nurses' false consciousness that the organisational processes would support their attempts to protect patient safety. Attention then turns to the four structural bases that contribute to the crisis: the propensity to apportion blame, wilful blindness, the network of hierarchical observation and discipline and, finally, the use of confidentiality as a mechanism with which to silence dissent and prevent disclosures external to the organisations. The focus then turns to interpreting the findings in order to explain what occurred in each case.

Chapter Nine concludes the study and recommends strategies for change and further research.

1.7 Conclusion

This, the first chapter of this thesis, has outlined the focus of the inquiry, the research questions and aims that guide the study. A working definition of whistleblowing was given and clarification provided on the meaning of other keywords used in the thesis. Finally, a synopsis of the chapters constituting this thesis was presented.

CHAPTER 2

BACKGROUND

2.1 Introduction

This background chapter has as its focus an examination of the term whistleblowing, its etymology, and use in the literature. The profession of nursing has a well-documented history of nurses raising concerns about unsafe practice to a person with authority in order to effect action. To illustrate this, a brief overview of nurse whistleblowing cases is presented. Following this an examination is made of some of the influential developments that had impact on quality of care and patient safety. The patient rights movement, the emergence of bioethics and the development of the professional codes of practice will be considered. It will be shown that all these issues have influenced (and in some cases mandated) nurses' responsibility (professional and perceived) to report incidents and events that threaten patient safety.

2.2 Etymology of whistleblowing term

Whistleblowing is a metaphoric term that, according to the *Oxford English Dictionary* (OED Online, 2012c), signifies the 'bring [ing of] an activity to a sharp conclusion, as if by the blast of the whistle'. It also represents 'the action of informing on (a person) or exposing (an irregularity or crime)'.

The first use of the concept has been credited to P.G Wodehouse in his 1934 novel *Right Ho, Jeeves:*

> Now that the whistle had been blown on his speech, it seemed to me that there was no longer any need for the strategic retreat which I had been planning.
>
> (OED Online, 2012c)

However, there are suggestions that the term 'whistleblowing' itself has appeared only in the last fifty years (Cook, 2008; Jubb, 1999). What is certain is that prevalence of its usage has increased in political, legal and social discourse since the early 1970s (Johnson, 2003; Vandekerckhove, 2006; Wright, 2008).

Much disagreement surrounds the origin of the term whistleblowing, and speculations as to the source of its metaphorical use are widely present in literature. There is, first, a referee's whistle whose shrill sound is used to stop play and refocus the teams by acknowledging the rules, before returning to the game (Davis, 2003; Jubb, 1999; Peternelj-Taylor, 2003; Ray, 2006). Similarly, the sound of a policeman's whistle was once used to alert the public to a wrongdoing or crime and to warn of danger (Davis, 2003; Johnson, 2003).

An analogy has even been drawn to the antiquated mining safety procedure – the 'canary down the coalmine': a canary is taken deep into a mine shaft and, if the canary dies, the mine is considered unsafe to work in due to toxic gases (Calland & Dehn, 2004; Lennane, 1995). It is proposed that, like the canary, whistleblowers provide insight into potentially toxic work environments in non-mining contexts (Armstrong, 2002).

These above examples serve to provide vivid visual descriptors of the sounding of an alarm. Even so, they fail to capture the most significant act of whistleblowing in its contemporary use: the sounding of the alarm *outside approved channels* (Davis, 2003).

2.3 Whistleblowing as a contested notion

Whistleblowing is a contested notion, definitions of what it is vary, with debate surrounding contemporary definitions of whistleblowing focusing heavily on what is an 'approved channel' and thus what and who lie 'outside' approved channels. Included in this debate is conjecture that 'internal' disclosures should not be included in a true definition of whistleblowing (Bok, 1981; Jubb, 1999; Miceli, Near, & Dworkin, 2008). The negative connotations associated with whistleblowing have resulted in calls to abandon the term, in order to create an increase in reporting of misconduct and wrongdoing within organisations (Johnstone, 2009, in press).

The disparities in the definitions of whistleblowing may however be related to the disciplinary focus used. For example, health professionals view internal reporting as a central element of clinical governance and not as a feature of a whistleblowing schema. Legal scholars who examine whistleblowing or protected disclosure laws, however, will often distinguish whistleblowers based on their choice of recipient for their reporting, limiting it to recipients outside an organisation (Grace & Cohen, 2010; Truelson, 2001). Meanwhile, social science researchers increasingly focus on the whistleblowers choice of recipient (internally and externally) and

examine the link between this choice and the response of the organisation, particularly regarding retaliation or retribution suffered by the whistleblower, as well as the effectiveness of the action in changing practice (Brown, 2008; Callahan & Dworkin, 1994; Miceli *et al.*, 2008). Social science researchers assert that restricting the definition of whistleblowing and whistleblowing inquiries to include only external disclosures risks limiting understanding of the phenomena. Accordingly, they tend to include reporting to authorities internal to an employing organisation in their definition of and research on whistleblowing.

Social science researchers have examined the phenomenon of whistleblowing in business and the public service, there are however few studies that examine whistleblowing in healthcare services. The definitions used by social scientists which include internal reporting cannot uncover the realities of the current practice in healthcare, a social system made unique by its particular historical, economic and political forces. Thus while the definitions espoused by social scientists offer interesting insights, they cannot effectively answer the questions related to whistleblowing and nurses.

Although a contested notion, Micelli and Near (1984) offer the following plausible definition

> the disclosure by organization members (former or current) of illegal, immoral, or illegitimate practices under the control of their employers, to persons or organizations that may be able to effect action.
>
> (p. 689)

This definition bears a close resemblance to the definition used by McDonald and Ahern (2002) as:

> a nurse who identifies an incompetent, unethical, or illegal situation in the workplace and reports it to someone who may have the power to stop the wrong.
>
> (p. 16)

And as such informed a foundation for the working definition presented in Chapter One.

2.4 Alternative terms and negativity surrounding the term whistleblower

Despite ostensibly being described as an act of moral courage, whistleblowing has tended to be described in pejorative terms (Comer & Vega, 2011; Lachman, 2007). For example 'informant', 'complainant', 'peer and even professional reporter' (Commonwealth of Australia, 2009). Informant is a term often linked to public sector and law enforcement agencies (Banisar, 2009; Miller, 2010). Other descriptive terms, such as 'conscientious objector', 'ethical resistor', 'concerned employee', 'principled dissenter' and 'public interest disclosure' are also sometimes used instead of whistleblowing in order to re-characterise the reporting of illegal, unethical or illegitimate practice as pro-social behaviour (Burrows, 2001; Dozier & Miceli, 1985; Eschenlauer, 2002; Shahinpoor & Matt, 2007; Vinten, 1994). This shift is often a strategic attempt to create distance from

negative discourse associated with whistleblowing (Peternelj-Taylor, 2003).[6]

Whistleblowers have also tended to be viewed as disloyal or disaffected members of staff who expose damaging information, thus betraying the organisation (Alford, 2001; Bather & Kelly, 2005; Oakley & White, 2005; Wright, 2008). One consequence of this negative focus is that the process to deal with the disclosure concentrates heavily on *establishing the credibility of the whistleblower* rather than dealing with the information disclosed. In the process the discloser may become victimised, the message they are trying to deliver is overlooked and the ability to effect action for public good or to protect public safety risks being lost. An example of the move away from the term 'whistleblower' can be found in the actions of Australian Senator Andrew Murray (2007) who used the title Public Interest Disclosure[7] rather than whistleblowing for the Private Members Bills he introduced to the Australian Senate (p. 1). Murray (2007), acknowledges that the use of alternate terminology was an explicit attempt to 'place primacy on addressing the issue raised rather than the person who raised it' (p. 1).

[6] A colloquial term common in Australian culture is the slang 'dobber', denoting someone who 'dobs on' or 'dobs in' another person. A dobber is an informant or traitor who reports someone for a misdemeanour (Lambert, 2005). It is a disparaging term often linked to betrayal. Other widely used negative synonyms include: stool-pigeon, rat, snitch, trouble maker and traitor (Fiesta, 1990; Henderson, 2008; Jubb, 1999; Lachman, 2008a; Ohnishi, Hayama, Asai, & Kosugi, 2008; Peternelj-Taylor, 2003).

[7] Australian Democrat Senator Andrew Murray introduced a private member's Public Interest Disclosure Bill to federal parliament on three occasions (2001, 2002 and 2007) only to have it lapse due to insufficient support (Commonwealth of Australia, 2009).

Despite these arguments,[8] in favour of changing the term, whistleblowing is a widely recognised term and it is doubtful that a name change will alter the many organisational factors that contribute to the negative connotations associated with it. At the same time, the largest study on whistleblowing in Australia has revealed that while 'reporting wrongdoing is rarely an easy experience', the 'bleak picture' many associate with the practice is not always an accurate one (Brown & Wheeler, 2008, p. 289 & 291). The *Whistling While They Work* national research project found that in the large majority (70 percent) of cases where employees raised concern with managers or colleagues, relationships within the workplace either remained the same or improved as a result of the action (Brown & Wheeler, 2008). Nursing researchers, too, note that not every nurse who reports wrongdoing in the clinical setting face a negative experience (Firth-Cozens, Firth, & Booth, 2003; Moore & McAuliffe, 2010).

Those outside the social research sphere do not commonly apply the term whistleblowing to reporting internally. Community perceptions of whistleblowing (often formed by news media championing the cause), link whistleblowing to disclosures made only to external sources, to ensure the information reaches the public domain and effects action (Brown, 2008). However, to 'effect action' in the first instance, the incident and/or concern would be reported internally (Lachman, 2008a). Certainly many publications related to nursing and health service provision limit their

[8] Evidence in Chapter 2 details how whistleblowers themselves suffer retribution and come under increased scrutiny, rather than drawing focus to the issue they are trying to bring to the public domain.

definitions and discussion of whistleblowing to external disclosures, which are infrequent and 'extraordinary events' (Brodie, 1998; Edwards, 1996; Erlen, 1999; Firtko & Jackson, 2005, p. 52; Fletcher, Sorrell, & Silva, 1998; Iliffe, 2002; Lachman, 2008a; Rennie & Crosby, 2002; Sloan, 2002; Snow & Doult, 2009; Starr, 2010; Tariman, 2007; Trossman, 2005; Wilmot, 2000).

2.5 Whistleblowing in nursing and healthcare: An historical overview

Reporting unsafe practice to a person with authority to effect action has a long history in nursing. Long before the term whistleblower emerged in contemporary discourse, there were nurses (singly and in union) asserting power and advocating for patients whose safety they deemed under threat. In the following section, a brief overview of a nursing history of whistleblowing is provided, examining examples of nurses who would fit the contemporary definition of whistleblowers.

2.5.1 Florence Nightingale – Scutari hospitals 1856-1858

As early as 1856, Florence Nightingale provided an example of reporting patient safety concerns to an entity that had the capacity to effect action. On return from her service in the Crimean war at Scutari hospital in 1856, Nightingale visited with Queen Victoria and Prince Albert and relayed her concerns about the appalling conditions and what she believed contributed to the high mortality rate amongst British soldiers (McDonald, 2010).[9] Additionally, in 1858, she published *Notes on Matters affecting the Health,*

[9] Dying from cholera, dysentery, typhus and typhoid, rather than from their battle wounds (McDonald, 2010).

Efficiency and Hospital Administration of the British Army, which increased public pressure on the government of the day (McDonald, 2010, p. 66).[10] Nightingale's accounts were challenged by 'doctors, purveyors, army officers, War Office officials, [and] ministers of the crown' (Smith, 1982, p. 72) determined to keep the conditions she had experienced in the Scutari hospitals from public scrutiny . Despite resistance, Nightingale was successful in marshalling support from influential government officials and the media, which later resulted in a Royal Commission into sanitary conditions in the Army (McDonald, 2010).

2.5.2 Laura Goodley –The London Hospital 1909

Laura Goodley, a nurse probationer (student) at The London Hospital in 1909, gained attention when reporting her concerns and detailed observations of unsafe practice (in this case involving a cocaine-addicted surgeon) to the hospital's Matron. Goodley's experiences are dramatised in a BBC1 television series that sources the actual hospital records, private papers and newspaper reports (Block, 2009). The second episode of the series profiles the early use of the spinal anaesthetic drug Stovaine, as administered by Mr Henry Dean, a London Hospital surgeon. Although Dean was recognised as one of the most eminent surgeons of his time for his pioneering work on spinal anaesthesia, his 'cocaine addiction became an open secret at The London [Hospital]' (Powell, 2010, p. 1334). Nurse

[10] The government responded later that same year by announcing a Royal Commission into sanitary conditions in the Army (McDonald, 2010). Nightingale's rich, upper-class social status and esteemed public standing compounded increased her influence and acceptance as an authority on 'the medical care and treatment of the sick and wounded', as well as Army sanitation reform (Smith, 1982, p. 78).

Goodley is depicted as witnessing patient complications in the form of severe headaches, paralysis of the legs and deaths. These she reports to the Sister of the ward:

Goodley: Other patients who have been operated on by Mr Dean have died subsequently.
Ward Sister: This concerns you?
Goodley: Greatly
Ward Sister: If there was any substance to your concerns do you not think that Mr Dean would have it already under consideration.
Goodley: But I have also observed Mr Dean on the ward and he behaves almost as if these effect are of scant consequence
Ward Sister: Do you believe you are in any position to question a surgeon's clinical judgment, Nurse Goodly.
Goodley: I am sorry, but I feel it is my responsibility to report to you what I have observed. Stovaine is, well, questionable at least.
Ward Sister: Having reported that, I would like you to return to your duties
Goodley: May I ask what will you do with what I have said?
Ward Sister: For the sake of your career, precisely nothing.
(Block, 2009)

When no action is taken, Goodley performs a chart audit and writes a letter to Matron Eva Luckes listing numerous cases of complications following surgery carried out under the anaesthetic Stovaine. Tellingly, Matron Luckes makes the submission anonymous by scratching out Goodley's name from the letter before presenting it to the Hospital Administrator. An internal investigation by the House Committee (made up of lay members) suspends the use of Stovaine and requests a Medical Council directive on its further use. This decision is immediately challenged by Dean, who posits that 'the remit of the house committee extends to hospital policy not medicine. A lay committee is not qualified to deliberate

on medical matters' (Block, 2009). The Matron locates Goodley on the ward and tells her:

> Well your letter has caused something of a stir...You have been brave, now you must be sensible in equal measure. Be assured that Mr Dean will seek out whoever wrote that letter. He will claim that he is unable to operate in an environment in which his clinical judgment is questioned and mistrusted. He will sniff out and hound the author from the ward and then the nursing profession itself.
>
> **Goodley:** But there is proof!
>
> **Matron:** He will destroy you, Nurse Goodley and there will be nothing I can do to prevent it. Which is why I am offering you a place in my office under my personal protection...
>
> **Goodley:** I don't know what to say.
>
> **Matron:** I am afraid you have little choice but to say yes, and to say it now.
>
> (Block, 2009)

The dramatic production provides an historical context which illustrates the serious consequences that nurses faced when they reported patient safety concerns, particularly when such reports questioned medical practice or a medical practitioner.

2.5.3 Frances Gillam Holden - The Children's Hospital Glebe 1887

One of the earliest cases of censure for whistleblowing in Australian nursing is the dismissal of Frances Gillam Holden, the Lady Superintendent of The Children's Hospital in Glebe in 1887(Bashford, 1993). Holden began nursing at the Sydney Infirmary in the early 1870s and continued for some time at the General Hospital in Hobart Town in Tasmania. In 1880 she returned to Sydney to take up the Lady Superintendent position at Glebe. Holden managed, by virtue of her education and class, to have the title of Matron changed to Lady Superintendent and sought increased influence and control over the hospital (Bashford, 1993).

From the time of her appointment until her dismissal, Holden made a series of complaints to the House Committee[11] about the conduct and behaviour of visiting doctors. Her most serious allegation (and the one that caught the attention of the Board) targeted Professor Anderson Stuart at Sydney University. Holden asserted that the premature death of a young patient, Rose Grant, might have been averted had Professor Stuart 'responded more promptly' to calls by staff within the hospital (Bashford, 1993, p. 322). The board considered the allegation and then asked for Holden's resignation. Rather than accepting her fate, Holden began a campaign of letter writing to the Press, true to her warning to the Board that:

> I have only to take a sheet of foolscap and pen and state the truth to show not Sydney only but all Australia that the management of this institution has been a mixture of burlesque and tragedy.
>
> (*Daily Telegraph*, 16 August, 1887, p. 8. In Bashford, 1993, p.322)

The public uproar that resulted from her campaign led to an Inquiry into the Hospital for Sick Children in 1887(Bashford, 1993). The case however was to set a precedent for Lady Superintendents and nurses who wished to challenge the power of the medical men. Holden's position was terminated and the Inquiry patronisingly 'recommended the appointment of a paid house surgeon, effectively as a way to constrain the ambitions of any future troublesome matron' (Bashford, 1993, p. 323). According to

[11] The House Committee was made up of four or five benevolent Sydney women. Its role was to meet weekly with the Lady Superintendent to discuss the management of the hospital. At the time there was no House Surgeon and the medical staff had visiting privileges only weekly. The male dominated Board of the hospital never met with the Lady Superintendent nor had meetings at the hospital (Bashford, 1993).

Bashford, no records exist to indicate that Holden undertook any nursing position again.

2.5.4 Mrs Edwards - Victorian Infant Asylum and Foundling Institute 1906

Another nurse superintendent who challenged the dominant powers of a Hospital Board and reported misconduct was also from a children's hospital. Mrs Edwards had been the Superintendent at the Victorian Infant Asylum and Foundling Institute for eleven years when, in 1906, she went on leave for six months (Lemin, 1999). On her return, she reported to the Hospital Committee cases of cruelty to women and children and criticised the slovenly manner in which internal matters were being managed since she got back. The Committee performed an investigation and found Edwards complaints not to be sustained by the evidence. Instead, they painted her actions as attempts to show the Committee how invaluable her own services were 'as compared to her locum tenens [substitute]' (*The Age*, 1906, p. 110 in Lemin, 1990, p. 204). Edwards resigned and, like Holden, chose to continue her campaign in the media, calling for an external inquiry. An inquiry, initially avoided, was eventually held. However, it was presided over by the institution's honorary solicitor (who happened to be the husband of the Committee president) and he did not (or would not) recognise the significance of her claims, or institute any investigation into them. Edwards indicated in her report to the Press that she:

> objected to the inquiry being held in that way, but they went on and I soon discovered that instead of investigating the cases properly they were putting me on my defence. The

> inquiry lasted three days, and on the third day, I again objected in writing and asked that I might be allowed to have a solicitor present. That was refused. Then I put some documentary proof in their hands, but just twelve minutes afterwards the inquiry was abruptly closed.
> (*The Age*, 1906, p. 110 in Lemin, 1990, p. 205)

2.5.5 The Holden and Edwards cases

In both cases the response found legitimised the power of medical men and the boards that ran the hospitals. The nurses' position as subordinate and loyal to the profession of medicine and the patriarchal order of the hospital boards was reinforced. The loyalty expected from nursing staff towards the organisation that employed them was not required of doctors, many of whom were already at the top of the patriarchal political hierarchy that characterised hospitals and hospital management at that time. Johnstone (1994) notes that while nursing's historical literature contains abundant examples of calls for obedience and unquestioning loyalty, 'no comparable discourse can be found arguing that doctors ought to be 'obedient' and loyal' to the hospital hierarchy'(p. 139).

The discourse of the Victorian virtues of loyalty and obedience expected of nurses under the patriarchal hospital system has largely disappeared from contemporary nursing. However, when nurses do speak out, reporting misconduct, malpractice or mistakes, in an effort to advocate for their patients, they continue to face considerable obstacles. Changes made to nursing education, legitimised levels of autonomy and new codes of ethical conduct, may all have changed nursing practice and the way nurses are perceived. However, the status of the moral authority of the nurse remains dubious as noted by Sinclair (2000) reflecting on the historical

practices and entrenched medical hegemony that influence nurses. In the *Report of The Manitoba Pediatric Cardiac Surgery Inquest*, Justice Murray Sinclair (2000) declared:

> For nurses, there is the additional matter of overcoming the historical burden of silence expected of their profession. Nurses who speak out, particularly in a manner that is critical of doctors, are still seen as committing an act of disloyalty, regardless of the legitimacy of the concern. Alternatively, the hospital may not be interested in investigating the issue, perhaps for reasons of legal liability.
>
> (p. 356)

Nurses who speak out about breaches of patient safety standards and report illegal, substandard, or illegitimate practice continue to face censure and put at risk their future careers.

2.6 Contemporary nurse whistleblowing cases

Over the past decade, notable cases in Australia, the United Kingdom and the United States have highlighted the perilous journey whistleblowing nurses have taken to bring to the light their concerns about patient safety. In each case, once the organisation was exposed, rather than view the actions of the nurse whistleblower as an opportunity to review systems and improve practice, measures were employed to protect the organisation itself, often resulting in retribution to the nurse whistleblower.

2.6.1 Australian case – Kevin Moylan

Kevin Moylan was a senior psychiatric nurse working in a clinic in Tasmania when he reported concerns about 'poor quality work practices' (Armstrong, 2002, p. 19). These concerns included:

- the temporary employment of an unregistered psychiatrist,

- the reluctance of police to provide support to staff, when they were called to deal with dangerous patients,[12] and
- episodes of sexual harassment of patients and staff.

When no action was taken by management to address his safety concerns, Moylan, feeling 'isolated and intimidated into silence' (p.19), wrote to the Tasmanian Health Minister expressing his ongoing concerns at the lack of action. The Shadow Health Minister gained a copy of Moylan's letter and raised the matter in the Tasmanian Parliament, naming Moylan as the whistleblower. Once Moylan's anonymity and privacy were breached, he describes a 'journey into hell' whereby he was 'threatened, isolated, intimidated and abused' and suffered post-traumatic stress syndrome (pp. 18-19).

As a result of this experience and after 25 years as a psychiatric nurse, Moylan left the profession and was unable to work. He laments that his 'actions were motivated by a desire to see justice done. I tried to protect my patients, but no-one protected me'(Moylan quoted in Armstrong, 2002, p. 19). The psychiatric clinic at the centre of the reports was later closed and Moylan did receive compensation. However, the amount received was, according to Moylan inadequate to cover the 'loss of his health, his reputation and livelihood'(p. 19).

[12] Moylan himself was attacked by a patient, and it was this focussing event that propelled him to 'take action, to protect not only himself but patients and other staff members'(Armstrong, 2002, p. 19).

2.6.2 United Kingdom (UK) cases

There have been two contemporary cases in the last decade in the UK that show the challenges nurses face when trying to expose inaction to serious concerns raised related to patient safety. The first, Margaret Haywood, a registered nurse in the UK who brought to light what she believed was negligent practice and poor standards of care in a healthcare organisation. [13] The second, Barbara Allatt, a student nurse at Staffordshire University, who reported to university tutors, hospital mentors and senior nurses' substandard clinical practice she witnessed while in clinical placement. These two cases below, like that of Kevin Moylan, illustrate the inaction of hospital executives to address the issues to a satisfactory level thus preventing the internal reporter resorting to whistleblowing.

2.6.2.1 Margaret Haywood

In 2005, Liverpool nurse Margaret Haywood, was employed as a bank nurse on the Peel and Stewart Wards at the Royal Sussex County Hospital. After observing a lack of care provided to vulnerable elderly patients in the unit in which she worked, Haywood voiced concerns to her line manager (Edemariam, 2009; Wainwright, 2009). Despite her internal reporting Haywood recalled that 'nothing was really taken on board' and no action was taken to address her concerns or improve patient conditions (Wainwright, 2009, p. 659). Convinced that the right course of action was to expose the neglect care of elderly patients, Haywood then approached the

[13] Ms Haywood made this revelation with the assistance of undercover film footage obtained by the BBC Panorama programme

BBC *Panorama* programme. [14] She recalled: 'I had reported the issues and nothing had been done. I felt I owed it to the people on the ward'(Plunkett, 2009).

The BBC asked Hayward to take undercover footage of conditions in the hospital, which she did. The footage was edited and patients who remained in the final cut of the documentary were then contacted for their consent prior to the airing of 'Undercover Nurse', in July 2005 (Plunkett, 2009; Wainwright, 2009). The patients' personal contact details were provided to the BBC's filmmaking team by Hayward.

In the months following the airing of the documentary, an internal investigation by Sussex University Hospitals National Health Service (NHS) Trust found 'serious lapses in the quality of care' (Grant, 2010, p. 471). Despite this, almost four years later, on 16 April 2009, the Nursing and Midwifery Council (NMC) removed Hayward's nursing registration for failing to 'follow her obligations as a nurse'(Wainwright, 2009, p. 659). The NMC specifically identified that Hayward failed to report her concerns 'in accordance with the Trust policy' and that her action of releasing patient contact details to the BBC breached patient confidentiality (Wainwright, 2009, p. 660). The NMC's 2009 ruling (in Grant, 2010, p. 469) reads: 'Although the conditions on the ward were dreadful, it was not necessary to breach confidentiality to seek to improve them by the method chosen'.

The decision to strip Hayward's registration was not a popular one and, following a campaign that began in the media and was supported by the

[14] Hayward had previously worked for the BBC as a consultant on a TV programme about care homes (Edemariam, 2009).

Royal College of Nursing (RCN), the decision was overturned. In October 2009, following an out-of-court settlement, Hayward was cautioned only, with a probation period of 12 months (Grant, 2010; Royal College of Nursing, 2009). Hayward, unlike Moylan did not suffer financial hardship following the whistleblowing event. [15] However, the decision to strip her of her registration caused her significant grief. To a reporter from *The Guardian* newspaper (Edemariam, 2009) Hayward recalled looking at the Nursing and Midwifery Board website where she discovered that her name was ranked alongside:

> People who'd had inappropriate sexual relationships with patients. Nurses who had administered the wrong drugs. One was even charged with manslaughter. To put me in the same bracket as them! It really upset me. The first days afterwards were awful, and without the support of family and friends I would have been ill.
>
> (Edemariam, 2009).

2.6.2.2 Barbara Allatt

The second UK whistleblowing case comes in the form of former student nurse Barbara Allatt. Allatt was on clinical placement at Stafford Hospital and Cannock Chase Hospitals, from the Mid-Staffordshire NHS Trust, when she expressed concerns to university tutors, hospital mentors and senior nurses, that nurses she was working alongside left patients in soiled sheets, shouted at dementia sufferers and sedated patients by slipping sedatives into

[15] After the documentary aired Hayward went to work in a Sheffield care home, first as a registered nurse and later as a training manager. During the period when her registration was suspended in 2009 she accepted a 'four-month contract to tide her over until her appeal was heard' (Edemariam, 2009).

their cups of tea (Schlesinger, 2010). Allatt, a mature-age student,[16] claimed that she was unjustly labelled a 'troublemaker' after raising her concerns and this was known by nurses in her next placement (Schlesinger, 2010). She further claimed that despite passing all theoretical components of her course, she was suspended for four weeks in January 2010 due to her apparent 'inappropriate' attitude, behaviour and fitness-to-practise. Notwithstanding two appeals, the fitness-to-practise panel at the University withdrew her place in the undergraduate program in April 2010 (Schlesinger, 2010).

An RCN representative who supported Allatt in her two university fitness-to-practice appeals, suggested that there was 'collusion between several nurses, and that the decision [had] been made at some level that it is easier to remove Barbara from her training than pursue her allegations' (Schlesinger, 2010, p. 2). Little information is available to fully substantiate Allatt's media claims, as Staffordshire University did not publicly release the evidence used to justify terminating her enrolment in the nursing program. Allatt's threat [17] to take legal action against the university was not followed through. Nevertheless, the case raises questions about the power nursing students have to raise concerns about patient safety and for these concerns to be taken seriously.

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[16] Barbara Allatt aged 40 with prior experience as an occupational therapist (Schlesinger, 2010)

[17] According to Schlesinger (2010) Allatt planned to 'sue the university for breaching the Public Interest Disclosure Act, which is designed to protect whistleblowers'. However, in a discussion on The Cooperative Legal Service web site, it appears that Allatt failed to use the services of a solicitor despite being advised to do so, and as such, in January 2011 failed to convince the tribunal of her 'claims of discrimination over her beliefs, unfair dismissal and negative repercussions for revealing information that was in the public interest' (Jones, 2011).

The two hospitals in the Mid-Staffordshire National Health Service (NHS) Trust where Allatt was placed, have recently been at the centre of an independent Inquiry into care provided between January 2005 and March 2009 (Francis, 2010). In the final report of The Mid Staffordshire NHS Foundation Trust Inquiry, Chairman Francis (2010) commented on the culture of the hospitals where Allatt was placed, describing it as:

> characterised by introspection, lack of insight or sufficient self-criticism, rejection of external criticism, reliance on external praise and, above all, fear. I found evidence of the negative impact of fear, particularly of losing a job, from top to bottom of this organisation.
>
> (p. 184)

The details of Allatt's case are not able to be fully substantiated. Nonetheless, there is considerable scope to suggest that Allatt may have been a 'canary in the coalmine' and that the difficulties she faced raising patient safety concerns, even as a first year undergraduate student, reflected systemic cultural problems subsequently found to exist in the Mid Staffordshire NHS Foundation Trust.

2.6.3 United States case – The Winkler County Texas Nurses case

Nurse whistleblowing, perhaps first came to the attention in the US as a result of the 1988 Bardenilla case. Considered a landmark case it involved a Director of Nursing who reported two physicians to the local county health department (Fry, Veatch, & Taylor, 2011; Johnstone, 2009, in press).[18] A

[18] Sandra Bardenilla, a registered nurse and Director of Nursing, was awarded civil damages from a Los Angeles Superior Court for wrongful termination of her employment. She left her job due to a lack of support from hospital administrators when she attempted to intervene in a case of comatose patient. She asserted that the medical staff should not have directed removal of life support measures before a brain death assessment and declaration was made (Fry *et al.*, 2011; Johnstone, 2009; Stevens, 1988).

similar, more recent case occurred in 2009. The Winkler County Texas Nurses case involved two senior administrative nurses Anne Mitchell and Vickilyn Galle[19] from Winkler County Memorial Hospital who alleged that Dr Rolando Arafiles' practice at was below the acceptable standard of care (Texas Nurses Association, 2010b). They first raised their concerns to the administrator of the hospital, Mr Stan Wiley, and later, when no action was taken, by writing anonymously to the Texas Medical Board (TMB). The written complaint alleged that Arafiles' management of five patients[20] was below the accepted standard and that he was inappropriately sending emails to former patients about herbal supplements he was selling as part of a private business venture (*The State of Texas vs. Anne Marie Mitchell* No 5610).

When Arafiles was notified by the TMB that he had been reported, he claimed there was malice in the complaint. He initially contacted Wiley, the administrator of the hospital, and later the town sheriff [21] with whom he filed a complaint alleging harassment and requesting a full investigation (Sack, 2010). Sheriff Roberts then began a criminal investigation and contacted the TMB, which provided him with a copy of the report made by

[19] Mitchell as the hospital's compliance officer, and Galle in the position of Quality Improvement Utilisation Manager.

[20] Two formal complaints related to Arafiles were made to the TMB. The first was a letter of complaint on 7 April 2009 to the TMB by family nurse practitioner Naomi Warren highlighting five patient cases. The second a letter authored anonymously by Mitchell and Galle requested a review of a five different patient cases identified by file number only, as well as related to Arafiles practice of soliciting former patients to purchase herbal preparations. In the TMB notification to Arafiles given to Sheriff Roberts ten cases were cited which Roberts then investigated to determine a misuse of official information charge (*The State of Texas vs Anne Marie Mitchell* No 5610).

[21] Sheriff Robert L. Roberts was well known to Arafiles. Roberts had suffered from a heart attack and was treated by Arafiles, who he attributed to saving his life (Sack, 2010). Arafiles and Roberts also met socially at Golf (see *The State of Texas vs Anne Marie Mitchell* No 5610 Transcript of proceedings 9 February 2010).

the nurses (Yoder-Wise, 2010). Although there was no identifying information on the report to indicate that Mitchell and Galle had authored the complaint, Roberts, using verbal information from the TMB that the complaint was made by 'two nurses who had worked at the hospital for about 20 years and were about 50 years old', speculated on their identities (Yoder-Wise, 2010, p. 147).

Acting on this information Roberts obtained a search warrant and seized the work computers of the two nurses, wherein he found a copy of their original letter. Mitchell and Galle were indicted on a third degree felony charge of misusing official information[22] and in June 1999 their positions at the hospital were terminated (Lowes, 2010). The charges against Galle were dropped, but the case against Mitchell went to trial eight months later on 8-10 February, 2010, where she was acquitted (TNA, 2010b).

The Winkler County nurses were supported financially by the TNA in their campaign to clear their names. The case galvanised support from other nurses throughout the United States, who actively contributed to their legal fighting fund (TNA, 2010a). In a postscript to this case, the nurses successfully took legal action against the main players. Dr Arafiles pled guilty to and was convicted of 'misuse of official information and retaliation' (the same charge originally foisted on the nurses) and was sentenced to a 60-day jail term and $5000 fine (Lowes, 2011). Roberts' act of deceptively gaining access to the nurse's confidential letter from TMB

[22] Which if found guilty the nurses would face up to 10 years in prison (Lowes, 2010).

and sharing this information with Arafiles and his attorney resulted in a conviction of two counts of retaliation and misuse of official information and two counts of oppression. He was sentenced to 100-day jail term, four year probation and fined $6000 (Lowes, 2011). Wiley, the hospital administrator, who sacked the nurses, pled guilty to a single count of abuse of official capacity, and was sentenced to a 30-day jail term (Lowes, 2011). In a civil matter the nurses settled an out-of-court proceeding that accused Arafiles, Roberts, Wiley and Scott Tidwell (the attorney) of violating their free speech rights and breaking the Texas Whistleblower Law (Lowes, 2011).

The Winkler County nurses case opened the gates to much debate in Texas and across the United States, about whistleblowing and the effectiveness of the mechanisms and processes nurses and other healthcare staff are supposed to use to report concerns regarding patient safety and violations of practice standards. As with most whistleblowing cases that gain public notoriety, the nurses first reported their concerns to authorised persons within the organisation, resorting to disclosures outside only when no internal action occurred.

Researchers examining whistleblowing in other contexts have found that internal reports typically precede external reports, rather than the reverse, confirming this behaviour (Brown, 2008; Miceli *et al.*, 2008; Rehg, Miceli, Near, & Van Scotter, 2008). Inaction in each of the above cases catalysed these nurses to become whistleblowers, often at significant risk to their own professional standing and personal health. While all the nurses in

the cases above were eventually vindicated by external inquiries or legal action, their journeys were arduous and incurred heavy personal and professional costs.

2.7 Internal reporting and patient safety

Since the inception of modern healthcare systems, examining quality healthcare and devising measures to improve patient safety have been goals for regulators of healthcare organisations and the health professionals who work in them. The following section briefly recounts some of the history related to the quest for improvements in patient safety and quality care in hospitals and the role of nurses over time.

2.7.1 The development of hospitals and the authority of medicine

One of the most influential developments to impact on quality of care and patient safety was the emergence of the hospital. The history of the early institutions (particularly in Europe) which became hospitals coincided with a change in the way doctors treated their patients. A change in the medical 'gaze'[23] prompted doctors to move away from the bedside and instead undertake mass observation of the sick in institutions or clinics (Cooke, 2008). This transformation in practice was driven by a popular notion of the time: that regulating poverty through the supervision of the poor, sick and infirm in workhouses would benefit the community (Monteiro, 1985; Nelson, 1995).

[23] A term developed by Foucault to describe the change in perspective according to which medicine observed and analysed the symptoms of the sick (Foucault, 2003). Investigation, diagnosis and treatment were designed to distinguish the diseased organ (deviance) from the healthy one. The new medical gaze generated new truths, knowledge, practices, and social relations (Gastaldo & Holmes, 1999).

These new organisations, however did not improve outcomes for patients,[24] predominantly because workers were recruited from lower strata of the social classes and their management of patients was characterised by menial tasks and domestic service, rather than application of caring duties. Disease and infection increased the mortality rate (Gamarnikow, 1991; Helmstadter, 2008). It was eventually recognised that what was required was a reliable worker at the bedside to carry out the observations required by the doctors and to care for the ill in overcrowded workhouse infirmaries [25] (Cooke, 2008; Monteiro, 1985; Reverby, 1987). That reliable worker became the nurse.

Reforms in nursing, in the mid-nineteenth century, which saw the social and educational status of the nurse change, were attempts to improve the conditions of patients in hospitals. Many early nursing reforms are linked to Nightingale herself, particularly the establishment of a female chain (superintendant) of command at the hospital. [26] She is also credited with the creation of formalised hospital training that provided 'a systematic approach to nursing as a distinct discipline, with a stress on strict hygiene, order and obedience to authority' (Godden, 2001, p. 277). Nightingale, in her classic book *Notes on Nursing* (1980, first published in 1859), was an

[24] See Nightingale's notes on hospitals from 1863 where she states: 'It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm. It is quite necessary, nevertheless, to lay down such a principle because the actual mortality in hospitals, especially in those of large crowded cities, is very much higher than any calculation founded on the mortality of the same class of diseases amongst patients treated out of hospital would lead us to expect' (in Cook, 1913, p. 415).

[25] In the UK the move to develop large institutions to house the poor and infirm resulted from British Poor Laws (Monteiro, 1985).

[26] Although it has been demonstrated that Matrons already existed in both Australian and UK hospitals before the Nightingale reforms. Many trained by Roman Catholic religious orders, particularly Irish Sisters of Charity (Godden, 2004; Helmstadter, 2008; Nelson, 1997).

early advocate of a system-wide approach to improve quality. This included an 'organised system of attendance' by nurses or 'trustworthy women in charge of the wards' to avoid the occurrence of 'fatal accidents' within the hospital (p. 29).

The early measures taken to increase the social and education status of nurses were not readily accepted by doctors and particularly by surgeons. This was so despite the fact that it was they who had the most to gain from skilled nurses systematically applying new sanitation techniques such as those learned during the Crimean war (Baly, 1987; Johnstone, 1994). [27] As such, despite the gains that early reforms to nursing practice and education made on improving patient safety, the fear that educated nurses would threaten the authority and autonomy of the medical men who controlled the hospitals, limited their impact (Godden & Forsyth, 2000; Reverby, 1987).

The Australian experience was similar to that which occurred in Britain, and shows that the early training of nurses was more about exploiting an available source of cheap labour force and improving the authority of medicine, than on improving quality of care to patients (Castle, 1987; Godden & Forsyth, 2000). The prevalence of medical power over the types of training and curriculum and the authority of registration persisted in

[27] See Ashley (1976) who presents a compelling argument throughout her work that control of nursing education and subordination of nursing practice by medicine and hospital administration in America had little to do with improving patient outcomes and the professional development of nurses, and more to do with protecting the economic interests and prevailing power of the medical profession. By selling and exploiting nursing services, ongoing revenue and profits were gained for the hospital.

Australia until education was transferred to the tertiary sector beginning in 1973 (Browning, 2000; Castle, 1987; Herdman, 1995; Johnstone, 1994). [28]

Thus, since the early development and rise of the modern teaching hospital there have been attempts by nurses such as Nightingale to reform practice to improve the safety and quality care of patients. This same period also saw an increase in power and authority by medical men who set 'sharp patterns of superordination – subordination, in expectations of strict discipline and obedience, and in distinct status differences among organizational members' (Georgopoulos & Mann, 1972, p. 296).

Until the 1960s medical men and (usually male) hospital administrators maintained dominant power and authority over the manner in which hospitals were run. This included setting standards for how staff were, renumerated, educated and regulated (Rothman, 2003; Sharpe, 2000). Social movements, beginning with civil rights and feminism in 1960s, and patient rights and rise of bioethics 1960s and 1970s challenged medical dominance (Rothman, 2001; Sharpe, 2000). However, patients no longer deferred without question to the authority the individual physician. Healthcare delivery and the effectiveness of medicine was now 'subject to debate and review by colleagues and laypeople' (Rothman, 2003, p. 2). Sharpe (2000, p. 39) attributes this force of change to 'four intertwined

[28] In 1899 the Australasian Trained Nurses Association (ATNA) and the NSW Trained Nurses Association were founded by a Board consisting of a group of doctors and nurses in order to set the training conditions required for registration. Four out of the five Executive members, including the first president were male doctors. In 1916, resolutions guiding the governing council required that one –fifth of the board be qualified medical practitioners. Even when the Registration Act came into force in 1924, replacing the ATNA, four of the seven members of the Nurses Registration Board were to be doctors (Castle, 1987).

strands of challenge' – bioethics, consumerism, law and regulation.[29] Over time these external forces exerted pressure on medicine, hospital administrators and healthcare regulators to re-examine patient safety and accountability (Sharpe, 2000).

The next great influence on quality of care and patient safety came with the escalation in healthcare costs and the pressure to contain them (Sharpe, 2000; Wall, 2012). New technological developments in diagnostics and treatment, specialisation of services, as well as increasing patient/consumer expectations, resulted in bourgeoning expenses for healthcare provision. Governments and private enterprise sought methods to measure both the variation in service and cost (Duckett, 1998; Sharpe, 2000). In 1983, the US implemented a prospective payment system, which underwrote public healthcare organisations with pre-determined funding for specific medical admissions and surgeries (Wall, 2012). This system, called case mix,[30] was developed by Fetter, Shin, Freeman, Averill, and Thompson (1980) at Yale University who proposed a patient classification scheme called Diagnosis Related Groups (DRG),[31] which was based on the International Classification of Diseases. Modified case mix and DRG

[29] Sharpe's (2000) examination of medical accountability and its historical evolution in health care is focused on developments in the US. Sharpe's contention that the type of accountability expected from medicine and health care providers is shaped by societal influences, means that some of her four strands of challenge that prevailed in the US may not be fully transferable to other societies. Certainly the structure of healthcare provision and legal systems differ in Australia and the UK, particularly the way consumers access healthcare and take legal action when medical treatment contributes or causes injury or death. Nevertheless her line of reasoning that bioethics, consumerism, law and regulation all changed the way in which patient safety and medical accountability was conceptualised are sound.

[30] Developed by Fetter and colleagues (1980) from Yale University.

[31] The purpose of using DRG's was to 'identify in the hospital acute-care setting a set of case types, each representing a class of patients with similar processes of care and a predictable package of services (or product) from an institution' (Fetter *et al.*, 1980, p. 3)

funding systems were introduced into other healthcare systems worldwide including Australia, allowing hospital budgets to be based upon performance targets and output rather than historical funding models.

In 1993 the Australian state of Victoria adopted the case mix funding model, the first state to do so in Australia, other states soon followed suit (Duckett, 1998). During this period of cost containment, questions were being asked by governments, about the appropriateness or necessity of some healthcare services (Sharpe, 2000). Doctors were required to demonstrate the criteria they used for medical decisions based on effectiveness and cost. Some who were confronted by this requirement rejected the moves towards the development of evidence-based medicine and multidiscipline clinical care pathways (Boaden & Harvey, 2008).

The rise in public expectation, the escalating costs of contemporary healthcare, the increasing rates of litigation when things went wrong,[32] the research and government reports that showing persistently high levels of healthcare error and patient safety breaches, [33] as well as high profile judicial inquiries,[34] all contributed to calls for change in the governance of

[32] Runciman, Merry and Walton (2007) contend that the number of legal claims against medical practitioners in Australia began to rise in the 1970's with a marked increase in the 1990's. The rise in litigation saw a direct relationship with the cost associated with medical insurance premiums which in 1970 was $50 and in 2000 ranged between $2,000-100,000 (pg.87).

[33] Research on the prevalence of medical error in Australia (Wilson *et al.*, 1995; Wilson & Van Der Weyden, 2005) United States of America (Institute of Medicine, 1999), UK (Vincent, Neale, & Woloshynowych, 2001), Canada (Baker *et al.*, 2004) and New Zealand (Davis *et al.*, 2003).

[34] For example cases in Australia: Inquiry into obstetric and gynaecological services at King Edward Memorial Hospital 1990-2000 (Douglas, Robinson, & Fahy, 2001), in Canada: The Report of The Manitoba Pediatric Cardiac Surgery Inquest. An Inquiry into Twelve Deaths at the Winnipeg Health Sciences Centre in 1994 (Sinclair, 2000) and in the UK: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995 (Department of Health, 2001).

quality care and patient safety (Braithwaite & Travaglia, 2008; Flynn, 2002; Wolff & Taylor, 2009).

2.7.2 Impact of bioethics and patient rights movement

The rise of whistleblowing in contemporary healthcare coincides with the development of bioethics and is commensurate with patient rights movements of the 1970s and 1980s. The social movement addressing patient rights during this time was characterised by suspicion and distrust of the authority of medical institutions, and particularly of doctors (Rothman, 2001). Patient autonomy and consent were the two central issues highlighted by the patient rights movement and the emerging field of study that is now termed 'bioethics' (Rodwin, 1994). This new focus on ethical considerations was underpinned by emerging medical scandals [35] and legal cases that brought to light shocking abuses of patient rights: medical experimentation without consent, experimentation offering no benefits to the patient, and physicians neglecting to gain consent from patients about critical decisions in their treatment, such as surgery (Rodwin, 1994).

It was during this period, the 1960s to the 1980s, that the term whistleblower came to be applied to persons who brought such scandals to the public's attention (Wright, 2008). It is no coincidence that during this same period, when patients were beginning to challenge the authority of medical organisations (and medicine itself), that nurses withdrew their willingness to remain silently obedient to doctors regarding their patients'

[35] Medical scandals such as the American Tuskegee Syphilis study (Reverby, 2009), the cervical cancer study performed at New Zealand's National Women's Hospital (Coney, 1988), and the Deep Sleep scandal at Chelmsford in NSW, Australia(Lupton, 1993).

interests. This emergent change was echoed in the language of nursing's professional codes.

2.7.3 Responsibility to report – development of professional codes

Since as early as 1893, nurses have tried to capture the structure and nature of their work by developing professional codes. The first such charter, while not an official code, was the 1893 *Nightingale Pledge*[36] developed by Lystra Gretter for her students at the Farrand Training School for Nurses in Detroit for recitation as a graduation oath (Fowler, 1999; Meulenbergs *et al.*, 2004). The Pledge captures the virtues of the nineteenth century nurse in florid Victorian prose[37] and remained an inspirational code and was recited by graduating nurses in many Western countries until 1953, when the International Council of Nurses (ICN) ratified its first official code (Madsen, 2007; Meulenbergs *et al.*, 2004).

This first *International Council of Nurses Code of Nursing Ethics*, introduced fourteen statements that represented the 1950's notions of a nurse's role and responsibilities (Madsen, 2007). While many of the statements continued to reflect the core values found in the *Nightingale Pledge*, two new items specifically addressed the actions required of nurses should they witness incompetent or unethical conduct:

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[36] Not authored by Florence Nightingale

[37] 'I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavour to aid the physician in his work, and devote myself to the welfare of those committed to my care' (Fowler, 1999, p. 56).

> 7. The nurse is under an obligation to carry out the physician's orders intelligently and loyally and to refuse to participate in unethical procedures.
> 8. The nurse sustains confidence in the physician and other members of the health team; incompetence or unethical conduct of associates should be exposed but only to the proper authority.
>
> (First International Code of Nursing Ethics, 10th Quadrennial Congress of the International Council of Nurses, 10 July 1953, as cited in Smith, Lew, & Tomlinson, 1965, pp. 6-7 emphasis added)

Statement seven, provides for the first time, an attempt to legitimise the (until then, repressed) power of the nurse to refuse to participate in unethical procedures.[38] The eighth statement, noting that the incompetent or unethical conduct of a colleague be reported, also raises the profile of the nurses as an arbiter of conduct, albeit the caveat that the nurse reports to a 'proper authority'. At this time, before the development of many external institutions such as consumer rights organisations and profession-based investigative tribunals, the 'proper authority' would most likely have been an individual eg. the nurse in charge or Matron, within the organisation in which the nurse was working.

During the twentieth century, in its quest to attain professional status, the nursing profession continued to develop codes of professional and ethical practice. According to Meulenbergs, Verpeet, Schotsmans, and Gastmans (2004), code development acted as a mechanism to leverage

[38] It is interesting to note the appearance of this statement in the 1953 code, particularly as it followed the 1945-46 Nuremberg trials, where nurses were charged alongside medical staff for their role in assisting in patient deaths as part of the euthanasia program at the Kaufbeuren psychiatric institution in Bavaria (Ost, 2006). Another influential case altered the perception of nurses unequivocal obedience to a physician's order is that of Lorenza Somera. Somera, a registered nurse in the Philippines, in May 1929, was found guilty of the manslaughter of a thirteen-year-old patient after failing to question the preparation for administration an order for 10 percent cocaine and adrenaline. The Somera case highlighted a change in attitude that nurses should not follow a physician's orders if the action was likely to incur unnecessary harm (Johnstone, 1994)

professional status, by serving as an 'expression of identity and a means of self-regulation'(p. 332). More recent codes, including those refined by the International Council of Nursing (ICN) (2012) and ratified by the Nursing and Midwifery Board of Australia (NMBA, 2008a)[39] contain explicit statements outlining a nurse's responsibility to take 'appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person'(ICN, 2012, p. 5).

A nurse's duty to report instances of sub-standard practice or misconduct by health professionals and/or cases of health professional impairment that result in behaviour that puts the public at risk, has now been enshrined in Australian law. [40] The Australian legislation requires mandatory reporting of serious transgressions and advises the voluntary reporting of instances that do not meet the threshold for mandatory reporting.

2.7.4 The National Law

Mandatory reporting[41] is a new feature that has emerged with the national registration of health professionals[42] and requires health professionals to

[39] In May 2013 the Nursing and Midwifery Board of Australia rebranded the Australian Nursing and Midwifery Council ANMC Code of Ethics. (NMBA, 2008a).

[40] Health Practitioner Regulation National Law Act 2009, Part 8 Health, performance and conduct, [section 142]

[41] An important note for consideration in later chapters of this study is that during each of the cases at the centre of this study, i.e Camden Campbelltown Hospitals in NSW in 2001-2005 and Bundaberg Base Hospital in Queensland 2003-2005, neither state had mandatory reporting requirements in their regulatory state laws governing health professionals. In NSW, mandatory reporting of medical practitioners was required from 2008, but this requirement was replaced and broadened to apply to all regulated health professionals included in the National law by 2010 (HCCC, 2010).

report serious instances of sub-standard practice or misconduct by health professionals and/or serious cases of health professional impairment to the Australian Health Practitioner Regulations Agency (AHPRA). The notification is then referred to the appropriate professional board for investigation (*Health Practitioner Regulation National Law Act 2009*).

According to the Nursing and Midwifery Board of Australia (NMBA) (2010) the reporting requirements outlined in the Act are consistent with the ethical obligations under which nurses must safeguard their patients' wellbeing as set out in their professional code. Thus, the responsibility for nurses to report to an appropriate authority any incidents and events that threaten patient safety is codified and well documented.

As can be seen, nurses have been encouraged by their professional codes to take action and report unethical unprofessional conduct by other health professionals since as early as 1953. Nonetheless, there continues to be a reluctance to do so. Research into the ethical perceptions of nurses has identified various reasons for such a reluctance to report malpractice. The reasons include apathy, an assumption that no action will be taken, fear of retribution to their professional standing or personal lives, as well as negative physical and emotional affects (Ahern & McDonald, 2002; Attree, 2007; Black, 2011; Jackson, Peters, Andrew, Edenborough, Halcomb, Luck,

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[42] There are currently ten health professions included in the Act including are chiropractic, dentistry, medicine, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology (*Health Practitioner Regulation National Law Act 2009).*

Salamonson, & Wilkes, 2010; King, 2001; King & Scudder, 2013; Kingston, Evans, Smith, & Berry, 2004; Malmedal, Hammervold, & Saveman, 2009; McDonald & Ahern, 2000; McDonald & Ahern, 2002; Ohnishi *et al.*, 2008; Orbe & King, 2000).[43] Moreover, in many of the cases where the actions of nurse whistleblowers have been made public, the journey for the nurse has been a perilous one.

2.8 Conclusion

Whistleblowing is a complex and contextually based social phenomenon. Its definition is contested, with diverse interpretations largely dependent upon the disciplinary lens through which it is viewed. The introduction of the term 'whistleblowing' into contemporary discourse appears to have begun only within the last fifty years. Nonetheless, as seen in this chapter, nurses whose actions align with what is now regarded as whistleblowing are present in the literature as far back as 1853. The emergence of the patient rights movements, bioethics and the development of nurses' codes of ethics, taken together encouraged nurses to take a more active reporting role in the protection of patients, and when no action was taken to address their concerns as seen in the contemporary cases, it set the scene for whistleblowing.

[43] These research papers are examined in further detail in Chapter 3.

CHAPTER 3

REVIEW OF RESEARCH LITERATURE

3.1 Introduction

In this chapter, attention is given to contemporary whistleblowing research. The review begins with whistleblowing research in business and social science. It then focuses on research undertaken in Australia and internationally that specifically examines the whistleblowing and reporting behaviours of nurses in healthcare organisations. The challenges and limitations of researching this complex phenomenon are discussed. Meanwhile, gaps that remain and which can be answered by this study are highlighted.

3.2 Whistleblowing research: Contemporary findings

Research into the phenomenon of whistleblowing dates back to the 1970s, coinciding with the rise in interest in corporate social responsibility[44] and has primarily been driven by the business and social science disciplines. The bulk of whistleblowing research to date involves the corporate sector, the military or policing, although there have been some key studies examining the issue in health services.

Researchers from many different disciplines including sociology, psychology, ethics, law and business have examined the phenomenon of

[44] See Blumberg' s (1971) Corporate Responsibility and the Employee's Duty of Loyalty and Obedience: A Preliminary Inquiry.

whistleblowing. Early sociological and psychological researchers who sought to understand whistleblowing based their study on Latane and Darley's 1968-70 theory of 'bystander effect' (Miceli & Near, 2010).[45]

Building on this early work, social researchers derived a model of whistleblowing called 'prosocial organizational behaviour' (POB) which suggested that whistleblowing was not merely a single decision but a complex process (Dozier & Miceli, 1985; Miceli *et al.*, 2008). Those researchers using the POB model suggested that whistleblowing decision-making consisted of three phases. In the first phase, an employee witnesses a focal activity (wrongdoing) and perceives that no wrongdoing has occurred, and then no action is taken. Alternatively, if they perceived a wrongdoing, then they had to decide if there was anyone responsible for the action or the act to stop it. The second phase encompasses an employee witnessing wrongdoing that is not reported or corrected by others, who then develops a perception that the organisation tolerates bad behaviour. The third phase encompasses an employee's decision to report the wrongdoing on the basis of the avenues and actions available to them. It is in this phase that the employee weighs up the costs and benefits of their reporting action (Miceli & Near, 2010).

The POB model of whistleblowing also examines variables that may affect the employee's decision to blow the whistle, including 'personal' and 'situational' characteristics or an interaction of both'(Miceli & Near, 2010,

[45] Latane and Darley (1968; 1970) performed a series of experiments to explain why some individuals intervened when they witnessed crimes or emergencies, while others remained bystanders.

p. 76). In an attempt to gather empirical evidence to support many of their hypotheses and establish causal links between personal and situational characteristics, prosocial behaviour and whistleblowing, social researchers have gathered data from large surveys of employees who reflect on their past actions in reporting wrongdoing (Brown, 2008; Miceli *et al.*, 2008; Near, Rehg, Scotter, & Miceli, 2004; Rehg *et al.*, 2008; Rothwell & Baldwin, 2006).[46] They have also conducted experimental simulations depicting wrongdoing and then gathered data related to participants' stated intentions to report or blow the whistle (Ashkanasy, Windsor, & Treviño, 2006; Liyanarachchi & Newdick, 2009; Miceli *et al.*, 2008; Starkey, 1998; Trevino & Victor, 1992). The key challenge and weakness in these studies is that they rely on recollections and self-reported perceptions of activities from their past, which invariably 'is subject to errors in recall and specificity' (Brown & Donkin, 2008, p. 20).

Despite their acknowledged weaknesses, the studies cited have generated some important insights into the processes of internal reporting, particularly situational variables that promote or facilitate reporting such as:

- a perception that the problem will be corrected (Brown, 2008; Miceli *et al.*, 2008; Near *et al.*, 2004; Wortley, Cassematis, & Donkin, 2008),
- protection from retaliation (Brown, 2008; Liyanarachchi & Newdick, 2009; Mesmer-Magnus & Viswesvaran, 2005; Miceli &

[46] These social researchers include reporting wrongdoing to internal sources as whistleblowing and as such much of their research reflects the processes and inhibitors of internal reporting rather than the final (and here, the defining) act of reporting outside the organisation.

Near, 1984; Starkey, 1998; Trevino & Victor, 1992; Wortley *et al.*, 2008),[47]

- the observers level of moral development (Ashkanasy *et al.*, 2006; Dozier & Miceli, 1985; Trevino & Victor, 1992)
- seriousness of the offending behaviour or wrongdoing (Mesmer-Magnus & Viswesvaran, 2005; Near *et al.*, 2004; Wortley *et al.*, 2008)

As well as situational variables that inhibit reporting:

- more than one person involved (Wortley *et al.*, 2008),
- when the wrongdoer is more senior in the organisation (Near & Miceli, 1995; Wortley *et al.*, 2008),
- and reprisals such as perceived threat to career advancement (Miceli & Near, 1984).

The impact of demographic identifiers such as age, gender and tenure on internal reporting are not consistent in the research findings. International researchers have considered and then discounted independent demographic variables in whistleblowing behaviours. For example, age could not be separated from other variables such as tenure, role in the organisations, salary and status (Mesmer-Magnus & Viswesvaran, 2005; Wortley *et al.*, 2008). Gender is another difficult variable to isolate. For example, Wortley *et al.* (2008) identified females, particularly those employed in an organisation for a longer time as less likely to report wrongdoing. Mesmer-Magnus and Viswesvaran's (2005) meta-analysis of

[47] Protection form retaliation will promote reporting while its mirror image or reverse inhibitor is fear of reprisal. All of the researchers here indicated this dichotomy.

whistleblowing studies found the opposite was true. Others reported no relationship between gender and whistleblowing (Dworkin & Baucus, 1998; Lee, Heilmann, & Near, 2004).

Rehg *et al*. (2008) found women perceived a greater incidence of retaliation and proposed this as an influencing factor to explain the variation of gender-related incidents of whistleblowing in other studies. However, the validity of these assumptions can be questioned since the study involved 3288 US Air Force employees functioning under hierarchical structures and organisational cultures that differ from non-military organisations. Only 37% of their sample was female, and these were predominantly in 'nonsupervisory' roles (p. 229). These findings, then, must be taken with caution and consideration applied to the cultural and jurisdictional boundaries of the studies. The lack of consistency in demographic identifiers results in these studies being viewed as 'very weak bases for trying to predict who is likely to blow the whistle' (Vadera, Aguilera, & Caza, 2009; Wortley *et al.*, 2008, p. 54).

Two research designs used in the above social research studies have raised a number of questions. The first relates to surveys assessing participants' intentions to report wrongdoing after reading and reflecting on simulated scenarios. Mesmer-Magnus and Viswesvaran (2005) assert that 'measures of behavioural intention' account for as little as '10% of the variance in overt behaviours' (p.297). Citing Bagozzi's (1992) work on self-regulation of attitudes, intentions and behaviour, Mesmer-Magnus and Viswesvaran (2005) make the point that 'intention and actual overt action

are "separated" by extensive psychological, motivational, and implementation processes' (p. 279), which cannot be captured by the intention-based surveys adopted by social researchers.

The large-scale self-reporting surveys adopted by many of the researchers above are dependent not only on the memory of the employee, but may be affected by bias. Because whistleblowing is very contextual and these quantitative surveys offer limited or no capacity to share the context of the situation, there is insufficient data to offer robust conclusions about the phenomenon. Additionally all of these studies include internal reporting in their schema, consistent with the social research view that external reporting 'is a continuation of a dissent process, not an entirely different act' (Miceli & Near, 2010). However, many of the studies (the Australian public sector study is an exception) [48] did not explicitly identify the percentage of participants who reported outside of the organisation. Thus, for those researchers who view 'whistleblowing' as by definition the act of reporting outside of the organisation, many of the variables outlined in the social research cannot easily be extrapolated. While these research findings offer interesting insights, they did not include nurses; therefore these findings cannot be interpreted as applying substantively to whistleblowing and nurses.

[48] The incidence of external reporting or whistleblowing in the Australian study was 2.9 percent to an external agency or body in the first instance, 9.7 percent of whistleblowing involved an external agency or body at any stage of the process and less than 1 percent 'went outside official channels to the media at any stage-typically as a last resort' (Brown, 2008, p. xxv).

3.3 Whistleblowing research in nursing

The complexities and protections offered to health professionals who raise concerns about standards of practice, either internally or more controversially by whistleblowing to external authorities are also raised in the international literature. The level of discourse and research into the topic appears to have increased concomitantly with those calls for measures to increase patient safety and accountability for quality of patient care and the influential forces of bioethics, public expectation, law and regulation, discussed in the previous chapter. Nursing researchers have been slow to examine the complexities of the phenomenon, particularly since calls to report unethical and unprofessional conduct performed by other health professionals according to professional ethics began as early as 1953. Articles linking whistleblowing to nursing ethics began to appear in the 1980s,[49] when much of the published literature on the topic was first presented. [50] Research into nursing and whistleblowing seems to have begun with King (1994) [51] and since that time, there have been a range of studies examining the complexities associated with whistleblowing. These will now be examined.[52]

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[49] See Hull (1980), Kiely and Kiely (1987) and Fry (1989)

[50] See Fiesta (1990), Vinten (1994), Edwards (1996), Brodie (1998), Vousden (1998), Erlan (1999),Wilmot (2000), Yamey (2000), Peternelj-Taylor (2003), Vinten and Gavin (2005), Hannigan (2006), Tariman (2007), Duffin (2007), Graveson (2008), Lachman (2008a, 2008b), Myers (2008a, 2008b), Snow and Doult (2009), Gallagher (2010), Murray (2011) King and Scudder (2013) .

[51] Granville King is not a nurse. He completed his PhD in the department of Speech Communication at Indiana University. One of his supervisors was Dr Janet Near a prolific researcher on whistleblowing and co-author of the most recognised definition. In his literature review King (1994), laments that empirical research 'examining whistleblowing among nurses and physicians is either scarce or non-existent' (p. 2).

[52] A table outlining the studies that investigated internal reporting and whistleblowing reviewed in this chapter is available in Appendix 1.

Developing theory that accounts for the complex phenomenon of internal reporting and whistleblowing is difficult (Miceli *et al.*, 2008; Park & Blenkinsopp, 2009). Organisations have been known to block access to inquiry from outside researchers and use strategies similar to those that thwart whistleblowers in order to discourage employees from becoming research participants, particularly when there is a risk of revealing the realities of unprofessional and or unethical conduct (Mesmer-Magnus & Viswesvaran, 2005; Pierson, Forcht, & Bauman, 2007). This lack of opportunity to study whistleblowing behaviour directly has resulted in most researchers relying on indirect measures.

Indirect research methods have included: anonymous surveys asking nurses to draw on past lived experiences of reporting and whistleblowing events, avenues of reporting and outcomes (Black, 2011; Burrows, 2001; Davis & Konishi, 2007; Firth-Cozens *et al.*, 2003; Grube, Piliavin, & Turner, 2010; King & Scudder, 2013; McDonald & Ahern, 1999, 2000; McDonald, 1999; McDonald & Ahern, 2002; Moore & McAuliffe, 2010; Public Concern at Work, 2008), or surveys that provide nurse participants with scenario statements or full vignettes as examples of substandard practice or unethical conduct. These ask nurses to record their intention to report, suitable avenues of reporting and expected outcomes (Beckstead, 2005; King, 2001; King & Scudder, 2013; Malmedal *et al.*, 2009; Mansbach & Bachner, 2010). While these methods have provided instructive insights that help build an understanding of the whistleblowing phenomenon in healthcare, they share some of the same limitations identified with previous

social research. [53] They also fail to isolate the boundaries between the real-life phenomena of whistleblowing and the context in which it occurred.

Firstly, research methods that rely solely on participants recollections of past events must acknowledge that autobiographical memory is constructivist in nature, and retrieval is susceptible to biases based on current contexts (Holland, Tamir, & Kensinger, 2010). In other words, when the nurses were completing the questionnaire, both the original emotions of the experience and the 'emotional goals present at the time of retrieval' would affect their answer (p. 504). Holland *et al*. (2010) conclude that 'retrieval of events, even those that are highly emotional and remembered with a great deal of confidence, are not consistent across multiple retellings' (p. 504). Therefore, the results found by such studies require support by other forms of data and research, or cautious acceptance at the very least.

Research methods that provide nurse participants with vignettes and scenario simulations face limitations. First, it is not possible for researchers to correlate the stated intention captured in the response with subsequent action. Further the technique of using scenarios results in an oversimplification of the context, which limits its capacity to capture the complex and nuanced nature of the decision-making that surrounds nurse whistleblowing. [54] Vignettes and scenario simulations also fail to uncover the problematic interpersonal relationships that can occur as a consequence of reporting, not only with the person who committed the wrongdoing, but

[53] The limitation of the methods adopted by social researchers is discussed on pp.71 and 73 of this thesis

[54] As indicated previously in reference to Mesmer-Magnus and Viswesvaran a participants intention to report does not always reflect overt behaviour when they are faced with reality.

also with those to whom they report the wrongdoing. It would be impossible to simulate these in a written scenario. The contextualisation of the interpersonal relationship and reactions and or inaction of line managers throughout the reporting processes leaves a gap in this research. Nevertheless, these studies still contribute to building a picture of the phenomenon.

Employing anonymous surveys as a research strategy is understandable since researchers would find it near impossible to simulate in the clinical setting a wrongdoing serious enough to warrant action or to set circumstances that would precipitate reprisal because of reporting. For Miceli *et al.* (2008):

> The types and nature of wrongdoing and retaliation that would pass ethical or university research committee standards would likely not result in a design realistic enough or powerful enough to evoke meaningful variance across conditions.
>
> (p.26)

Other researchers recognise the limits of quantitative anonymous surveys in gaining and understanding of the contextual properties associated with internal reporting and whistleblowing and sought alternative qualitative or mixed method approaches. Orbe and King (2000), for example use a phenomenological approach to analyse 202 critical incidents (see footnote).[55] Attree (2007) and Ohnishi *et al*. (2008) recognise the lack of available substantive theory and use a grounded theory approach. Jackson *et al*. (2010; 2011; 2010; Peters *et al.*, 2011) produced a series of publications

[55] This study attached two critical incident open-ended questions to a larger exploratory quantitative survey of US nurses from Midwest (see King 2001).This research project gained 372 returned surveys (used for quantitative analysis) from registered nurses.

to release the results of their narrative inquiry study undertaken in Australia.[56]

Grube, Piliavin and Turner's (2010) mixed method study, quantitatively analysed 330 surveys and, when nurses identified that they would not report an incident that was considered 'unsafe', they were invited to answer open-ended questions designed to ascertain their rationale. Seventy-six responses were analysed using two theoretical frameworks: identity theory and group identity theory (Grube *et al.*, 2010). Grube *et al.* (2010) found that when nurses observed a high frequency of unsafe practices this increased their probability to report, particularly if they had the support of their supervisor. However, the nurses' role identity [57], risk and organisational values had little impact on internal reporting of unsafe practice. In the qualitative results of Grube *et al's* (2010) study the most cited answer to why participant nurses chose not to report was 'fear of repercussion' (p. 162).

From all the studies reviewed there is an emerging picture of internal reporting practices in healthcare organisations, as well as new knowledge related to whistleblowing - the act of reporting to an authority outside of the organisation. This picture involves nurses from the UK, US, Australia, Ireland, Japan, Israel, Norway, and New Zealand revealing the scope of the international problem. A further examination of their findings reveals the

[56] These qualitative studies relied on nurses recalling past reporting behaviour. In none of these studies did the researcher have access to the organisation's records to confirm the events had occurred. Thus like the quantitative studies that relied on recall, there is a risk of recall bias.

[57] Grube *et al* (2010) referencing the work of McCall and Simmons (1996) suggest that role identify occurs when the components of the self that correspond to social roles are internalised.

following key themes: not being listened to, lack of support, investigation and feedback and retribution/retaliation which will later inform the case study analysis outlined in Chapter Eight. The themes from whistleblowing research are now addressed.

3.3.1 Frequency of events observed

The most revealing finding from many of the studies was the frequency of bad clinical practice, error and or incompetence observed and reported by participants. In Moore and McAuliffe's (2010, p. 174) study 64 per cent of Irish nurse participants 'observed an incident of poor care as often as one to five times and 19 per cent of nurses observed incidents of poor care six to ten times in the past six months'. Seventy three per cent of Black's (2011) nurse participants from Nevada in the US had previously reported unsafe patient care, 30 percent of nurse participants in King and Scudder's (2013) study (n= 238) observed wrongdoing (n= 72) with 94 percent (n= 68) reporting it. In the UK two-thirds or 68 percent of the nurses 'said they had a concern about a serious risk to patient safety in the last three years and almost all (87%) raised it'(Public Concern at Work, 2008, p. 1 of 3).

The UK figures in the Public Concern at Work (PCaW) (2008) study match Firth-Cozens (2003) study performed five years earlier with 68.1per cent of nurses reporting poor clinical practice and 56.4 percent poor behaviour. In Japan, 42 percent of the nurses in Davis and Konishi's (2007) small study (n=24), recorded reporting another nurse for a wrongful act in the past, while 50 percent had reported a physician for wrongdoing. It is worth noting that wrongdoing, bad clinical practice, error and/or

incompetence were often not defined for the participants in these studies. Nevertheless given that it is estimated from research conducted in the US, UK, Australia, Canada, and New Zealand that between four and 16.6 percent of patients suffer harm from adverse events while hospitalised, and that approximately 50 percent of these could have been prevented (Johnstone, 2007), it is not unreasonable that nurses are observing and reporting to this level.

3.3.2 Methods of reporting

The method chosen to report and the person or authority to whom nurses reported is demonstrably contextual. [58] For example, 92 per cent of Japanese nurses in Davis and Konishi's (2007) study identified that reporting a colleague for wrongdoing depended on the results of first going directly to the wrongdoer. While in the US, 93 percent (368) of nurses identified that they reported to their manager or supervisor (Black, 2011). In Australia, McDonald and Ahern (2000) found that of the 70 nurses who witnessed and reported incompetent, unethical, or illegal situations in the workplace, did so by raising their concern verbally:

- 51percent (36) spoke to the wrongdoer,
- 60 percent (42) spoke to their supervisor,
- 40 percent (28) percent told the nursing administrator,
- 11percent (8) told the administrator of the organisation,

[58] It is important to note that the participants were given few alternatives to choose from, and no space to write comments on the context of the decision of how, and to who they reported to, at what phase of the process.

- 19 percent (13) verbally informed another professional e.g. Physician,
- while only 33 percent (23) documented in writing the wrongdoing on an official incident report form.

According to Grube *et al* (2010) contextual factors influence the probability of nurses using internal reporting mechanisms. In their US based study, the key factor found to have an impacted on nurses reporting actions was a rise in the frequency of observed unsafe practices. A higher rate in observed episodes, the greater probability of reporting. However, this was moderated by the strength or weakness of a nurses' role identity, whether the nurse had a strong organisational identity and if they perceived that they had supervisory support for the practice of reporting. In King's US based study (2001) the severity of the wrongdoing had the greatest influence on reporting behaviours. Whereas in King and Scudder's (2013) later study 'moral responsibility' featured as the strongest rationale for reporting (82 percent), with situations that violated their professional code as the second strongest (65 percent) (p. 632).

Reporting to an authority outside of the organisation presents a higher risk for nurses, although the actual incidence of this was found in most studies to be low. Only four percent of nurses identifying this as an option in the UK (Public Concern at Work, 2008), while Australian researchers McDonald and Ahern (2000) found ten percent recall that they resorted to complaining to an authority outside the organisation (none were to the media). McDonald and Ahern's findings are consistent with Brown's (2008)

larger Australian non-health sector study where 9.7 percent of whistleblowing involved an external agency, with less than one percent using the media. Other research such as Mansbach and Bachner's (2010) study of 83 Israeli nurses, found that internal rather than external reporting was the preferred option when considering an ethical dilemmas outlined in the two sample vignettes used. The results from research reviewed is consistent with known whistleblowing cases, as seen earlier in the Chapter Two where nurses first attempt to resolve the matter internally, before resorting to whistleblowing.

3.3.3 Not being listened to

A defining feature revealed by researchers was the notion that internal reporting 'would not be listened to' (Firth-Cozens *et al.*, 2003, p. 334; Moore & McAuliffe, 2010, p. 176). Referred to by Jones and Kelly (2014, p. 14) as the deaf effect' Coupled with this view was an expectation that little or nothing would be done (Attree, 2007; Black, 2011; Firth-Cozens *et al.*, 2003; Jones & Kelly, 2014; Moore & McAuliffe, 2010; PCaW, 2008). [59]

Research suggests that many nurses find that once they have reported internally there is insufficient feedback and/or action to deal with the concern raised. Managers reluctant to handle and address the problems which ward nurses had documented were evident in Cooke's (2006) qualitative study of discipline and misconduct in nursing. Cooke described

[59] Thirty- eight percent of Black's (2011) participants held this view; it was the number one reason cited by nurses in the PCaW (2008) study for not raising patient safety concerns; close to 13 percent of nurses in Firth-Cozens et al (2003) study identified that after reporting 'nothing happened to change the situation'(p.333); with 56 percent of nurses in Burrow (2001) study lamenting that it was unlikely to 'make any difference' (p.122).

features of ‘seagull management’ that had contributed to a defensive culture in nursing. Seagull management is a term applied by ward nurses to describe the actions of middle management who ‘fly in from a great height, make a lot of noise, drop a lot of crap, then they fly off again’(Cooke, 2006, p. 223). When ward nurses use documentation to protect themselves and report unsafe practice, such as insufficient or experienced staffing levels, they found that this ‘led to conflict, [since] these were matters that their managers did not want to see written down’(Cooke, 2006, p. 238).

Inaction by management to address the concerns sets the internal reporter on a path to becoming a whistleblower. As indicated by many researchers who have examined the complex phenomenon of whistleblowing outside nursing, internal inaction and a lower level of trust in, an support from, management can be a significant motivating factor to report to an external body able to affect action (Hunt, 1995; Miceli *et al.*, 2008; Wortley *et al.*, 2008).

3.3.4 Support

The level of support in their workplace for nurses who reported internally varied. Sixty four percent of the Nevada nurses, indicated that reporting wrongdoing was supported in their workplace (Black, 2011), compared to 53 percent in Norway (Malmedal *et al.*, 2009), 27 percent in Ireland (Moore & McAuliffe, 2010), and only ten percent of community nurses in Burrow’s (2001) UK study. Few studies examined what occurred to the level of workplace support when nurses chose to blow the whistle. One Australian study has done so, and found that for those nurses who raised

concerns outside, support inside the hospital all but disappeared, replaced instead by bullying, exclusion and damaged interprofessional relationships (Jackson, Peters, Andrew, Edenborough, Halcomb, Luck, Salamonson, Weaver*, et al.*, 2010).

3.3.5 Retribution/Retaliation

Fear of retribution and/or retaliation was articulated as the most common and consistent theme that contributed to the perception that there was a lack of support for reporting in the workplace.[60] The incidence this fear was reported in research studies is as follows: In the UK, fear of retribution was the most accounted reason for not reporting in Firth-Cozen *et al*'s study (2003).[61] With 47 percent of the nurses in Moore and McAuliffe's (2010) study and 44 percent of the nurses in Burrow's (2001) study sharing this view. In the US forty four percent of Black's (2011) participants indicated concern about retaliation, while in Norway the fear about what would happen was expressed by 16 percent of nurses (Malmedal *et al.*, 2009).

These nurses' fears were well founded. Research examples of actual retaliation include: victimisation from colleagues reported by over 27 percent of UK nurses (Firth-Cozens *et al.*, 2003) and nurses providing examples of suffering serious and or lasting damage to their careers (PCaW, 2008). In Australia twenty eight percent of nurse whistleblowers reported

[60] Retribution and retaliation are both forms of repayment or requital. Retribution more in terms of a punishment while retaliation in terms of requital for an injury or wrong (Yallop, 2005).

[61] Fear of retribution the highest factor identified by nurses as a rationale for not reporting. No percentage offered only a mean of 1.92 and standard deviation 1.17 (Firth-Cozens *et al.*, 2003). In the method section of the Firth –Couzens *et al* paper it explains that the questionnaire asked participants to nominate their reason for not going ahead with reporting scored on a four-point Likert scale, with scores ranging from 0-3.

official reprisals, which consisted of verbal or written reprimand, demotion, suspension and referral to psychiatrist,[62] while 100 percent reported 'unofficial reprisals' which included 'threats, isolation, ostracism and pressure to resign' (McDonald & Ahern, 2000, p. 318).

These studies did not present an encouraging picture of how healthcare organisations have dealt with internal reporting and whistleblowing. Attree's (2007) nurse participants identified a series of disincentives related to reporting wrongdoing including fear of repercussions, retribution, labelling and blame for raising concerns. The organisational culture in which these nurses worked was characterised as 'closed, concealing and blaming', which resulted in them reflecting that reporting wrongdoing 'was a high-risk: low-benefit act' (p.359 & 398). Orbe and King's (2000) US nurse participants also shared a number of negative repercussions, such as personal attacks and labelled as 'not a team player', as well as loss of job security. In Australia, Jackson *et al*. (2010; 2010) thematically reduced some of the negative experiences shared by their nurse participants into main themes which included a 'Climate of fear: *You are just not safe'* (2010b, p.2197) and 'Bullying and excluding: *They've just closed ranks'* (2010a, p.37).

Fear of and/or actual retribution as a motivating factor not to report internally is strongly supported by other research studies both in nursing (Calcraft, 2005; Duffin, 2007; Espin *et al.*, 2007; Grube *et al.*, 2010; Hunt, 1995; Kingston *et al.*, 2004; Throckmorton & Etchegaray, 2007; Uribe,

[62] Ten percent were referred to a psychiatrist (McDonald & Ahern, 2000).

Schweikhart, Pathak, & Marsh, 2002) and other disciplines (Brown, 2008; Eschenlauer, 2002; Liyanarachchi & Newdick, 2009; Mesmer-Magnus & Viswesvaran, 2005; Near *et al.*, 2004). Likened to a bee, an employee is seen to have only one sting and using it is career suicide (Burrows, 2001; Vinten, 1994; Yamey, 2000).

3.3.6 Impact of whistleblowing on nurses' health

The prevalence of fear and actual retribution/retaliation associated with whistleblowing has led some researchers to focus on the impact that this action has had on the nurse's health. Studies undertaken by McDonald and Ahern (2002) and later by Peters *et al* (2011) have shown that whistleblowing had a deleterious effect on both the emotional and physical health of the whistleblower. Adverse emotional and physical symptoms were also reported by the nurses who worked with the whistleblower and even the nurses who chose not to report.

It is clear that nurses who witness wrongdoing in health services, particularly cases where patients have suffered, often have to battle with 'more powerful others' either physicians or administrative hierarchies in order to protect patients (McDonald & Ahern, 2002, p. 24). If whistleblowing is then, the final action taken to raise awareness the outcome will often involve both personal and professional suffering.

Some of these forms of personal and professional suffering were referred to by the 14 whistleblower nurses in the study by Jackson *et al* (2010a) and include: being stood down, being moved from their primary ward, being encouraged to resign, and spoiled relationships with colleagues

that resulted in 'ostracism, marginalisation and open hostility' (p. 39). As summarised by Peters *et al*. (2011, p. 2910):

> For these participants, the whistleblowing had life and career changing ramifications and culminated in major changes, including having to take new jobs, sometimes in new cities and in new specialty areas.
>
> (p.2910)

The emotional distress experienced and expressed by the whistleblowing nurses in Peters *et al*'s (2011) study resulted in three themes:

- overwhelming and persistent distress: *I felt sad and depressed;*
- Acute anxiety, nightmares: I was having panic attacks and hyperventilating; and
- Flashbacks and intrusive thoughts: *I had all this playing on my mind.*

(p.2909)

The experiences of the nurse whistleblowers reported in McDonald and Ahern's study were similarly identified in the study by Peters *et al* (2011). However, McDonald and Ahern (2002) focussed on both whistleblowers and those who remained silent, non-whistleblowers. They suspected that both whistleblowers and non-whistleblowers would suffer from stress associated with witnessing misconduct and their findings confirmed this, with 94 percent of whistleblowers and 92 percent of non-whistleblowers reporting 'symptoms of stress-related emotional problems when they identified misconduct at work'(p. 19). Thus 'remaining silent in the face of misconduct [did] not seem to protect one from emotional pain' (p. 22). Feeling unworthy (guilt and shame) was reported higher (40 percent) by non-whistleblowers, compared to (19 percent) whistleblowers

(McDonald & Ahern, 2002). Whistleblowers more frequently reported feelings of disillusionment, distrust, loss of job satisfaction, loss of respect for the workplace and uncertainty about future.[63]

Unlike Peters *et al.*'s (2011) study, McDonald and Ahern (2002) also surveyed nurses about their perceived physical symptoms associated with stress linked to identifying misconduct at work. In the following categories, whistleblowers reported 'a higher percentage of' past symptoms: restless sleep, fatigue, insomnia, exhaustion, nightmares, increased smoking, weight and appetite loss, palpitations and chest pain (p. 21). In other categories, non-whistleblower reported a higher percentage of blood pressure, abdominal pain, digestive problems, irritable colon, weight gain, backache and headache. Both of these studies suggest that when misconduct and wrongdoing is not dealt with effectively in a clinical environment, this leads to stress as well as debilitating emotional and physical symptoms for all nurses.

The retribution faced by whistleblowers, particularly those disclosing to external public sources, has also been the focus of contemporary media with various movies presenting the complex experiences of both prominent real life and fictional whistleblowers. Movies such as *Serpico* [64] *(1973), The China syndrome* [65] *(1979), Silkwood* [66]*(1983)* and *The Insider* [67] *(1999)* all

[63] See McDonald and Ahern (2002, p. 23) See Emotion effects Figures 5-9

[64] Serpico, based on the true story of New York City policeman Frank Serpico who reported corruption in the New York Police to outside agencies and the New York Times. (Grant, 2003; Lumet, Maas, Salt, Wexler, & Kingsley, 1973).

[65] The China Syndrome follows the story of Kimberly Wells a reporter who is invited by Jack Godell the control room supervisor of the Los Angeles Ventana nuclear power plant to witness a radioactive leak and falsified documents and reports on the potential for a meltdown (Bridges, Gray, & Cook, 1979).

reveal the courageous acts by individuals who attempted to bring to the light misconduct by their own organisation that places their community at risk. In all these scenarios, going public occurs against a barrage of harsh personal and professional retributive consequences.

3.4 Conclusion

A review of contemporary whistleblowing research has found various themes that contribute to the development of theory to explain the complex phenomenon of internal reporting and nurse whistleblowing. Nevertheless contextual gaps remain, partly due to the methodological limitations of gathering empirical evidence from organisations keen to protect their own reputation and interests. Whistleblowing by nurses is a controversial issue, where some of the boundaries between the real-life phenomenon of whistleblowing and its context in acute health services remain unknown. Research on whistleblowing often lacks data enabling the phenomena to be placed within the context in which it occurred. In this study the large amounts of data made available via the Commissions of Inquiry have enabled a detailed description of the context.

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[66] Silkwood, inspired by the real life and suspicious death (car accident) of Karen Silkwood, who according to associates was on her way to meet with a New York Times reporter and union representative to present details of her investigation into alleged wrongdoing at the Kerr-McGee plutonium plant where she worked(Nichols, Ephron, & Arlen, 1983)

[67] The insider, follows the experiences of two intersecting whistleblowers, the first Jeffrey Wigand a scientist and vice president of research who attempted to bring to light the fact that the industry was aware of the addictive properties of cigarettes, and the second Lowell Bergman, CBS 60 minutes television producer who fights to have the Wigand interview, central to their expose on the tactics of the tobacco industry, go to air (Brenner, 1996).

CHAPTER 4

METHODOLOGY AND THE STUDY METHODS

4.1 Introduction

This chapter has at its focus a discussion of the comparative case study method used to advance the inquiry. First, attention is given to describing the methodology and key analytical theories, as well as examining their philosophical underpinnings. Attention is then directed, to discussing the research processes, such as sample selection, data collection and data analysis techniques, and to the processes used to ensure rigor, to identifying the strengths and weaknesses of the study, and finally to ethical considerations pertinent to the study.

4.2 Social phenomenon

For the purpose of this inquiry, nurse whistleblowing has been positioned as a social phenomenon. A social phenomenon entails a situation where a phenomenon (what is perceived and what is in question), together with the context in which it occurs, are intertwined (Yin, 1982, 2009). Fay and Moon (1994) explain, social phenomena consists of 'actions (and other events) which actually occur in particular places at particular times' (p.24). In sum, a social phenomenon may be described as a life event for which the explanations of why it occurred, shaped by the context in which it occurred, remain unknown. The nurse whistleblowing events examined in this inquiry constituted 'life events' - the contributing contextual factors of which, prior to this inquiry, had not been adequately explained and were unknown.

4.3 Methodology

Methodology refers to the main beliefs, and assumptions and philosophical underpinnings used to inform research practice. It influences such things as the types of questions asked, the manner in which data are collected and analysed (Holloway, 1997; Oliver, 2004). A critical approach to investigation requires researchers to overcome illusions and lay bare assumptions that may develop regarding the epistemological and political baggage that are brought to the research site (Kincheloe & McLaren, 2011). Enunciating one's worldview is especially important in this process since it establishes credibility and minimises criticisms of bias (Kincheloe & McLaren, 2011). This is particularly so in this study where a variety of theoretical and inquiry techniques is used (Sim & Van Loon, 2004).

A worldview and research practice is shaped by ontological and epistemological considerations. These are considered under separate subheadings below.

4.3.1 Ontological considerations

Ontology represents the form and nature of reality; what is known about reality and its measurability (Boden, Kenway, & Epstein, 2005; Oliver, 2004). There are varied ontological stances and manners according to which reality can be viewed, ranging from the notion of a single verifiable reality that exists independent of the human mind, to the belief that multiple, socially constructed realities can exist (Oliver, 2004; Patton, 2002). Positivists, for example, believe that an objective social reality exists external to the individual or human mind and the goal of positivist inquiry is to find generalisable laws that explain such

a tangible reality (Brew, 2001; McEvoy & Richards, 2006). However, the positivist belief in a single reality significantly limits understanding of human behaviours, which can be seen as complex and consisting of multiple realities.

Because this study seeks to understand the phenomenon of whistleblowing and the reporting behaviours of nurses, it could not be advanced by a foundation in a mere single verifiable reality. By acknowledging the existence of multiple socially constructed realities, the generation of rich knowledge about these complex human phenomena is enabled.

This study was guided by the following premises, each of which contributes to the research's ontological position.

- Reality is socially, historically, economically, and politically constructed (Fay, 1993; Kincheloe & McLaren, 2011).
- Reality is transformed by social interaction, with each interaction allowing the individual to construct and reconstruct new meaning (Lincoln & Guba, 2003).
- Humans view reality, and themselves, on the basis of their own personal experiences (Fay, 1987).
- At any point in time, multiple realities exist, and each person's perspective should be valued for the contribution it makes to understanding the phenomenon under investigation (Fay, 1987).
- Nothing about reality can be known for certain; one 'should never be arrogant or imperious about even our most cherished warranted beliefs: any of them may be false' (Fay, 1996, p. 208).
- Neutrality and objective truth can never be attained in 'reality'.

4.3.2 Epistemological considerations

The above ontological statements position the 'nature of the knower' and these conceptions of reality have significant impacts on the limitations of epistemology or 'theory of knowledge' brought to bear on the research (Boden *et al.*, 2005, pp. 41-42). In research, the concepts of ontology and epistemology are entwined; theories of knowledge generation are linked directly to beliefs governing the nature of the knower and the state of reality. Extending the previous example from positivist ontology, a positivist will propose that new knowledge can only be generated from a verified set of hypothesis where results demonstrate clear causal and effectual links (Lincoln & Guba, 2003). This view of a single verifiable reality outside of the human mind shapes a positivist's assumptions of the nature of knowledge. The positivist paradigm requires the researcher to put aside any preconceived ideas, and to seek objective 'facts' based only on directly observable relationships between dependant and independent variables. The resultant 'truth' transcends personal opinion and bias, and so knowledge consists only of that which is observed and measured, that is, empirical data (Denzin & Lincoln, 2003; Trochim, 2006).

The notion of putting aside preconceived ideas in the search for objective fact significantly limits the development of broad and meaningful knowledge on the phenomenon of whistleblowing. Whistleblowing is a complex human action, such that gathering objective quantitative data to verify a limited set of causal and effectual links would be inadequate to the task of answering the research questions guiding this study (Hoff & Sutcliffe, 2006). Therefore with the rejection of a single version of reality comes the adoption of a critical

epistemological position, one which assumes that humans, by their intelligence, curiosity, reflectiveness and wilfulness, are capable of altering their beliefs and behaviours and generating new knowledge (Fay, 1987, p. 48). This position also acknowledges that through enlightenment, empowerment, and emancipation, humans can transform for the better the injustices that restrict their access to a full and happy life (Fay, 1987, 1993; Kincheloe & McLaren, 2011; Lincoln & Guba, 2003).

4.4 Critical theoretical orientation

Applying an explicit theoretical orientation to the analytical process of academic research is essential if a project is to make a valid contribution to credible knowledge (Boden *et al.*, 2005). The analytical orientation applied to this project follows that of critical social theory (CST) (Fay, 1987) augmented by philosophical inquiry (Jameton & Fowler, 1989; Jecker, Jonsen, & Pearlman, 2007; Seech, 2004). It uses the basic scheme of CST developed by Brian Fay (1987) as well as principles of retributive and restorative justice as the central interpretive frame (Johnstone, 2009, in press). Other analytical tools such as documentary assessment, (McCulloch, 2004; Scott, 1990) and content and thematic analysis (Fairclough, 2003; Hale, 2004; Joffe & Yardley, 2004; Tonkiss, 2004), were also applied directly to witness transcripts and documents submitted in the Commission of Inquiry cases, as well as to other forms of evidence gathered.

4.4.1 The origins of Critical Social Theory

No universal definition or consensus explains the characteristics of critical theory or of critical social theory (Kincheloe & McLaren, 2011; Sim & Van Loon, 2004). Indeed, there are many critical theories, and the tradition continues to evolve (Sim & Van Loon, 2004).

The origins of Critical Social Theory (CST) can be found in the work of social theorists at the Institute of Social Research or Frankfurt School, founded in Frankfurt, Germany, in 1923 (Rodgers, 2005; Schneider, Elliott, Beanland, LoBiondo-Wood, & Haber, 2003; Simons, 2004). These scholars were deeply influenced by social upheaval amid the rise of fascism and Nazism. The early forms of CST were a direct reaction to the inflexible scientific Marxism used in the Soviet Union, and to the 'value free' positivist social science then prevalent in the West. The approach of traditional positivistic and scientific Marxism failed to account for oppression and power in social changes and did not offer any insight into the more practical aspects of research in the prevailing social milieu (Johnstone, 2009; Schneider *et al.*, 2003; Simons, 2004). Variants of critical theory have been influenced by French philosophers, by radical social justice movements such as feminism and civil rights in the 1960s, and by other social movements that examine the domination of people within modern society (Simons, 2004). Its scope ranges from classical critical theory to more contemporary and widely adopted critical theory.

Kincheloe and McLaren (2011) hypothesise that one reason that critical theorists avoid specific blueprints of their socio-political and epistemological beliefs is that they acknowledge the need for disagreement. Sim and Loon

(2004) suggest that the outcome of such a wide catalogue of analytical theories is that contemporary critical researchers operate in 'magpie fashion', choosing fragments of theory for their own personalised approach (p. 6).

This study uses Fay's CST to examine two case studies: the Bundaberg Base Hospital (Bundaberg Hospital Commission of Inquiry/Queensland Public Hospitals Commission of Inquiry) and Macarthur Health Service (Special Commission of Inquiry into Campbelltown and Camden Hospitals). Analysis of the case studies proceeded by using documentary analysis (DA), content thematic analysis (CTA) and philosophical inquiry (PI), with retributive and restorative justice providing the central interpretive bioethical frame.

4.5 Study Methods

The following section focuses on the approach adopted to address the research question underpinning this study. It provides and illustrates a rationale of the key analytical theories used to examine the two central case studies. It begins by explaining case study method and the decision to use more than one case. Attention is then directed to Fay's CST, explaining its role and the development of theoretical propositions required by case study method. It then provides insight into philosophical inquiry and the decision to use 'justice' as the central bioethical frame to address components of the research questions that could not be answered by the empirical data from the case studies. Finally, an outline is given of the selection of comparative sample cases.

These ideas are presented in Figure 4.1 a conceptual map of the study illustrating the two cases used, the three analytical methods applied and the consideration of the bioethical frame – justice.

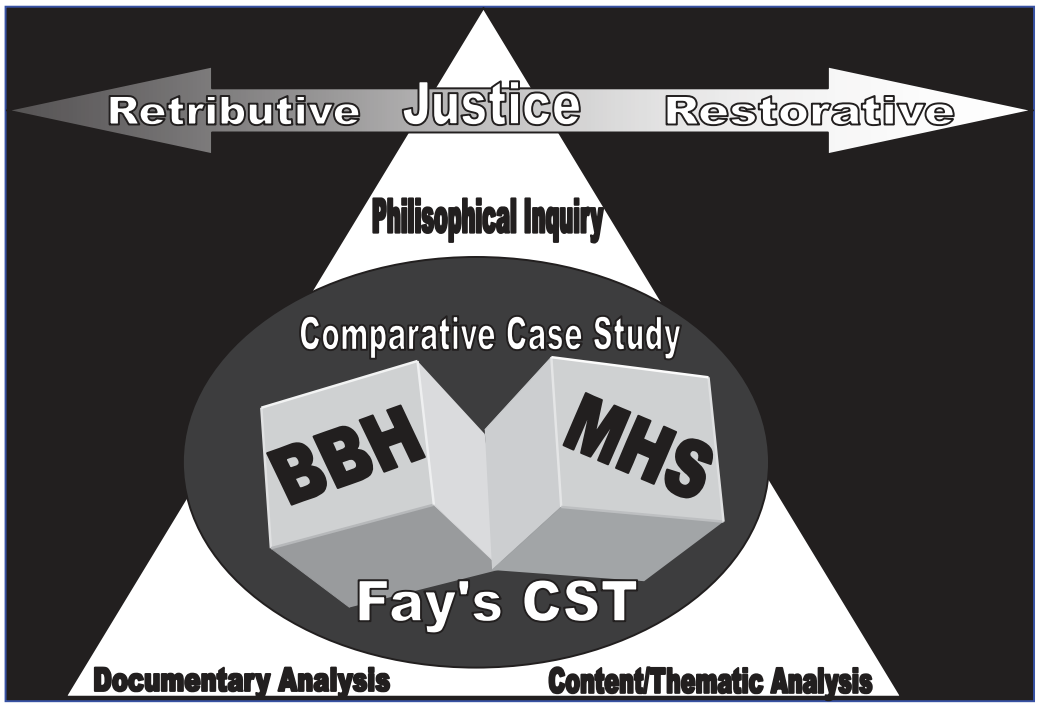

Figure 4.1: Method Conceptual Map.

4.5.1 Comparative case study

Case study is an approach that may be applied in qualitative inquiry when researchers wish to explore the complex interactions of human behaviour that are not readily distinguishable from their context (Luck, Jackson, & Usher, 2006; Yin, 2003a). The first two research questions informing this study are examined using case study method.

What is the nature of the social phenomenon of whistleblowing of substandard practice, unprofessional and unethical conduct in acute health services?

What are the contextual effects of power, information dissemination and ethics on the reporting behaviours of nurses?

These research questions require evidence that illustrated the social phenomenon and contextual properties of whistleblowing and reporting by

nurses in acute health services. Because of the noted lack of evidence in the preceding literature review, the boundaries between the real-life phenomenon of whistleblowing and its context in healthcare were not clearly known, and this condition directly influenced the decision to adopt a case study approach (Stake, 1995, 2000; Yin, 2003b).

Case study method seeks explanations as to 'how' and 'why' of social phenomena and their contexts are related, as well answers to the 'what' questions that provide the basis of descriptive evidence (Yin, 2003b). Multiple case studies required the researcher to attain an understanding of the uniqueness and complexities of each case (Stake, 1995). Situating the case study within a critical frame is necessary in order to explain the cases and reveal the social relationships that allowed the circumstances to occur, and finally, to explain this in such a way that the research can become the catalyst for transformation (Neuman, 2011). Adopting more than one case in the unit of analysis enhances generalisability and thus necessarily increases the power of conclusions.

The two cases chosen to provide evidence into the complex phenomenon of whistleblowing nurses are the public inquiries of Bundaberg Base Hospital in Queensland and the Macarthur Health Service in NSW. Each case had as its focus the investigation of claims of unprofessional and unethical conduct that resulted in adverse clinical events, reported publicly by nurse whistleblowers (HCCC, 2003; Queensland Government, 2005b).

Examining more than one case is a strategic choice since doing so exposes more than one organisational structure and allows the researcher to seek to uncover the mechanisms or prior events and conditions that led to

whistleblowing (Littlejohn, 2003; Wainwright, 1997). Revealing and confirming the causal conditions in more than one case of whistleblowing and the reporting behaviours of nurses was an important tenet, in keeping with the critical frame, as it ensured that the evidence generated was robust (McEvoy & Richards, 2003; Yin, 2003b). Yin (2003) recommends that each case be selected for theoretical replication to determine if the results support or contradict the initial set of propositions. In this process a rich theoretical framework is developed (Yin, 2003b). Each case is considered as 'whole', with individual reports that link to the initial propositions outlining whether the proposition is confirmed or found to be unproven (Yin, 2003b, p. 50).

4.6 Fay's basic scheme of critical social science

When choosing a frame to interpret and guide the organisation of complex phenomena into reasoned and clear categories, it is important to select one that fits the purpose of the study (Kaufman, Elliott, & Shmueli, 2003). The central purpose of this study was to illustrate the social phenomenon and contextual properties of whistleblowing and reporting by nurses and to uncover the organisational distortions and constraints that might impede or enable nurses' free, equal and un-coerced participation in the upholding of shared principles of patient safety and quality care. The interpretive framework of Fay's CST (CST hereafter) was chosen precisely because of its capacity to instruct and inform responses to the research questions.

The use of case study method employed in this research required the researcher to explore complex interactions of human behaviour within the context in which they actually occurred (Yin, 2003a). It also required the

researcher to develop theoretical propositions about the causal relationships within such behaviour (Yin, 2003b). The four major theories of CST all focus on explaining individual features of a social situation, providing rich guidance to develop theoretical propositions that can then be examined using the case data.

4.7 Examinations of power

This inquiry adopted a situated conception of power. First, it highlighted that power exists in a co-relationship between the *disempowered* and the *empowered*, where both sides contribute to its existence. An important aspect of CST is the recognition that the disempowered are recognised as co-contributors to power. Second, the inquiry called attention to the role that a 'social field'[68] plays in the constitution of power relations, and in doing so draws on a wealth of theoretical exploration that has been undertaken over the past three decades. This exploration is particularly pertinent to this inquiry as it provides important insights into the bases of power and the different forms it can take. Finally, it is acknowledged that most power relationships are mixtures of various forms of power and that rarely, if ever, are they found in a singular or pure form. Acts of power are inherently part of a broader network of social interaction (Fay, 1987).

To progress this inquiry it has been necessary to first establish a working definition of the term *power* and to contextualise its application as an interpretive frame to guide the textual analysis of the documents sampled. To this end, first, consideration is given to the etymological origins of the term

[68] 'Social field' represents the wider social context in which two social agents (the dyad of the powerful agent and the subordinate or disempowered agent), interact. By recognising the existence of a social field, one concedes that 'peripheral social others' (Wartenberg 1992, p 80), as well as the external environment are important features in the conception of power.

'power'. Following this, a critical examination is made of the various theoretical underpinnings of renowned contested conceptualisations of power, notably those advanced by Giddens (1982; 1984; 1985), Parsons (1963), Foucault (1980), Fay (1987), Wartenberg (1992), Wrong (1979, 1995) and French and Raven (1959; Raven, 1988; Raven, 2001; Raven *et al*., 1998). Finally, a summative statement is made and a comparative table outlining the different forms and bases of power is presented.

4.7.1 Etymology of the term 'power'

The word power originates from the Anglo-French noun *poër* and the Latin verb *potere*, meaning 'to be able' (Marquis & Huston, 2009, p. 321; Simpson & Weiner, 1989). The Oxford English Dictionary (1989, p. 259) defines power as the 'ability to do or effect something or anything, or to act upon a person or thing'. This 'something' often refers to the controlling, influencing or willing of others (Clegg, 1975, p. 1). Arriving at a universal definition of 'power' that can be used across social science disciplines has resulted in deep-seated disagreement (Powell, 2007) and theories of power have been marked by debates that span ideologies and philosophies (Thye, 2007). The definitions above fail to recognise the different forms that power can take and the various processes underpinning them. As indicated by Lukes (1974), power is fundamentally a contested and complex term. The formation of a working definition of power to frame this study must thus take into account the various theoretical understandings of what power is. It is to providing such an account that the discussion now turns.

4.7.2 Giddens on power

The ability or capacity to act indicated in the origins of the word power implies the action of a human agent. In Giddens' (1984) explanatory theory of power, the human agent and their ability to act, or 'human agency', are inextricably linked. Giddens describes human agency as not only the *intention* that a person has, but their *capacity* to do something in the first place.[69] He implies that a human agent has a choice regarding whether to act or not, or to 'act otherwise' (Craib, 1992; Giddens, 1984, p. 14 & 15). This is essential to his proposition that human power has a 'transformative capacity' which he defines as the 'capability to intervene in a given set of events to as in some way to alter them' (1985, p. 7). Giddens' (1984) proposes power as an action deployed by the human agent to achieve outcomes; to 'influence a specific process or state of affairs'(p. 14).

In regard to an agent's capacity to act Giddens' (1984) recognises that an individual's power or 'capability to make a difference' can be 'confined by a range of specifiable circumstances'(pp. 14-15). Although he claims that human capability is constrained and often controlled by contextual elements within the institution in which the action takes place, he does not clearly identify these (1982a). Instead, Giddens' (1984) invites researchers to identify these elements within their own field of study and consider the 'duality of structure' in power relations that consists of rules and resources, or what he describes as the media in which power is exercised (p.15). A key aim of this study is to improve understanding of the factors that act to constrain nurse whistleblowers'

[69] Here Giddens (1984) returns to the Oxford English Dictionary for the definition of *agent* and finds it there to mean 'one who exerts power or produces an effect' (p.9)

capacities or actions. In light of this, Giddens' theory is not appropriate. This is because Giddens' theory does not offer a distinction between 'action' and 'power', nor does it enable clarifications to be made of the institutional circumstances or elements which may constrain individual capacity.

4.7.3 Parsons on power

Parsons is another of the many philosophers to have examined power. Unlike Giddens, who links power to agency, intent and capacity, Parsons places power within a larger contextual scheme (Parsons, 1963b). He argues that power is a property of social community, a network of relationships, 'a circulating medium' that, as a construct, can be used to analyse large-scale and complex social systems (Parsons, 1963b, pp. 232, 236). Parsons clearly identifies the productive and enabling features of power while linking it to the medium of exchange and control (Clegg, 1989; Robertson & Turner, 1991). He often uses the example of money to illustrate the complexities of his theory (Parsons, 1963a, 1963b).

While Parson's work on explaining power was influential and challenged many of the conceptions of power upon its publication in the 1960s, his structural-functionalist focus on the economic and productive aspects of power resulted in considerable criticism (Dowding, 2011). Many claim his concept of power fails to acknowledge a theory of conflict or theory of change (Clegg, 1989; Giddens, 1984; Robertson & Turner, 1991; Wrong, 1995), an important feature of any critical approach. As such his work is limited in that it provides 'no concept of power but only a notion of influence' (Robertson & Turner, 1991, p. 10).

Yet, despite these criticisms, there are some elements of Parsons' work, particularly when organisations are examined, that resonate with this research. The notion that shared values and communal trust define positions of authority and leadership are particularly relevant when examining social organisations such as hospitals. Thus, although Parsons theory of power is not directly included in the interpretive frame, elements related to his theory of influence have merit and are explored in Appendix 2 as a base of power.

4.7.4 Foucault on power

Foucault is one of the most influential writers on the subject of power (O'Farrell, 2005; Scott, 2001; Wrong, 1995). Like Parsons, Foucault places power within a larger conceptual scheme. For instance, he describes power as something which

> circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing or exercising this power… in other words, individuals are the vehicles of power, not its points of application.
>
> (Foucault & Gordon, 1980, p. 98)

Central to Foucault's position on power is his desire to 'reverse the mode of analysis' that previously considered power as an entity or capacity, which can be possessed by a state, a class or an individual (Foucault & Gordon, 1980, p. 95; O'Farrell, 2005; Scott, 2001). According to Foucault, previous examinations of power focus on 'general mechanisms of power' and the

'modes in which power was exercised' in terms of the relationship between a sovereign and its subjects (Foucault & Gordon, 1980, p. 104).

Foucault (1980) refers to this limited examination of power as reflecting a theory of sovereignty,[70] where power is conceived as being possessed by individuals or social bodies, or analysed by considering 'conscious intention or decision' (p. 97). Foucault presents his concept of power as an 'antithesis of that mechanism of power which the theory of sovereignty describes or sought to transcribe' (Foucault & Gordon, 1980, p. 104). Through his work in factories, prisons, the military, asylums, schools and hospitals, Foucault attempts to illustrate a new approach to power: modern power (Fraser, 1981; Scott, 2001). Unlike sovereign power, Foucault's view of 'modern power'[71] incorporates both the authoritarian features of sovereign power and the emergence of expertise or disciplinary power that includes a new regime of power/knowledge (Foucault & Gordon, 1980; Fraser, 1981).

There are important features of Foucault's work, such as the linking of knowledge and power, that are useful for this research, particularly its focus on discipline and expertise as mechanisms of power. However, the overall concept of power offered by Foucault is amorphous, a flaw recognised by others (Clegg, Courpasson, & Phillips, 2006; Giddens, 1982b; Wrong, 1995). Consequently, while Foucault's work offers rich, interconnected arguments for describing

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[70] The theory of sovereignty being the 'discourse of right from the time of the Middle Ages'(Foucault & Gordon, 1980, p. 95). Foucault's theory of sovereignty stems from his historical analysis of monarchies, law and politics.

[71] Modern power, according to Foucault (1980), lies outside of sovereignty. He explains that power in modern societies stems from more than just the 'right of sovereignty', but also includes a 'mechanism of discipline' or 'disciplinary power' (pp. 105-106). Disciplines possess the discourse of rule – not the rules of law, but of normalisation – which is comprised of the 'procedures, practices, objects of inquiry, institutional sites, and, above all, forms of social and political constraint' (Foucault & Gordon, 1980; Fraser, 1981, p. 276; Scott, 2001)

power as a circulating medium, critics such as Fraser (1981), argue that his lack of specificity, and descriptions of power as being 'everywhere' results in an inability to unmask the characteristics of modern power and 'ends up, in effect, inviting questions which it is structurally unequipped to answer' (pp. 280-281). Therefore, in this study and the quest to develop an operational definition of power, Foucault's work and concept of power will be considered only peripherally. The concept will instead be examined at its most basic level: as the social relation between two agents.

4.7.5 Fay on power

Fay (1987) theorises power as a 'dyadic' concept involving a social relationship between 'the powerful and the powerless, with both sides contributing something necessary for its existence' (p. 120). The dyadic nature of power counters theories that either view power as an external force, or that do not acknowledge or recognise the contribution of the powerless or disempowered. Like Giddens, Fay argues that unless the disempowered are recognised as contributors to power, strategies to ensure a change of power relationships within society will not be found. This conception of power fits well with the emancipatory goal of CST and the anticipatory notion that straightforward strategies will empower nurses in the future. However, other influences need to be considered within the concept of power. Fay (1987) briefly acknowledges these 'exercises of power' as force, coercion, manipulation and leadership (p. 120). The success of each of these exercises of power is contingent on the allegiance of followers, without which, the ability to generate affect is doomed (Fay, 1987).

Fay's (1987) conception of power highlights the social relationship between the powerful and powerless, but lacks a developed consideration of forms or bases of power. He provides consistent reminders that 'power rests with the voluntary obedience of the powerless' (p. 131) and that emancipation enables the powerless to reshape their self-conceptions, particularly of their present relationships in terms of the 'exercises of power'. Within the context of this research, it is proposed that in order to achieve emancipation, nurses must first identify their own contribution and status in the power dyad. In order to reshape self-conceptions, however, further knowledge is required about the social field in which forms or bases of power are exercised.

4.7.6 Wartenburg on power

Wartenburg (1992) claims that Fay's dyadic concept of power misses the fact that power is situated within social contexts. Advancing his thesis of a 'situated conception' of power Wartenburg claims that 'social power relationships require a social field that goes beyond the two central agents' since power relations are often created by 'social others' who are not directly involved in the dyad itself (p. 87). Wartenburg identifies such things as institutional power and expertise, these bear a close resemblance to French and Raven's classic typology (1959; Raven, Schwarzwald, & Koslowsky, 1998). The forms and bases of power explored by Wartenburg and theorists above are summarised in Appendix 2.

4.7.7 Forms and bases of power

It is important to be aware that, in reality, different forms or bases of power blend, integrate and overlap, and are rarely found as pure examples (Wrong, 1995). Accordingly, not even an exhaustive taxonomy of the bases of power can fully represent its complexities and varied nature. Wrong (1995) asserts that stable power relationships are often successful because they use multiple forms of power. For example, Krause and Kearney's (2006) research in hospitals, schools, orchestras and companies demonstrates that the number and importance of power bases (from existing classifications) vary considerably depending on the context in which they occur. Thus the choice of power bases considered in an analytical frame must take into consideration 'specific context conditions, because different power bases become salient depending on situational variables' (Krause & Kearney, 2006, p. 69).

4.8 Philosophical inquiry and ethical reasoning

The strategies of philosophical inquiry and ethical reasoning were also applied as an adjunct to the comparative case study approach since it is known that not all knowledge can be derived from empirical research (Jameton & Fowler, 1989; Johnstone, 2004a). Philosophical inquiry and ethical reasoning are analytical tools that attempt to provide answers to research questions that cannot be answered by the empirical evidence alone (Jameton & Fowler, 1989; Jecker *et al.*, 2007; Kikuchi & Simmons, 1992). For example, a determination of the types of ethical issues that confront nurse whistleblowers is capable of being derived from the case study evidence. However, developing this further

in order to assess ethical propositions, such as whether nurses were justified in their actions requires a philosophical approach (Nagel, 1987).

According to Nagel (1987) philosophical inquiry proceeds by 'asking questions, arguing, trying out ideas and thinking of possible arguments against them, and wondering how our concepts really work' (p. 4). The results of this process lead to a logical progression of ideas with sound reasoning to underpin it. Ethical reasoning is used to support ethical judgements in specific cases (Jecker *et al.*, 2007).

4.9 Justice - the central bioethical interpretive frame

Ethical propositions related to nurse whistleblowing were examined using 'justice' as the central bioethical interpretive frame. It must be stated, however, that a single unifying principle of justice in bioethics has not been quantified and defined, and there continues to be philosophical debate about the concept (Johnstone, 2009, in press; McCullough, 1981). Nonetheless, justice, both as a concept and principle, appeals to the human need for coherence and regularity (Shelp, 1981; Taylor, 2003, 2006).

4.9.1 Justice

Theories and principles of justice have been developed and refined over time, each influenced by prevailing values held within a society (Shelp, 1981). Although a single unified theory of justice is elusive, there is nevertheless a consensus in the bioethics literature that conceptualisations of justice encompass the central themes of fairness, desert and entitlement (Beauchamp &

Childress, 2013). The most common of these themes will now be examined, followed by a justification of their adoption or otherwise.

4.9.2 Justice as fairness

Contemporary conceptualisations of 'justice as fairness' are credited as having originated in the 1958 work of Harvard University philosopher John Rawls (Audard, 2007). The concept was further developed and became a central theme in his 1971 book *A Theory of Justice,* a classic text in the field of social and political philosophy (Audard, 2007; Rawls, 1971). Rawls work on justice as fairness contains two central principles, the first being that 'each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others' (Rawls, 1971, p. 60; 1999, p. 53). The second deems that

> social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all.
> (Rawls, 1971, p. 60; 1999, p. 53)

The first principle deals with social and political influence on individual freedoms to think, speak, choose particular lifestyles, and differ in political and religious allegiance (Schneewind, 2001). The second suggests that social and economic inequalities are to be managed by institutions to ensure equity in the distribution of primary (social and economic) goods and that everyone has an equal chance to access these goods (Denier, 2007). It is this principle that governs the distribution and access to primary goods that has been advanced and linked by others to healthcare delivery (Nolan, 2013). Denier (2007) warns that while Rawlsian theory offers a frame in which to reflect on healthcare, the object of Rawls' inquiry was social justice with little reference to healthcare.

Denier (2007) further points out that 'health, sickness, medicine or medical care' do not exist in Rawls index of primary goods.[72]

Rawls' concept of justice also fails to take account of the subjective differences in health, where some people experience a greater subjective need than others. This concept is explored in depth by Nussbaum (2006), who argues that the tension in Rawls' theory centres on his failure to consider differences in each person's capacity (Denier, 2007).[73] Thus, while justice as fairness argues that each person in society should have equal access to adequate levels of healthcare, there continues to be fierce debate surrounding the constituents of 'adequacy' (Beauchamp & Childress, 2013; Darr, 2005)

Adequacy of health service delivery stems from the recognition that healthcare is not an endless resource that can meet the expectations of all individuals in the community. As such, healthcare must be distributed. In these circumstances theories of distributive justice have been proffered to help address this debate, as they are concerned with the 'distribution of scarce resources and opportunities among the individuals in a given society' (Matravers, 2007, p. 65).

4.9.3 Distributive-redistributive justice

Conceptions of distributive-redistributive justice represent the view that all people are entitled to an equal share of the benefits and burdens of society (Beauchamp & Childress, 2013; Johnstone, 2009). The concept of distributive

[72] The lack of an explicit reference to healthcare in Rawls condensed index of primary goods has been considered by many critics, who argue that adopting a model using 'primary goods' at its focus is inflexible when significant variations exist in expectations of what constitutes a primary good (Denier, 2007).

[73] Nussbuam's (2006) work examines the place of 'people with severe and atypical physical and mental impairments' in society (p. 14).

justice has been applied to debates about universal healthcare models that allow all members of the society to access medical care, as well as dealing with programs that address the known social determinants of health and reduce the burden of disease (Glannnon, 2005; Waymack, 2001). Distributive justice appears to be the most frequently debated conception of justice in healthcare, with empirical evidence showing that unfair distributions of healthcare linked to race, gender and economic status (Daniels, 2006; Smedley, Stith, & Nelson, 2003).

Although interesting and central to the debate of justice in healthcare, neither the concept of fairness nor distribution-redistribution will adequately inform the complex phenomenon of whistleblowing. While breaches in patient safety can be viewed as patients not being afforded their just deserts, it is difficult to see how examining the data from the commissions of inquiry with these frames could elucidate new knowledge. Instead, a closer look at the actions and reaction within organisations to instances of whistleblowing led to theories of justice outside those commonly described in bioethics. In this search, two forms more common in legal ethics were found: retributive justice and restorative justice.

Retributive justice informs propositions central to the theory of false consciousness,[74] as it adequately describes the reactions that follow the act of whistleblowing, while restorative justice frames the propositions essential in the

[74] False consciousness is characterised by self-misunderstanding. Specifically, it is the manner of thought that precludes the thinker from comprehending the true nature of their social situation (Fay 1987). The nurses' false consciousness stemmed from their underlying expectation that their formal complaints of substandard clinical practice, unprofessional and/or unethical conduct would be investigated and that appropriate action would be taken. This is further examined in Chapter 8 of this thesis

theory of enlightenment. Both retributive and restorative justices are examined below with insights into how they relate and frame propositions within Fay's CST.

4.9.4 Retributive justice

Retributive justice applies the notion that offenders or rule violators get their 'just deserts', where punishment is the response to the event of injustice or wrongdoing (Maiese, 2004; Moriarty, 2002; Victor, Trevino, & Shapiro, 1993, p. 225). The act of punishment attempts to reinforce the rules that are perceived to have been broken and to restore the balance of justice. Proponents of retributive justice believe that the act of punishment restores the 'victim and offender to their appropriate positions relative to each other'(Maiese, 2004 para. 3). One significant negative outcome related to the application of retributive justice is the tendency for retribution to become revenge (Maiese, 2004), that is, where retribution reflects ancient biblical notions of an 'eye for an eye' (Exodus, 21:23-21:27).

The term 'retributive justice' is most commonly found in literature and debate surrounding criminal legal cases and social psychological research. Retributive justice reactions have been acknowledged to occur in large corporate organisations and even informal settings such as the family (Vidmar, 2002). It has also been recognised as a core construct in organisational justice in business ethics, where research has been undertaken to determine its influence on peer reporting (Victor *et al.*, 1993). While no direct references to the term retributive justice were found in nursing or medical literature it is interesting to note that the term 'fear of retribution' and of blame following the

reporting of error that harmed patients is commonly reported (Hebert, Levin, & Robertson, 2001; Kinnaman, 2007; Runciman, Merry, & Tito, 2003).

This descriptive language of 'name, blame, shame' and other forms of retribution that follow self-reporting of error, internal reporting or whistleblowing in the clinical setting, demonstrates a link to the concept of retributive justice (Cohen, 2001; Ehrich, 2006; Erlen, 1999; Hyman & Silver, 2005; Kinnaman, 2007). Particularly where the focus is on punishment as a normative tool to maintain behavioural standards or the status quo by making an example of the rule violator (Victor *et al.*, 1993). As seen in the literature reviewed for this inquiry the actions of management and their attempts to silence whistleblowers with retribution is very much about maintaining the reputation of the organisation and the status quo. It appears that elements of retributive justice currently dominate healthcare culture where whistleblowers and those self-reporting error are themselves attributed with blame, which inhibits open disclosure to the victims and those who may be positioned to rectify antecedent causes (Runciman *et al.*, 2007; Runciman *et al.*, 2003).

Alternatives to retribution and blame, elements central to retributive justice, have been proposed by health professionals within the industry open disclosure policies are proffered as one model to re-establish trust between patients and health professionals, as well as provide a focus on cooperative measures to examine antecedent causes and prevent further episodes of error (Kinnaman, 2007; Runciman *et al.*, 2003). This vision and desire for a transition from retribution to cooperation and healing are principals found in the concept of restorative justice.

4.9.5 Restorative justice

Restorative justice is viewed as a process that actively involves all stakeholders implicated in the injustice to collectively acknowledge and address the 'harms, needs and obligations in order to heal and put things as right as possible' (Braithwaite, 2006, p. 36). The notion of restorative justice to address conflict and injustice within a community has been around for centuries, although in Western societies justice was transformed away from restoration following the Norman conquest of Europe at the end of the Dark Ages, when crimes were no longer seen as those committed against individuals but against the Crown (Braithwaite, 1999; Van Ness & Strong, 2002). While notions of restorative justice have remained strong in some indigenous cultures, in mainstream Western society it only began to re-emerge in the 1970s when critics sought new models to reform the criminal justice systems and to move them away from dominant retributive and rehabilitative models under the control of legal professionals (Braithwaite, 1999; Dzur & Olsen, 2004; Van Ness & Strong, 2002).

Although this theory is more commonly practiced and researched within the criminal justice sphere, proponents of restorative justice recognise that its principles can be applied more broadly. Braithwaite (2006) argues that it has the potential to be applied in 'all institutions of private and public governance at any point where injustice is experienced'(p. 34). Certainly hospitals are institutions were injustices can and do occur. It is worth remembering that the modern format of restorative justice is a fairly recent development, and more time and debate is required to translate its critical values into modern day

practices, particularly those outside the criminal justice sphere (Braithwaite, 1999; Johnstone & Van Ness, 2007; Morris, 2002). However, Braithwaite (2006) contends that although there is no clear settlement on the values of restorative justice, one value that remains paramount is that 'because injustice hurts, justice should heal' (p.36).

Restorative justice theory recognises that the implications of a crime or offence and the subsequent legal process are felt not only by the victim, but also the offender, community and government (Van Ness & Strong, 2002). When errors occur and patients are harmed in healthcare, there is always a risk that further injustice can occur. Restorative justice theory offers a new way to examine the harm. Open disclosure is just one of the strategies that attempt this.

4.9.6 Open disclosure

Application and consideration of some of the key values and processes in restorative justice theory are starting to become apparent in healthcare. Restorative justice values can be seen in the ongoing debate surrounding management strategies of adverse events in clinical practice. There has been a historical paradigm shift away from never discussing medical errors and adverse events with affected patients, to the practice of 'open disclosure', which focuses on finding opportunities for system improvement (Koh & Alcock, 2007; Levinson & Gallagher, 2007; Victorian Government Department of Human Services, 2007).

Open disclosure refers to communication with the patient and support person when adverse events occur in healthcare. Recommended communication includes an expression of regret, a factual explanation of what happened,

consequences of the event and finally, what steps will be taken to manage the event and prevent recurrence (Australian Council for Safety and Quality in Health Care Complaints Commission, 2005; Madden & Cockburn, 2006). Within the principles of open disclosure, there is recognition that staff should be supported through the open disclosure process, which demonstrates a shift in thinking from a 'name, blame and shame' reaction to recognition that more than the patient is adversely affected by the injustice of an adverse event.

Although the Open Disclosure Standard developed by the Australian Council for Safety and Quality in Health Care (ACSQHC) were endorsed by Australian Health Ministers in 2003, barriers to its implementation continue to be raised (Civil Litigation Committee, 2002; Gilmore, 2002; Madden & Cockburn, 2006). Threats of litigation, legal and insurance requirements, as well as organisational cultures within the hospital that are reluctant to support employees who make mistakes, have all slowed implementation of the standard (Civil Litigation Committee, 2002; Gilmore, 2002; Levinson & Gallagher, 2007). However, open disclosure continues to be a priority for those involved in the national patient safety movement, particularly the ACSQHC. Additionally, patients themselves support an emphasis upon change in the management of adverse events in clinical practice. Research undertaken to examine patient perspectives of 'patient-provider communication' following adverse events clearly shows that patients who have been injured while hospitalised desire honest and open communication about the incident, as well as being briefed on 'what is being done to prevent recurrence' (Duclos *et al.*, 2005, p. 483).

4.9.7 Therapeutic jurisprudence

The principles of restorative justice can also be uncovered in therapeutic jurisprudence and in debate on models of regulating health professionals, particularly in the context of disciplinary investigations and hearings that deal with unprofessional conduct (Freckelton, 2006; Freckelton & Flynn, 2004; Kjervik, 2005). Therapeutic jurisprudence has as its focus studies of the action of law and discerning its therapeutic or counter-therapeutic potential (Freckelton & Flynn, 2004). Those who advocate therapeutic jurisprudence recognise that legal processes impact not only on the victim, but on the emotional and psychological wellbeing of each of the stakeholders (Freckelton, 2006).

Therapeutic jurisprudence draws attention to the health consequences of legal decision-making and creates an opportunity for constructive improvements, rather than a focus on punitive elements (Freckelton & Flynn, 2004; Kjervik, 2005; Schma, Kjervik, & Petrucci, 2005). For example when a health professional has been accused of engaging in unprofessional conduct, the investigation and hearings by health regulatory bodies and resulting sanctions are often conducted within a legalistic frame (Freckelton, 2006; Freckelton & Flynn, 2004). Freckelton and Flynn (2004) applied a therapeutic jurisprudence lens to analyse disciplinary practices used by registering bodies dealing with medical practitioners engaged in unprofessional conduct. They found that much of the current structure and process to be counter-therapeutic to both the informant and the medical practitioner. Formal hearings are likened to a roller-

coaster ride for both the medical practitioner and the person notifying the board of the offence (Freckelton & Flynn, 2004).

While no explicit examination using therapeutic jurisprudence to critique the regulation and disciplinary practices of professional nurses has been found, the implications of the emotional and psychological wellbeing of nurses faced with an allegation of unprofessional conduct have been studied (Pugh, 2006). The findings of Pugh's study certainly confirm the counter-therapeutic nature that formal inquiries into unprofessional conduct have on the wellbeing of the nurse. Restorative justice theory may offer guidance to develop a transformative theory of action, a new way to address complex issues such as reporting by nurses of unprofessional and or unethical conduct and adverse events in healthcare.

4.10 Selection of comparative sample cases

The nature of the first two research questions necessitated selecting cases where unprofessional and/or unethical conduct resulted in adverse clinical events and were publicly reported by nurse whistleblowers. The public inquiries of BBH in Queensland and MHS in NSW had as their focus the investigation of claims of unprofessional and/or unethical conduct that resulted in adverse clinical events that were reported publicly by nurse whistleblowers (HCCC, 2003; Queensland Government, 2005b). The terms of reference from each of these inquiries contributed to the selection of each case. The inquiries sought answers relating to the reporting of adverse events.

The BBH and MHS inquiries specifically investigated the adequacy of response to internal reporting and the organisations' responses to the

individuals who attempted to alert management to unprofessional and unethical conduct that was leading to adverse clinical events. The nature of the associated social phenomenon of whistleblowing and nurse reporting was understood by examining the comprehensive publicly available data from these cases.

4.10.1 Data collection

This study required data related to the reporting behaviours of nurses. Perusal of publicly available inquiry data from the Bundaberg Hospital Commission of Inquiry (BHCI) and the Special Commission of Inquiry into Campbelltown and Camden Hospitals (SCICCH) transcripts, witness statements, documents, archival records, and final reports showed that in each inquiry the role of nurses was investigated. Individual nurse testimonies in these cases provide insight into the complexity of patient advocacy, the nurses' actions and their attempts to safeguard patients from specific clinicians and environments that they considered were conducive to unprofessional and/or unethical conduct.

Accessible documentary evidence available to the public and used for analysis in this research included the following: the BHCI which, from July 23 to August 26, 2005, took evidence from 84 witnesses and presented documentary evidence consisting of 311 exhibits. It was terminated by the Supreme Court on September 2, 2005, following a successful appeal by Mr Leck, the District Manager, and Dr Keating, the Director of Medical Services at BBH, who accused Commissioner Morris of 'reasonable apprehension of bias' (Davies, 2005). As a result of public pressure the Queensland Government appointed a new Commissioner and extended the terms of reference to include all Queensland public hospitals (Thomas, 2007). The Queensland Public

Hospital Commission of Inquiry (QPHCI) proceeded from September 8 - October 27, 2005, calling 37 new witnesses and tendering another 200 exhibits (Davies, 2005). All evidence, (except some that was provided and tendered by Mr Leck and Dr Keating to the BHCI) is made available online at the QPHCI web site. It includes over 7000 pages of transcript, 511 exhibits and 29 submissions.

The SCICCH began in December 2003 following a flawed Health Care Complaints Commission (HCCC) external investigation of nurses' complaints to the NSW Health Minister in November 2002 (Hindle, Braithwaite, Iedema, & Travaglia, 2006). It held six days of public hearings and three days of public forums between 26 March and 24 May 2004 that generated 767 pages of transcript. Unlike the BHCI, the written submissions, interviews with the eight nurses and exhibits, were not made available to the public via the Inquiry web site. Nevertheless, a number of other inquires and investigations assisted in providing other sources of rich data: the NSW Parliamentary Inquiry into Health Complaints (2004) and the Independent Commission against Corruption (ICAC) (2005) investigation of the alleged mistreatment of nurses, and alleged misconduct relating to the former South Western Sydney Area Health Service.

Seech (2004) advocates the use of analogical evidence, particularly when a fresh perspective from new empirical evidence is proposed. As such, further sources of analogical evidence were sought in order to increase an understanding of the issues at stake and to provide a rich background to the social conditions and factors that influenced behaviours at the time. These included: professional and scholarly journal articles, transcripts and pod casts

of radio and television broadcasts, television program online forums, local, regional, and national newspaper articles, books, movies, Acts of Parliament and internet sources from professional and lay organisations. These sources strengthened the theoretical propositions related to the false consciousness and crisis elements in line with Fay (1987).

4.11 Data analysis

Data analysis techniques were informed by the theoretical framework of CST and the overall aims of the study (Yin, 2003b). Yin argues that the leading and most preferred strategy for analysing case study evidence is to rely on the theoretical propositions framing the case study itself. Thus, and in keeping with this stance, Fay's CST was kept at the forefront of each analysis strategy, particularly when developing the original theoretical propositions (Fay, 1987). As previously explored in this chapter Fay proposes four major theories which focus on explaining individual features of a social situation. Thus the documentary evidence from the commissions of inquiry and gathered analogical evidence were examined for explanations of the causes and nature of (I) the 'self-(mis) understandings', (II) the crisis in the social system, (III) the theorised conditions required for enlightenment and (IV) the resolution of the social crisis (Fay, 1987, p. 37). Having obtained copies of all the available online documentary evidence presented to each commission of inquiry, due consideration was given to the most suitable method for analysing their contents and determining the quality of the data.

4.11.1 Documentary analysis

Working through and relying on such a large volume of documentary sources can be problematic. Scholars in social science and historical research have long grappled with determining the quality of data that is available from documentary sources such as those used in this study (McCulloch, 2004; Scott, 1990). Nevertheless, both Scott and McCulloch argue that the same basic, well-established rules that are applied to most social science research to determine the quality of available evidence can be applied to documentary sources. These include authenticity, credibility, representativeness and meaning of documents.

4.11.2 Authenticity of documents

Authenticity of documentary sources used in research refers to the evidence that substantiates that the document is genuine (McCulloch, 2004; Scott, 1990). The documentary sources used in this study were proceedings, exhibits and submissions from the commissions of inquiry. The State Reporting Bureau Queensland Department of Justice and Attorney General and the NSW Attorney General's Department have published the transcripts of proceedings of each inquiry. The verbatim accounts of proceedings were recorded each day by numerous court transcribers. Every page of transcript records the date, day, transcribers' number and their initials, as shown below.

23052005 D.1 T1/HCL BUNDABERG HOSPITAL COMMISSION OF INQUIRY (QPHCI, 2005, Transcript Day 1, p. 1)

23052005 D.1 T2/SLH BUNDABERG HOSPITAL COMMISSION OF INQUIRY (QPHCI, 2005, Transcript Day 1, p. 15)

The SCICCH transcripts were all produced by Computer Reporters Pty Ltd Court Reporting Services, Sydney, NSW.

In the QPHCI, all submissions to the inquiry were numbered, stamped as received by the inquiry and dated. Most were accompanied by a covering letter and signature of the author. All submissions were then made publicly available in the QPHCI web site. All exhibits referred to during the inquiry (other than selected confidential exhibits where patients and relatives declined the release) were numbered and made available to be downloaded on the QPHCI web site.

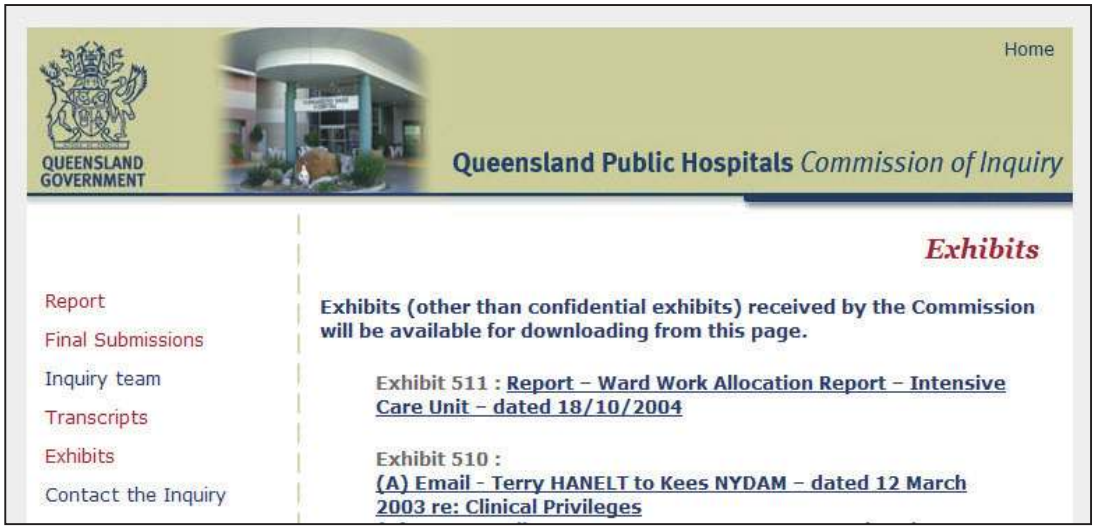
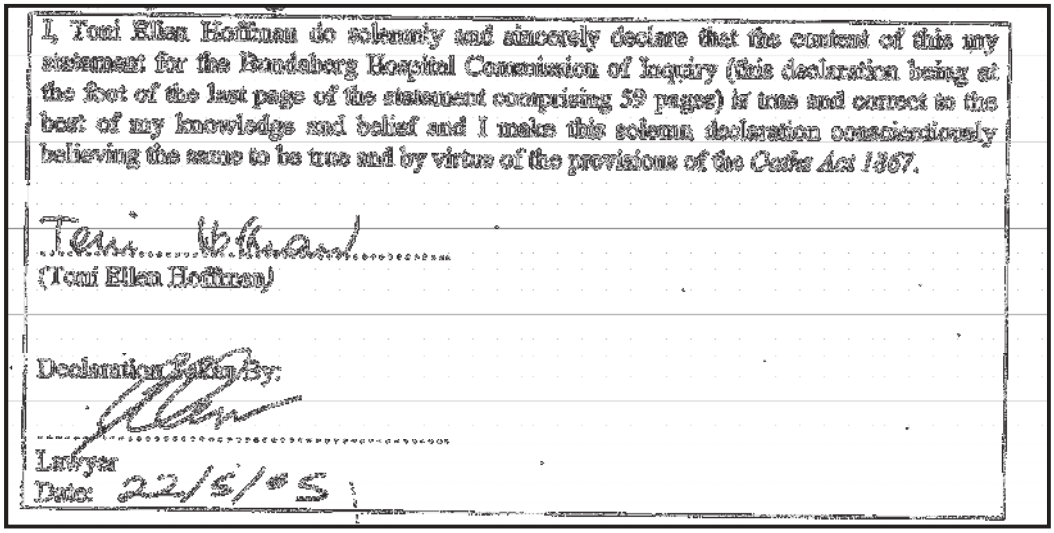


Figure 4.2 Queensland Public Hospitals Commission of Inquiry Exhibit http://www.qphci.Queensland.gov.au/exhibits.htm (accessed 29 August 2007).

Statements from witnesses in the commission of inquiries were all authenticated by declarations that the contents were true and correct within the provisions of the *Oaths Act 1867*.


I, Toni Ellen Hoffman do solemnly and sincerely declare that the content of this my statement for the Bundaberg Hospital Commission of Inquiry (this declaration being at the foot of the last page of the statement comprising 59 pages) is true and correct to the best of my knowledge and belief and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

(Toni Ellen Hoffman)

Declaration taken by:

Date: 22/5/05

Figure 4.3 Example of Oath Declaration (QPHCI 2005 Exhibit 4, p.59)

The SCICCH process differed from the QPHCI in that there were limits placed on the public availability of evidence collected. Only the evidence collected by the six days of public hearings (493 pages of transcript) and four days of public forums (304 pages of transcript) were made available on the Inquiries' website http://www.lawlink.nsw.gov.au/special_commission (Walker, 2004a). To comply with the *Special Commissions of Inquiry Act 1983 section 8*

> A Commissioner may give directions preventing or restricting the publication of evidence given before the Commissioner or of matters contained in documents lodged with the Commissioner.
> (New South Wales Government, 1983).

Commissioner Walker prohibited the publication of information received to 'maintain the integrity of evidence and information received by the Inquiry, and to preserve the principle of patient confidentiality' (Walker, 2004a, p. 173).

The combined evidence from the BHCI and QPHCI amounted to over 7000 pages of transcript and 511 exhibits. In the final report, Commissioner the Hon Geoffrey Davies stated that all parties involved in the commission process were given leave to object to any of the evidence. None did (Davies, 2005).

Thus, the origin, legitimacy and genuineness of the documentary evidence support their authenticity as a representation of what happened in the Commissions of Inquiry.

4.11.3 Credibility of documents

Documentary evidence is considered credible if the account can be relied upon to be undistorted and free from error or censorship (McCulloch, 2004; Scott, 1990). The researcher must interrogate each document to determine if the

author was able provide a true account of the event depicted (McCulloch, 2004; Tosh, 2002). In the cases selected for this study, two factors contributed to ensuring credibility of the documentary sources.

First, each witness statement concluded with a declaration that the contents were true and correct to the best of their knowledge according to the *Oaths Act 1867* (see Figure 4.3). Second, the intense interrogation and cross-examination of the witnesses and their formal statements during actual proceedings required the witnesses to continue to justify their recollections of events reported in previous testimony and in their written witness statements. Most witnesses were subjected to rigorous and often gruelling cross-examination by various barristers representing opposing plaintiffs. The rigorous nature of the inquiries provided rich data as various witnesses gave evidence on the same clinical incident, confirming such data's credibility as evidence for use in the case study.

4.11.4 Representativeness of documents

The representativeness of documentary sources requires the researcher to assess the 'typicality, or otherwise, of the evidence'(Scott, 1990, p. 7). These criteria are important for historical research when only small portions of documentary evidence are available for study, due to standard document attrition or interference from interested parties (McCulloch, 2004). In such cases the documents that do survive may be those that represent the views of official sources rather than subordinate or oppressed groups (McCulloch, 2004).

The significant advantage secured by researchers who examine commission of inquiry documentary evidence is the wealth of available

sources. Under the Provisions of the *Commissions of Inquiry Act 1950*, the Commissioner is accorded considerable power to uncover evidence within a particular inquiry's terms of reference, which results in access to organisational documents that would not have been made available to the researcher in other circumstances. Internal minutes, reports, memos, emails and letters are usually considered confidential by an organisation, and in other investigations, the organisation has no obligation to release these to investigators. The unique nature of the commission of inquiry and the decision to publicly present most of documentary evidence online has yielded an abundance of material data to analyse.

The final issue related to representativeness of the documents concerns the notion that the circumstances accounted for are conventional or regular, so levels of generalisability can be applied. This may be a crucial factor in many studies, particularly historical reconstructions. Scott (1990) recognises that researchers do not always seek evidence that is typical and this will depend on the aims of the study, and so it is in this study where it is precisely the 'atypical' nature of nurse whistleblowing that is under investigation. However Scott does insist that researchers acknowledge that limits be applied to the conclusions derived from such atypical evidence (Scott, 1990). For instance, it would be inappropriate to conclude that every hospital Executive would react to reports of breaches to patient safety and unprofessional and or unethical conduct in the same way as the organisations studied.

It is precisely the atypical nature of the events at BBH and MHS where nurses resorted to whistleblowing, which make the cases interesting from a

research perspective. The Commissions of Inquiries emphasised for the first time the role of nurse whistleblowers, placing nurses at the forefront of reporting breaches in patient safety and unprofessional conduct.

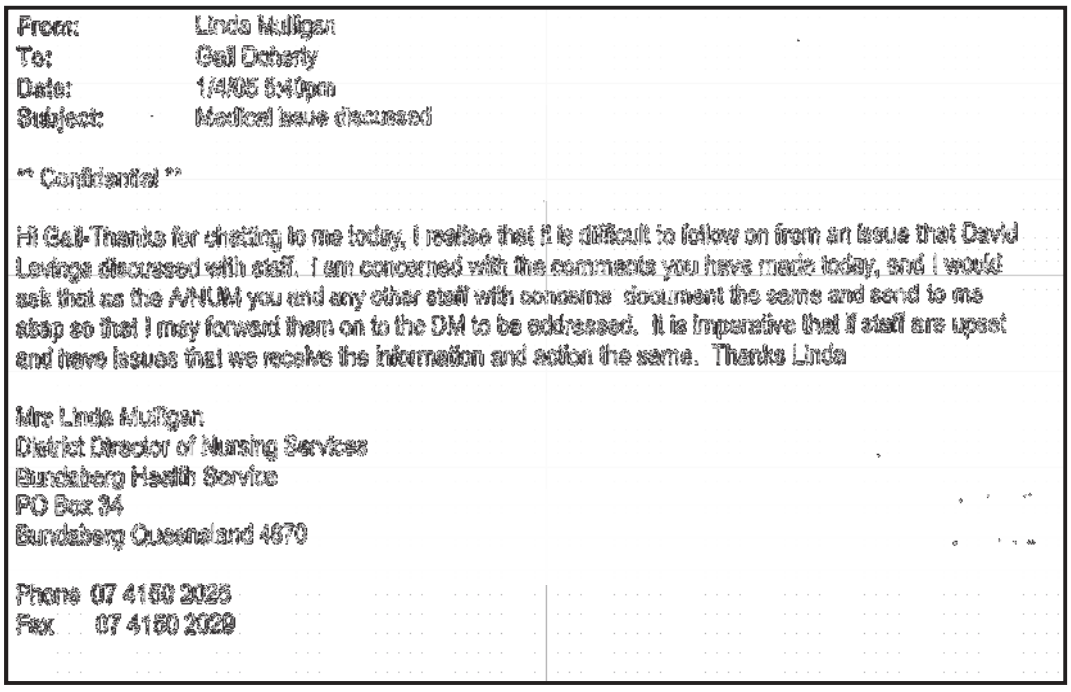
4.11.5 Meaning of documents

Meaning, the last but by no mean least of the qualitative measures imposed on documentary sources, relates to the extent to which the 'evidence is clear and comprehensible to the researcher: what is it, and what does it tell us?' (Scott, 1990). It is here especially that the theoretical framework through which the document is analysed should be transparent (McCulloch, 2004; Scott, 1990). As discussed previously the meaning of the documentary sources was progressed by applying Fay's CST interpretive framework. However, Fay does not offer specific methodological formulae or techniques for analysing text. To address this and continue to progress the study in a critical way, the technique of critical discourse analysis was adopted.

4.11.6 Content/thematic analysis informed by critical discourse analysis

Critical discourse analysis (CDA) is situated within the critical social science tradition. Its development is influenced by CST and its goal is to examine the relationship between language and ideology (Chouliaraki & Fairclough, 1999; Smith, 2007; Threadgold, 2003; Travers, 2001). Although it draws on a wide range of approaches to analyse language through text (Fairclough, 2003), the central assumption of CDA is that language and text cannot be viewed as 'transparent or value free' (Cheek, 2004, p. 1144).

According to Cheek (2004) text not only characterises and exposes a version of reality, it also plays a part in the very creation and preservation of that reality itself. If we take, for example, the email and letter exhibits presented to the QPHCI (Queensland Government, 2005a) we can see that these textual documents represent correspondence formed at the time concerns were raised by nurses to the Executive about substandard conduct of a senior surgical clinician. Responding correspondence provides evidence to the researcher about the nature of the official response and how matters were to be dealt with. However, to their intended audience, that is, the nurse reporting the substandard conduct, they actively contributed to the construction of their reality and, as will be shown the false belief that a positive outcome and protection from retribution would result from their actions.



From: Linda Mulligan
To: Gail Doherty
Date: 1/4/05 5:47pm
Subject: Medical issue discussed

** Confidential **

Hi Gail-Thanks for chatting to me today, I realise that it is difficult to follow on from an issue that David Lovings discussed with staff. I am concerned with the comments you have made today, and I would ask that as the A/NUM you and any other staff with concerns document the same and send to me asap so that I may forward them on to the DM to be addressed. It is imperative that if staff are upset and have issues that we receive the information and action the same. Thanks Linda

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone 07 4150 2025
Fax 07 4150 2029

Figure 4.4 Example of Exhibit (QPHCI 2005 Exhibit 180-2 LMM21)

A text is situated within its social, cultural, political, and historical context (Cheek, 2004; Smith, 2007). The process of situating the context of the text by application of CDA includes both micro and macro levels of analysis (Fairclough, 2003, pp. 15-16; Travers, 2001). The micro level of analysis focuses on how the text is formed: the particulars of the vocabulary, structure, syntax and style of text – sometimes referred to as the minutiae of the text (Poynton, 2000 ; Smith, 2007). This level of analysis was adopted from research fields such as linguistics and content analysis (Wodak, 2001).

According to proponents of CDA the level of analysis depends entirely on the overall aims of the research (Meyer, 2001). Analysis can be highly-detailed, for example the semantic analysis found in research that examines particular text genres such as newspaper or policy documents, or alternatively, the analysis can have a more thematic focus (Fairclough, 2003; Smith, 2007). It is the latter, thematic form of microanalysis that is applied to this research. This was primarily because of the significant volume of text-based documents under examination, which precluded a single researcher from undertaking such deep analysis of the minutiae of language. Second, in keeping with the aim of this research, attention needs to focus on finding general themes that related to the overall debate, this was best achieved by adopting a content/thematic level of text analysis.

This type of content/thematic analysis does not require the researcher to provide an account of every line of text transcript that is studied (Tonkiss, 2004). Rather it is more appropriate, and revealing, to extract the richest sections that provide valid forms of analytic material. This analysis technique

does not advocate selecting data extracts that support the argument while ignoring the adverse or ill-fitting sections of text (Tonkiss, 2004). Instead the researcher actively examines the text for contradictions to the initial set of propositions (Tonkiss, 2004; Yin, 2003b). By working closely with the text, 'trying out alternatives', building new propositions while also systematically rejecting analytic schemes that do not work (Tonkiss, 2004, p. 377), the researcher adopts a pragmatic approach to sifting, comparing and contrasting the themes that emerge from the data. The researcher follows the trail of emerging analytical assertions that are grounded in evidence and detailed argument (Tonkiss, 2004).

The macro level of CDA requires a specific focus on the sociocultural context in which the text was formed (Fairclough, 2003; Smith, 2007). Two dimensions are examined in macro level analysis. First, is discursive practice, where text is examined to determine processes of production and utilisation, such as where and when it was produced, and the rules that govern its development, distribution and use (Fairclough, 1992; Phillips & Jorgensen, 2002; Smith, 2007). Second, is social practice, which requires consideration of the link between the environment in which the text was formed and the broader issues related to power and ideologies that dominate the sociocultural context (Smith, 2007). Social practice analysis aims to provide explanations that assist the researcher to characterise the individuals and organisations identified in the text (Smith, 2007).

Consideration of the discursive and social practice of the text is particularly important in this study, where much of the data analysed involved

legal discourse, constructed in the context of evidence presented to the Commissions of Inquiry. This evidence, particularly the witness statements and transcripts, is not a neutral medium of discourse (Gee, 2005; Hale, 2004). Some speakers hold greater authority than others and certain modes of language are specifically used in argument to persuade (Tonkiss, 1998). Tonkiss refers to this as the rhetorical organisation of the discourses understanding that the speaker is clearly and deliberately using language to convey and persuade others to believe, their version of events.

In the Commissions of Inquiry, the prosecution and defence lawyers used rhetorical skills to interrogate each witness, and later to present possible alternative accounts, each with the intent of either supporting, countering or discrediting the witness' version of events. Legal discourse has a language structure that favours upper-class, powerful and articulate professionals who use powerful speech styles that are accepted in the rule-orientated context of legal proceedings, often disenfranchising people at the lower end of the socioeconomic and education scale (Mertz, 1994, p. 444). When analysing witness transcripts, due consideration was applied to recognising this imbalance of power and hegemonic order. Individual witness statements and transcripts were examined to determine the depth of rhetorical skill of the witness, for example, patients could be disadvantaged in their testimony because they were least able to present a compelling account using medical and legal discourse. Other witnesses were well briefed by professional legal teams, employed solely to provide aid with their testimony in the inquiry process.

Applying content/thematic level of analysis modified from traditional CDA techniques to the Commissions of Inquiry data provided a structured method to elicit the multiple layers of meaning that originally shaped the text. The content/thematic level of analysis provided the nexus to testing propositions developed through CST.

4.12 The strengths and weaknesses of the study

The study of complex, controversial and ambiguous issues in the healthcare sector is not always possible using conventional research approaches (Strom, 2007; Thorne, Kirkham, & O'Flynn-Magee, 2008). Furthermore, the traditional use of interviews, surveys, participant observation and experimentation to produce data is not always adequate to the task of generating sound answers to complex research questions such as those proposed in this study. The key strength of this study rests on its access to a wealth of data that would not normally be available to researchers attempting to collect evidence related to internal reporting processes and whistleblowing. Original documents that informed the proceedings of the commissions of inquiries such as incident reports, department, committee and personal correspondence provided ability to confirm testimonial recollections. Many of the witnesses were cross-examined, strengthening the validity of their recollections and self-reported perceptions.

Gathering empirical evidence from organisations keen to protect their own reputation and interests can be difficult. The SCICCH and the BHCI/QPHCI produced an abundance of publicly available data eminently suitable to answering the research questions related to the social phenomenon and contextual properties of whistleblowing and reporting by nurses. In each

inquiry, the Commissioner was accorded considerable power to uncover evidence within the particular Inquiry's terms of reference, in these cases related to patient safety within the public hospital system.

Nevertheless, consideration should be applied to the limitations of this study and its findings. The first limitation relates to the considerable amount of commission of inquiry data that was available. While data were analysed by first examining the commission transcripts and their related exhibits line-by-line, the sheer volume of the data meant that there was a need to re-extract the richest sections to test and validate propositions. Additionally, many of the exhibits collected by the BHCI/QPHCI were saved electronic images later transferred to an electronic portable document file (pdf) format. For many pdf exhibits the traditional scanning and searching tools to differentiate specific words used was not effective and each had to be opened and re-examined manually. Thus, there remains a risk that there are uncaptured examples in the data of 'what is interesting, important and epistemologically productive' according to the conceptual frame (Fay, 1996, p. 217), and which could have provided further validation of the propositions tested.

4.13 Ethical considerations

Data collection for the case study relied entirely on publicly available documentary sources recounting and detailing past events. The research proposal was presented to the Deakin University Research Committee which, because the study did not involve human subjects, deemed it to be low risk. This approval however, does not abrogate consideration of potential concomitant ethical issues related to the use of public documentary sources.

This section outlines some of the key ethical dilemmas that were considered in this light.

All of the evidence gathered to support the case study data was obtained using unobtrusive measures. Unobtrusive measures use existing sources of written and audio-visual material by accessing public and private archives (McCulloch, 2004; Schutt, 2006; Scott, 1990). The literature and ethical discussions regarding the use the unobtrusive archival evidence in research are divided on matters of propriety, and it is difficult to find a unified opinion on such material's 'proper' use; views are polarised (Bassett & O'Riordan, 2002; Mann & Stewart, 2000; White, 2002). The first view holds that any text in the public domain can, aside from adherence to copyright considerations, be reproduced without any consideration of the relationship between the text and the ethics of its use (Bassett & O'Riordan, 2002; Herring, 1996). Researchers who endorse this view focus heavily on the need to develop rigorous analysis techniques or on 'dealing with the text responsibly', in order to represent the authors' views accurately (Bassett & O'Riordan, 2002, p. 239).

The counter position recognises the symbiotic relationship between the text and personal identity, and thus advances the argument that ethical research guidelines that account for human subjects need to be applied (Bassett & O'Riordan, 2002; Sixsmith & Murray, 2001; White, 2002). This is where the highly-contested issue of obtaining prior consent from the participants members of public fora and the ensuring of the anonymity of participants is advanced (Roberts, Smith, & Pollock, 2004; Sixsmith & Murray, 2001).

The analogical evidence from online discussion forums used in this research is sourced from open fora created by television programs in their online manifestations to discuss healthcare issues and other matters, including whistleblowing. Such conversations include the ABC's *Four Corners Open Letters Current Affairs* message boards' 'First do no harm' forum. Contributors to that forum are made aware that any post to the forum will be moderated to ensure suitability for public display before being published on the website (ABC, 2003). Although the ABC holds copyright provision over all of the website's content, that content is clearly published in the public domain and as such consent and privacy considerations do not (legally) apply.

4.14 Conclusion

This chapter has as its focus a discussion of the comparative case study method used to advance the study. First, attention has been given to the methodology and key analytical theories and philosophical underpinnings used. The research processes, including sample selection, data collection, data analysis technique, the process used to ensure rigor, the strengths and weaknesses of the study are also examined. Finally, ethical considerations pertinent to the study itself have been undertaken.

CHAPTER 5

LEGISLATIVE AND CLINICAL GOVERNANCE CONTEXT

5.1 Introduction

In this chapter attention is given to contextualising the Macarthur Health Service and Bundaberg Base Hospital cases selected for this study. First, given the jurisprudential nature of this inquiry, a brief discussion of the international and national status of whistleblowing law is offered, placing into context the movement towards and development of legislative provisions designed to protect whistleblowers. The chapter will then progress by locating and examining whistleblowing legislation in the jurisdictions of New South Wales (NSW) and Queensland, where the cases were set. Second, at the time the nurses began raising their concerns outside the organisation there was a shift in the governance of healthcare organisations. New perceptions were emerging related to medical error, health care system failure and clinical governance. Locating the emergence of clinical governance and Reason's Swiss Cheese model of system failure here, will help to explain what occurred in both the BBH and MHS cases and provide focus for a broader analysis of the cases presented in Chapter Eight.

5.2 The importance of context

The importance of context in healthcare research is now becoming recognised (Bamber, 2014a). While there has been strong consideration of the importance of context in social science and organisational research, its role in healthcare and particularly in quality improvement has been slower to progress (Bate, 2014; Dopson & Fitzgerald, 2005). Nonetheless, context is now seen as 'central for understanding human action' (Locock, Ferlie, Dopson, & Fitzgerald, 2005, p. 60), and should be examined at macro, meso and micro levels (Dopson & Fitzgerald, 2005).[75] In this inquiry two macro level contexts of importance, these include whistleblowing legislation and the shift in governance of healthcare organisations.

5.3 Legislating for whistleblowing

In the last twenty years, whistleblowing has become a focus of legislative reform both in Australia and internationally (De Maria, 2006; Vandekerckhove, 2006; Wright, 2008). Legislative measures to protect employees who make public interest disclosures were first enacted in the US, with the State of Michigan introducing the first law in 1981(De Maria, 2006). Globally, measures to protect employees from internal retribution can be seen in many areas of the law, including

[75] Dopson and Fitzgerald (2005) drawing on the work of McNaulty and Ferlie (2002) who analysed management reform in the NHS, suggest that macro level context is the whole of the public sector including and government policy and legislation, macro the organisation of the individual hospital and the micro the history and dynamics within a particular clinical setting in the hospital. The latter two are exposed in the presentation of the MHS and BBH cases.

'corporate law, workplace relations law, consumer law and financial regulation' (Latimer & Brown, 2008, p. 766). However, when employees disclose malpractice they potentially breach their duty of confidentiality and may incur civil action against themselves such as defamation, disciplinary action or criminal prosecution (Brown, 2007). The risk of these actions has a significant impact on the willingness of individuals to come forward about internal malpractice, even if it would benefit the public.

Internationally, attempts to legislate to protect whistleblowers have paralleled the fight against corruption in public administrations (De Maria, 2006). Banisar (2009) and De Maria (2006) claim that the United Nations (UN) *Convention Against Corruption* (2004) influenced signatory nations to develop legislative measures to protect whistleblowers. Article 33 of the Convention - *Protection of Reporting Persons* is particularly pertinent in this regard: it states:

> Each State Party shall consider incorporating into its domestic legal system appropriate measures to provide protection against any unjustified treatment for any person who reports in good faith and on reasonable grounds to the competent authorities any facts concerning offences established in accordance with this Convention.
>
> (UN, 2004, p. 26)

Despite the fact that many countries have complied with and instituted protected disclosure or whistleblowing legislation, legislation in several jurisdictions remains too weak to adequately protect the whistleblower from retribution or unjustified treatment (Banisar, 2009;

Brown, 2007; De Maria, 2006; Latimer & Brown, 2008). In many international jurisdictions, employees remain subject to civil or criminal penalties for revealing internal company information. For example, in 2004, US engineer Joseph Mangan raised safety concerns about design flaws in the new Airbus A380 jetliner to the European Aviation Safety Agency (EASA) (Banisar, 2009). Mangan was employed by TTTech Computertechnik, an Austrian company supplying computer technology for controlling cabin pressure (Pae, 2005). His whistleblowing actions resulted in immediate sacking and criminal and civil charges filed by his former employer (Evans-Pritchard, 2005). A probe conducted by EASA, which found that the microchip at the centre of the complaint required more rigorous testing and did not comply with the safety rules, supported the initial concerns raised by Mangan. Evans-Prichard (2005) reports that ultimately EASA would not allow the final safety certification for the A380 Airbus until a review of the issues were completed. TTTech Computertechnik successfully applied to the Austrian court for a gag order to prevent Mangan from publicly discussing his case. Mangan violated this order in an online blog and was fined $185,000 by the Austrian court. According to Reynolds (2010) Mangan has not paid this fine and still faces a possible jail term.

For employees in government organisations the hazards of whistleblowing can be severe, especially when whistleblowing legislation is subverted by the imposition of other laws, such as *Secrets*

Acts, Crimes Acts or *Civil Service Acts* (Banisar, 2009). An Australian example is provided by the case of Allan Kessing, a former senior customs officer sentenced to a nine-month suspended jail term after being convicted of leaking classified threat assessments and risk analysis reports of airport security to *The Australian* an Australian broadsheet newspaper (Brown, 2007). Despite the clear public benefit of Kessing's safety report,[76] this case illustrates that the protected disclosure legislation could (and did) fall short in providing real protection to whistleblowing case law (Brown, 2007).

These and other limitations to domestic laws protecting whistleblowers have been recognised on an international stage. In a 2004 joint press release,[77] the UN called for steps to change or repeal laws that restricted access to information, particularly of secrecy legislation, that impaired protection to potential whistleblowers (Ligabo *et al.*, 2004). There, it was acknowledged that whistleblowers:

> are individuals releasing confidential or secret information although they are under an official or other obligation to maintain confidentiality or secrecy. Whistleblowers releasing information on violations of the law, on wrongdoing by public bodies, on a serious threat to health, safety or the environment, or on a breach of human rights or humanitarian law should be protected against legal, administrative or employment-related sanctions if they act in 'good faith.
>
> (Ligabo *et al.*, 2004)

[76] A major review of the Australian airport security system and $200 million in security enhancements (Brown, 2007).

[77] UN Special Rapporteur on the Promotion and Protection of the Right to Freedom of Opinion and Expression, the Representative on Freedom of the Media of the Organization for Security and Co-operation in Europe and the Special Rapporteur for Freedom of Expression of the Organization of American States (Ligabo, Haraszti, & Bertoni, 2004).

It is not within the scope of this thesis to consider all legislation that supports or inhibits individuals making public disclosures. However, since identification of the specific laws pertaining to whistleblowers in Australian jurisdictions, particularly in NSW and Queensland, is key to this study, attention is given to these jurisdictions. What follows thus sets the background for future discussion related to the case studies at the centre of this thesis.

5.4 Australian legislation on whistleblowing

All Australian jurisdictions have relevant legislation to protect employees in the public sector who make a public disclosure. In the private sector, the *Corporations Act 2001 part 9.4 AAA* offers employees some protection. Table 5.1 below summarises Australian whistleblowing legislation chronologically.

Table 5.1 Summary of Australian whistleblowing legislation, chronologically.

Act	Jurisdiction	Long Title
Whistleblowers Protection Act 1993	South Australia	An Act to protect persons disclosing illegal, dangerous or improper conduct; and for other purposes
Whistleblowers Protection Act 1994	Queensland	An Act to protect whistleblowers and for other purposes
Protected Disclosures Act 1994	New South Wales	An Act to provide protection for public officials disclosing corrupt conduct, maladministration and waste in the public sector; and for related purposes.
Public Interest Disclosure Act 1994	Australian Capital Territory	An Act to encourage the disclosure of conduct adverse to the public interest in the public sector, and for related purposes
Public Service Act 1999, section 16 (Protection for whistleblowers)	Commonwealth	An Act to provide for the establishment and management of the Australian Public Service, and for other purposes
Corporations Act 2001, part 9.4 AAA (Protections for whistleblowers)	Commonwealth	An Act to make provision in relation to corporations and financial products and services, and for other purposes
Whistleblowers Protection Act 2001	Victoria	No long title
Public Interest Disclosures Act 2002	Tasmania	An Act to encourage and facilitate disclosures of improper conduct by public officers and public bodies, to protect persons making those disclosures and others from reprisals, to provide for the matters disclosed to be properly investigated and dealt with and for other purposes
Public Interest Disclosure Act 2003	Western Australia	An Act to facilitate the disclosure of public interest information, to provide protection for those who make disclosures and for those the subject of disclosures, and, in consequence, to amend various Acts, and for related purposes.
Public Interest Disclosure Act 2010	Northern Territory	An Act to provide for the disclosure and investigation of improper conduct of public officers and public bodies, to protect persons making disclosures and others from reprisal, and for related purposes

Upon examination of these legislative provisions there is a rather curious feature of the Acts that becomes evident. Nowhere in the various Commonwealth and State legislation are the terms *whistleblowing or whistleblower* defined, not even when they are used in the title (Brown & Donkin, 2008; Brown & Latimer, 2008; Latimer & Brown, 2007). Certainly there is no definition that explicitly recognises the relationship between the whistleblower, the type of information disclosed and the person or entity to whom the disclosure is made and, most importantly, that this person or entity has the power to 'effect action'.

The overall goal of Australian public interest disclosure laws is obstenibly to protect individuals who disclose information, notably from other laws breached by the act such as confidentiality and defamation. Public interest disclosure law also attempts to put in place legal remedies for whistleblowers should they suffer reprisals for making disclosures (Latimer & Brown, 2007). Prima facie goals seem straightforward. However, on closer inspection, there remains significant variation between jurisdictions as to whom a whistleblower can disclose, whilst still benefiting from legislated protection.

It is only in NSW that a person can disclose to private persons in the media without foregoing legal protection. This comes with a codicil stipulating that the person must have first disclosed to an investigating authority and that that authority:

> (a) must have decided not to investigate the matter, or
> (b) must have decided to investigate the matter but not completed the investigation within 6 months of the original disclosure being made, or
> (c) must have investigated the matter but not recommended the taking of any action in respect of the matter, or

> (d) must have failed to notify the person making the disclosure, within 6 months of the disclosure being made, of whether or not the matter is to be investigated.
> (The Protected Disclosures Act 1994 No. 92 Part 2 s19 (3))

Appropriate persons or authorities to whom the whistleblower can report in other jurisdictions include:

- the Commissioner for Public Interest Disclosures/Public Sector Employment (NT, NSW, SA, WA)
- the Minister of the Crown (SA, WA)
- the Auditor-General (NSW, SA, Queensland, WA)
- the Ombudsman (Victoria, NSW, SA)
- anti-corruption authority or administrative units (NSW, SA, Queensland, WA)
- Members of Parliament (NT, Queensland, WA)
- the responsible Chief Executive Officer (NT, NSW, Act, SA, Queensland)
- Police (SA, WA)
- and/or the Police Commissioner (Victoria, WA).

In most Australian jurisdictions then, even after a person has exhausted many of the legitimate external authorities to no avail, they may not disclose illegal, unethical, or illegitimate practice to a third party, such as a journalist. If they do they forego legal protection from criminal or civil action (Brown, Latimer, McMillan, & Wheeler, 2008). The exception is in NSW where 'a whistleblower [can] legitimately repeat their disclosure to the media',

particularly if previous internal disclosures have not been seriously investigated (Brown *et al.*, 2008, p. 279).

The notion that employees who wish to be protected from disciplinary or other legal action should first follow internal reporting processes before moving to external regulatory or integrity agencies is implied in all current public interest disclosure legislation (Brown *et al.*, 2008). In NSW, frivolous or vexatious claims can be refused for investigation and the whistleblower then forgoes protection under the Act. In Queensland, intentionally providing information that is found to be false or misleading is an indictable offence with a penalty of two years imprisonment.

5.4.1 Public sector protection

Another important consideration regarding whistleblowing legislation concerns the complex interpretations of its scope of jurisdiction and coverage protection. In general, Australian whistleblower legislation is limited to government entities and their agencies (Brown, 2006; John, 2005). In NSW, for example, the *Protected Disclosures Act 1994* only protects persons who disclose corrupt conduct, maladministration or a serious and substantial waste of public money or wrongdoing in the public sector (Part 2 s 8). There is no provision, however, for protection from retribution for persons reporting wrongdoing in the private sector; protection from reprisal is afforded only to government or public sector employees identified as public officials.

Under the Queensland *Whistleblowers Protection Act 1994*, public officers (public sector employees) are the only persons entitled to 'disclose official misconduct, maladministration, negligent or improper management

affecting public funds, danger to public health or safety or environment' (s15-19). Yet, at the same time, it is legal for any citizen to disclose 'danger to the health and safety of a person with disability', 'substantial and specific danger to the environment', or 'acts of reprisal' (s19). Thus, there is mismatch of protection offered to public sector employees. For employees working in the private sector, the mechanism of protection, should they choose to blow the whistle, is to be found in the Part 9.4 AAA of the *Corporations Act 2001*.

5.4.2 Private sector protection

Brown (2006) explains that both the *Corporations Act* and the *Trade Practices Act* are used to protect private sector employees. In contrast to public sector regulation, private sector regulation falls under nine separate state and territory-based jurisdictions (Brown, 2006). Like much of the whistleblowing legislation, the *Corporations Act 2001* limits the parties to whom the whistleblower may disclose to:

> company's auditor, director, secretary or senior manager of the company, or person authorised by the company to receive disclosures of that kind.
>
> (Part 9.4AAA s1b)

The disclosing person must additionally provide, on reasonable grounds, evidence of how an 'officer or employee of the company', or the company itself 'has, or may have, contravened a provision of the Corporations legislation' (*Corporations Act 2001* Part 9.4AAA s1d). A whistleblower is therefore required to possess a working knowledge of the particulars of this Act in order to ensure their own protection. While this section of the *Corporations Act* offers protections against civil or criminal liability for making a disclosure, and

preventing retribution (such as termination of employment), like those of other state-based public interest disclosure legislations, it fails to offer avenues for reporting outside the organisation. There is no protection for disclosures to Members of Parliament or to the media.

5.4.3 The current status of Australian whistleblowing legislation

Australia currently has a patchwork of various intersecting laws ostensibly designed to protect whistleblowers. The limitations of each law were investigated by a team of researchers led by Brown, for the Australian Research Council 'Linkage' Project *Whistling While They Work* (Brown *et al.*, 2008; Brown, 2006). In an Australian Broadcasting Corporation (ABC) *Radio National* interview on the study, Brown stated that the current mix of state and federal laws had 'some rich threads'. But that the problem is that 'there's no single law which even approaches what would be reasonable best practice' (Carrick, 2006).

The variation in what constitutes whistleblowing or public interest disclosure has led to calls for legislative reform by researchers and regulatory agencies (such as the Ombudsman) (Brown *et al.*, 2008; Moss, 2007). Brown, *et al* (2008) recommend national uniformity and specific legislative changes to address the lack of support currently available to whistleblowers who have suffered as a result of their public interest disclosures. The three areas of improvement to the legislative framework include:

- defining the coverage of the act - that is, subject matter and jurisdiction - in a more comprehensive or 'inclusive' manner, to support an 'if in doubt, report' approach to managing disclosures within agencies

> - establishing minimum standards for internal disclosure procedures in agencies, particularly for managing the welfare of employees who report
> - introducing a new statutory framework for coordinating the management of public interest disclosures, through an external oversight agency and a new relationship between that agency and public sector organisations.
>
> (p. 262)

The most recent public interest disclosure legislation to be passed is the Commonwealth *Public Interest Disclosure Act 2013*. The Act comes into effect on 15 January, 2014 but disclosures of suspected wrongdoing made before then are not covered (Commonwealth Ombudsman, 2013). For members of the Australian Public Service, protection under the new Act covers only 'a disclosure within the government, to an authorised internal recipient or a supervisor, concerning suspected or probable illegal conduct or other wrongdoing' (*Public Interest Disclosure Act 2013 Part 2 Division 2, Section 25. p.23).*

5.5 Clinical governance

Contemporary healthcare manifests complex and imperfect systems, rife with the constraints caused by heavy workloads, inadequate resources and increasing public expectations (Braithwaite & Travaglia, 2008; Runciman *et al.*, 2007). The risk of failing to meet a standard of practice that ensures patient safety is omni-present (Pugh, 2009). One particular framework, developed in the UK in the late 1990s and intended to mitigate patient safety risk, is clinical governance (Department of Health, 1998; Scally & Donaldson, 1998).

Under a clinical governance model, healthcare organisations are deemed responsible for implementing measures to improve safety and the quality of

patient care (Allen, 2000; Braithwaite & Travaglia, 2008; Brook & Wallace, 2008). A fundamental feature of clinical governance that differentiates it from previous quality frameworks is the call for reciprocal responsibility and accountability between and among health boards (corporate governance), clinicians (professional responsibility) and 'most importantly, patients' (Travaglia & Braithwaite, 2008, p. 382).

Clinical governance is distinguished from corporate governance by the fact that the latter has clear focus on the business practices and processes of the organisation so as to protect public monies and ensure they are not wasted (Francis, 2013). Clinical governance in contrast emphases 'clinical quality, leadership, organisational culture and organisational quality strategies', rather than a more narrow-focus on corporate and financial accountability (Brennan & Flynn, 2013, p. 115).

A clinical governance framework prescribes processes for staff to enable the internal reporting of substandard clinical practice and procedural violations. These processes also prescribe the thresholds under which reporting to an external regulatory authority (whistleblowing) may take place. Thus clinical governance is an approach specifically designed to remedy healthcare failure. Part of this approach is an emphasis on the identification and reporting of adverse events and a concomitant system of response to and recognition of such reporting. It is anticipated that by maintaining 'a culture of trust and honesty, where errors and adverse events are discussed openly and responded to appropriately', healthcare organisations can effectively deal with system issues that threaten patient wellbeing (The Victorian Quality Council, 2004, p. 9).

Should errors and practice violations go unreported within a clinical governance framework, however, particularly errors resulting in preventable adverse events and/or injury to patients and staff, then the inherent processes of risk and quality management can do little to improve patient safety (Merry, 2008; WHO, 2005). Since the fundamental role of reporting is to enable learning from failure, it is critical that the cultures of healthcare organisations promote and encourage reporting and education, and that they provide support for those who do report. Failure to do so can be detrimental for at least two reasons: first because, as has been famously argued, 'You can't fix what you don't know about'(Bagian *et al.*, 2001, p. 522); and second, because the intractability of healthcare service executives who are unresponsive to internal reports can compel staff to go outside the organisation to effect remedial action, i.e., to blow the whistle.

5.5.1 Australian context

In 2001, Western Australia became the first Australian state to adopt clinical governance as

> the main vehicle by which hospitals are held accountable for safeguarding high standards of health care (including dealing with poor professional performance), for continuously improving the quality of their services, and for creating and maintaining an environment in which clinical excellence can flourish.
>
> (Office of Safety and Quality in Health Care, 2001, p. 2)

Four principles which guide clinical governance in Australia aim to:

- build a culture of trust and honesty, where errors and adverse events are discussed openly and responded to appropriately;
- foster commitment to continuous review and improvement at all levels of the organisation;

> - establish rigorous systems to identify, monitor and respond to incidents and adverse events, and to ensure care is safe, timely and appropriate;
> - evaluate and respond to key aspects of organisational performance (ensure the right things are done in the right way and the right time for the right person).
>
> (The Victorian Quality Council, 2004, p. 9)

It is noteworthy that clinical governance was not adopted in Australia until 2001. Thus an important contextual consideration is that the BBH and MHS whistleblowing crises occurred while clinical governance was still in its infancy in Australia. Moreover, at the time the MHS and BBH cases occurred, healthcare organisations were consumed by other processes such as the introduction of casemix funding and the imperatives of financial accountability demanded by corporate governance priorities.[78] During this time, attention was focused more on financial efficiency than upon the honing of effective processes to ensure that healthcare service managers, including CEOs, were accountable for overseeing the quality of health service provision and patient safety.

5.6 Reason's Swiss cheese model of system failure

Concerns for patient safety in the face of organisational shortcomings have piqued global interest in the development of alternative models to manage human error in healthcare, with particular focus being placed on examination of possible underlying systemic failures that influence staff behaviour (Reason, 2000b). Reason's research into the impact of human factors within organisations suggests that failures in healthcare result from inadequate defence

[78] See earlier reference to case mix in Chapter 2

systems weakened by ‘active failures’ and/or the ‘latent conditions’ under which they operate (p. 769). While these defence systems should be impermeable, they are in reality riddled with weaknesses and defects in a manner akin, according to Reason, to a stack of Swiss cheese slices whose holes represent a system’s weaknesses in the form of active failures and latent conditions.

For Reason (2000b) active failures reflect the fallibility and perversity of human nature, deliberate and non-deliberate, including ‘slips, lapses, fumbles, mistakes and procedural violations’ (p. 769). By contrast, latent conditions arise as a consequence of poorly-constituted strategic decisions and can result in error-inducing conditions in the workplace. Such weaknesses can be unrecognised or without impact in a system for years, until the slices of cheese are stacked in just such a combination that the holes (the weaknesses) come into alignment and a mistake or procedural violation is thereby enabled, resulting in adverse events. The impact of such weaknesses in the MHS and BBH systems will be examined later, in Chapter Eight.

5.7 Incident reporting systems

In the decade since the BBH and MHS cases, significant advances have been progressed within the healthcare sector to foster safe reporting. Patient safety and the importance of healthcare staff being able to access safe reporting systems, attained international recognition in 2005, when the World Health Organisation released its draft *Guidelines for Adverse Event Reporting and Learning Systems* (WHO, 2005). The guidelines provide a clear impetus for healthcare organisations to develop and improve their reporting and learning

systems to enhance patient safety. Key to this development is the message that reporting must be safe for healthcare staff and free from reprisal. Reporting can only be of value if the outcome leads to a constructive response, one that includes feedback from analysis, recommendations for changes in processes and systems, and recognition of lessons learned (WHO, 2005).

Voluntary reporting remains the most common method for detecting adverse events by healthcare organisations (Travaglia, Westbrook, & Braithwaite, 2009). Innovation and development in reporting processes have ensured that healthcare staff can now report incidents using confidential computer-based interfaces. Additionally, incident management systems[79] now being utilised in Australia have the capacity to apply severity assessment codes[80] in order to guide incident analysis, action and escalation (Clinical Excellence Commission, 2014; Queensland Government, 2013). These advances were not present when the nurses reported concerns in the MHS and BBH cases. Despite the advances made towards the improvement of reporting processes, and the related efforts to learn from the analysis and decrease adverse events, various studies suggest that little has changed (Classen *et al.*, 2011; Landrigan *et al.*, 2010; Queensland Government, 2013). Contemporary researchers examining the incidence of error and adverse events suggest that

[79] In Victoria the system is known as the Victorian Health Incident Management System (VHIMS)(Bamber, 2014b). Western Australia employs its Clinical Incident Management System (CIMS) (Robert & Fulop, 2014). In New South Wales they use an Incident Information Management System (IIMS)(Clinical Excellence Commission, 2014). Queensland Health uses a state-wide clinical incident management information system: PRIME Clinical Incidents (CI) (Queensland Government, 2013).

[80] In 2011 Thomas, *et al.* (2011) assessed the utility of healthcare incident reporting systems in Australia and recommended risk-based sampling in the initial data collection phase. Since that time severity assessment coding or incident severity rating methodology has been added to the incident reporting systems in Australia (Clinical Excellence Commission, 2014; Robert & Fulop, 2014). This is designed to produce a hazard score and prioritise investigation (Thomas *et al.*, 2011).

voluntary reporting systems may capture as little as 10 percent of the problem (Landrigan *et al.*, 2010; Queensland Government, 2013). For example Landrigan, *et al.* (2010) conducted a random retrospective chart audit of 2341 patients who had been discharged from ten North Carolina hospitals over a six-year period. By employing the Institute for Healthcare Improvement's Global Trigger Tool[81] to track rates of harm over time, they found no fall in the incidence of both preventable and non-preventable harm; this despite 'substantial resource allocation and efforts to draw attention to patient safety' (p. 2130). These results call into question the reliability of voluntary reporting systems for tracking organisational safety and learning from adverse events.

Closer examination of the limitations of internal reporting processes in light of the cases investigated are examined further in Chapter Eight.

5.8 Conclusion

This chapter has sought to describe the context in which the MHS and BBH cases occurred. In providing this evaluation international and national status of whistleblowing law was briefly examined and an overview provided on public disclosure legislation pertaining to the jurisdictions of New South Wales (NSW) and Queensland. This overview highlighted some of the perils associated with whistleblowing legislation and the deficits in current levels of protection. Attention was then directed to the development of clinical governance, Reason's Swiss Cheese model of system failure, and the limits of

[81] The Institute for Healthcare Improvement's Global Trigger Tool was developed to identify a more effective way to examine adverse events over time. It provides a methodology that can be used by a review team to retrospective asses a random sample of patient inpatient records using triggers that identify possible adverse events (Griffin & Resar, 2009).

incident reporting systems. It is to presenting the two select cases chosen for this inquiry that Chapters Six and Seven (following) now turn.

CHAPTER 6

CASE STUDY 1 - THE MACARTHUR HEALTH SERVICE CASE

6.1 Introduction

This chapter has as its focus a recounting of the events leading up to the Macarthur Health Service (MHS) inquiry and its findings. To this end three key areas of the case are presented. First, attention is given to a description of the two hospitals at the centre of the MHS case and the positions held by the whistleblowing nurses during the period 1989-2002. Second, a summation is provided of the reports of substandard clinical practice made by the nurses and the approach taken by MHS management to deal with these reports. Finally, an account is given of the external investigations into the nurses' allegations by the Health Care Complaints Commission (HCCC), the Walker Special Commission of Inquiry (SCICCH), the NSW Parliamentary Inquiry into Health Complaints and the Independent Commission against Corruption (ICAC).

6.2 Macarthur Health Services

Campbelltown and Camden Hospitals are the two acute care facilities that, along with Queen Victoria Memorial Nursing Home, constitute the Macarthur Heath Service (MHS). The MHS was created in 1998 and, during 2003-2004, the period of the Special Commission of Inquiry into Campbelltown and Camden Hospitals (SCICCH), formed part of the South Western Area Health Services (SWSAHS), being just one of seventeen

authorities reporting to the NSW Department of Health (Hindle, Braithwaite, Iedema, & Travaglia, 2006).[82] The MHS provided clinical services such as maternity, paediatrics, intensive care, cardiology, gynaecology, palliative care, respiratory care, stroke management, surgery and emergency medicine, as well as broad aged care services to the residents of Wollondilly, Camden and Campbelltown (NSW Government, 2009). In 2000-2004 the Campbelltown Hospital was a Level 5, major metropolitan facility [83] with a 320-bed capacity, while Camden Hospital was a Level 3 district hospital facility with an 84-bed capacity (HCCC, 2003; NSW Government, 2009; NSW Health Department, 2001).

During the early 2000s, population growth in and around South Western Sydney saw the MHS providing acute services to 12 percent of the NSW population, the largest population quotient of any of the seventeen Area Health Services in NSW (Hindle *et al.*, 2006; Walker, 2004a). According to figures published in 2004, of the 80,000 residents who relied on Campbelltown and Camden Hospitals over one-third were born overseas in a non-English speaking country (Walker, 2004a). In 2001, major capital upgrades to both the Camden and the Campbelltown Hospitals commenced, providing much needed improvements to the physical infrastructure and

[82] In 2010 the boundaries of the local area health services were reformed to eighteen local area networks and currently MHS is part of the South Western Sydney Local Health Network (New South Wales Government, 2011).

[83] The Levels 1to 6 represent the role delineation of the Emergency Department (ED) as set by the Australasian College for Emergency Medicine (ACEM). Individual levels categorise the capacity of the hospital according to the level of core and support services that facilitate the function of the emergency department: from Level 1, the lowest level, indicating access to a medical practitioner and an ability to provide only first aid services before moving the patient - to Level 6, the highest, representing the capacity to manage all emergencies, neurosurgery and cardiothoracic surgery on site, staffed 24 hours per day, 7 days per week, with specialised medical and nursing staff. (NSW Health Department, 2001).

resources of each hospital. Despite this the Campbelltown and Camden Hospitals failed to attract sufficient numbers of suitably qualified clinical staff compared to other hospitals of the same size (HCCC, 2003). Over the period 1998 to 2001, nurses at MHS raised concerns about patient safety and reported through internal mechanisms a number of incidents that they had perceived to be of substandard clinical practice.

On 5 November, 2002, four nurses became whistleblowers when they met with the NSW Health Minister. The nurses reported episodes of substandard clinical practice resulting in patient deaths and injury, as well as expressing their dissatisfaction with the clinical governance processes at MHS (HCCC, 2003; Walker, 2004a). It is to the dramatic unfolding of these events that the next section now turns.

6.3 The nurses

On 5 November, 2002, nurses Nola Fraser, Valerie Owen, Sheree Martin and Yvonne Quinn met with Craig Knowles, the NSW Health Minister. At this meeting, they raised allegations of substandard clinical practice, and alleged accounts of intimidation and inappropriate disciplinary action by MHS management in response to the reporting of patient safety concerns. These four nurses' accounts and allegations were later supported by the claims of four other nurses who were to come forward during the subsequent inquiries: Vanessa Bragg, Sandra Solarz, Angela Perez and Nurse Z.[84] The following is a summary of the positions held by nurses at

[84] Nurse Z is an anonymising appellation assigned by the HCCC. This nurse's actual name was not revealed at any of the subsequent inquiries.

the centre of the MHS case and a recounting of some of the events leading up to their decision to meet with the Health Minister.

6.3.1 Nola Fraser

Nola Fraser was a registered nurse (RN) who worked as an After Hours Nurse Manager (AHNM) at MHS between 1995 and 2002 (Walker, 2004a). Fraser reported the bulk of the allegations – 49 of the total 67 investigated by the HCCC and SCICCH. During this time, she was also a member of the Critical Care Review Committee (CCRC)[85] that examined many of the incidents resting at the centre of her allegations. As a member of this committee Fraser asserted that while she

> raised concerns about patient safety, these issues:… were never minuted because the administrators felt that my standards were too high and that Campbelltown Hospital has its own rules and I need to either get on the bus or get off. They were not minuted because they did not think that it was a problem. They really thought I was the problem.
> (Ms Fraser Evidence, 12 March 2004, p. 10 in Parliament of New South Wales, 2004f, p. 47)

By 2002, Fraser had become a Nurse Unit Manager (NUM) of a medical ward at Camden Hospital (HCCC, 2003; Walker, 2004a). During that year, too, she came into conflict with MHS management over her previous incident reports and what she perceived as a lack of internal action to address her concerns. In a submission to the Legislative Council investigation into complaints handling in NSW Health, Fraser claimed that she was unjustly subjected to informal disciplinary measures:

[85] The Critical Care Committee underwent a change of name during the course of the events recounted here (see section 5.8 below) to become the Critical Care Review Committee. To avoid confusion, this Committee will be consistently referred to in this study by its later appellation: the CCRC.

> The administrators accused me of stealing and accessing human resources files, all of which has been found to be untrue. The administrators were attempting to fabricate evidence against me to dismiss me for raising concerns re patient safety.
> (Submission 23, Nola Fraser p.2 in NSW Parliament 2004f, p. 50)

In October of 2002, after seven months of sick and unpaid leave, Fraser sent two emails. One was sent to Ian Southwell, the Chief Executive Officer (CEO) of the SWSAHS, detailing numerous complaints about what she perceived as 'mismanagement and misconduct within MHS' (ICAC, 2005a, p. 10); a second email was sent to the then Health Minister, Craig Knowles, requesting an appointment to meet with him.

Between October 2002 (the time of her request for an appointment), and the consequently scheduled meeting on 5 November, 2002, Fraser communicated with two other nurses from MHS, Sheree Martin and Yvonne Quinn. Each of these nurses believed that she had been unfairly disciplined during 2002 and thus shared Fraser's concerns about management practices at MHS. Fraser invited them to join her and a solicitor Mr Chalhoub [86] at the meeting with the Health Minister. In turn, Quinn contacted Owen, a colleague who had also been adversely affected by MHS disciplinary action. All four nurses agreed to attend the meeting with the Minister.

6.3.2 Sheree Martin

Sheree Martin arrived at MHS in July, 2001, and worked as a casual part-time Enrolled Nurse (EN). Her prior nursing experience included 13 years in a variety of other healthcare organisations. In February of 2002, Martin was

[86] Mr John Chalhoub is a solicitor and the brother of Fraser. He attended the meeting with Minister of Health Knowles as a support person for the nurses (ICAC, 2005a).

successful in her application for a full-time position on a medical ward at Camden Hospital. She worked there until she took sick and unpaid leave commencing 17 October, 2002, following a disciplinary hearing investigating allegations that she had breached her scope of clinical practice as an EN (HCCC, 2003; ICAC, 2005a). Under question were her performances of four clinical skills deemed to be outside her scope of practice; these included:

- using a bag valve mask device (Laerdal resuscitator);
- administering a scheduled 4 medication (Salbutamol)[87] to assist a patient in respiratory distress;
- inserting an in-dwelling catheter into a patient unable to void (pass urine); and
- inserting an intravenous cannula into a patient.

(HCCC, 2003)

Martin argued in her defence that she had performed these skills at other hospitals prior to her full-time employment at MHS, and that the skills identified in the incidents were employed under direction and with the full knowledge of the registered nurses working with her at the time. On each occasion inadequate staffing and an unreasonable skill mix had resulted in nurses' taking over 'duties, roles and responsibilities not normally required if the ward was adequately staffed and the skill mix reasonable' (HCCC, 2003, p. 158). She also argued that since commencing work at MHS she had

[87] Salbutamol is a liquid medication administered via nebulisation. It dilates the bronchioles of the lung, increasing air entry and the ability of a patient to breathe (Tiziani, 2010). It is a Schedule 4 medication and not one that could be initiated and administered by an enrolled nurse at MHS at the time of the inquiries, without medication endorsement (HCCC, 2003).

frequently been asked by members of the healthcare team to exceed the scope of practice for an EN as described in the SWSAHS clinical manual (HCCC, 2003).

Following the disciplinary investigation Martin was officially warned that if she failed to follow the hospital's policies governing an EN's scope of practice, she would be subject to further disciplinary action, which could include termination of her employment and referral to the Nurses Registration Board (HCCC, 2003). In July of 2002, Martin requested that the official warning be removed from her record after six months if she complied with the directive and her practice during that period did not exceed the scope of an enrolled nurse. Her request was considered by the Human Resources Coordinator of SWSAHS, who recommended to the General Manager of MHS, that the warnings in relation to each of the four matters remain. Martin was informed of this decision in writing and subsequently took sick leave followed by long term unpaid leave (HCCC, 2003).

Martin was later to raise four allegations for consideration by the HCCC and SCICCH (Walker, 2004a, p. 91) relating to Medical Emergency Team (MET) calls not being made when patients were found to meet prescribed criteria i.e. low blood pressure or high respiratory rate. Martin left nursing, stating later:

> Even though my husband and I are one payment off losing our home I can't go back to nursing. If I saw something a doctor or nurse shouldn't be doing, I'd have to stop and think: Do I say something and go through the living hell that I've been through over the last 18 months, or do I shut up? If I remained silent, I'd be the kind of nurse I don't want to be.
>
> (Zimmer & Jones, 2004, p. 4)

6.3.3 Yvonne Quinn, Valerie Owen and Sandra Solarz

Yvonne Quinn and Valerie Owen were Clinical Nurse Specialists (CNS) in the operating theatres at Campbelltown Hospital; their first line Nurse Unit Manager (NUM) was Sandra Solarz (HCCC, 2003). Quinn had been employed at MHS for 19 years, predominantly in the Operating Theatre (OT) (HCCC, 2003); Owen had been nursing for 30 years, the last five at MHS in the OT (ICAC, 2005a); and Solarz had 14 years' experience as an RN and NUM in the OT at Campbelltown Hospital.

On 15 January, 2002, a series of altercations occurred in the OT between Solarz, Owen and an anaesthetist (known only as D1) over whether an elective operative procedure on a ten-year-old child should proceed. The nurses expressed concern that the necessary safety precautions relating to the operative procedure had not been addressed. These precautions included conducting a more comprehensive assessment of the patient to rule out malignant hyperthermia,[88] ensuring anaesthetic equipment had been properly prepared, medication to treat malignant hyperthermia was available and, finally, that a more senior anaesthetist or Visiting Medical Officer (VMO) was onsite to deal with the case in the event of complications (HCCC, 2003). Compounding the situation was the distress of the child's mother, who became upset during the assessment interview conducted by the Anaesthetist D1 at the entry of the OT complex.

[88] Malignant hyperthermia is a pharmacogenetic disorder that can result in death from muscle contraction, muscle rigidity, cardiac arrhythmias and overheating (hyperthermia) when the patient is exposed to general anaesthetic. It is treated with Dantrium – Dantrolene Sodium a muscle relaxant medication (Rosenberg, 2010). In this case there was a family history of malignant hyperthermia.

In her role as NUM, Solarz initially contacted the Director of Medical Services (DoMS), and then the Director of Anaesthetics, who directed that Anaesthetist D1 should consult with a more senior anaesthetist or VMO. Having arrived on-shift to take over the case from Solarz, Owen waited with the child's mother until the VMO arrived. Owen also informed Anaesthetist D1 that operating theatres could not remain on stand-by awaiting the arrival of the VMO and suggested that the case should be postponed. When the VMO arrived, the case was cancelled and rescheduled.

In response to the dispute over the case, Anaesthetist D1 lodged a grievance against both nurses. The focus of her complaint was that the nurses had harassed and intimidated her in front of the patient's mother, thereby undermining her capacity to make a clinical decision (HCCC, 2003). The Quality Manager and the Director of Medical Services investigated this complaint. The investigation took two months to complete and all three staff were interviewed. On 15 March, 2002, the investigation report was released and recommended that Solarz and Owen be given a formal warning (HCCC, 2003).

6.4 The investigation of the dispute between the nurses and Anaesthetist D1

Upon release of the investigation report and because of the warning given to the two senior nurses, tensions within the OT rose. Staff began to realise that this altercation, rather than having been addressed as a staff grievance, had instead been processed as a disciplinary matter. In response to the rising tensions within the department and with the realisation that the events were

now viewed as a disciplinary matter, Owen submitted a delayed incident report on 12 April, 2002, recounting her version of events from the incident on 15 January. She also expressed her concerns that Anaesthetist D1was marshalling support among other nursing staff to substantiate her grievance against Owen and the other nurse involved, Solarz (HCCC, 2003). As a result of this incident report MHS management commenced meetings with other OT nursing staff.

On 18 April, 2002, Quinn also submitted an incident report regarding another altercation with Anaesthetist D1. This incident involved a patient undergoing a Caesarean section.[89] Anaesthetist D1 had difficulty performing a spinal epidural anaesthetic and decided to perform a general anaesthetic following a series of failed attempts to access the epidural space with the spinal needle, each of which increased the distress of the patient.

The altercations between Anaesthetist D1 and Quinn began when the latter raised concerns over the persistent attempts to insert the spinal needle to gain access for the epidural anaesthetic, and culminated in a full disagreement related to the choice of tube used for intubation (HCCC, 2003). Quinn reported that Anaesthetist D1 was uncooperative and rude when she tried to raise concerns about the patient, and that Anaesthetist D1 slapped her hands away when she attempted to inflate the cuff used to secure the intubation tube (HCCC, 2003).

[89] This case is known as Incident 43 in the HCCC and SCICCH reports.

Within the same week, then MHS management had received two separate incident reports from different nurses expressing concerns over patient care that had resulted in altercations involving the same anaesthetist.

6.5 The suspension of Quinn and Owen

On 19 April, 2002, just one day after Quinn had submitted her incident report, three nurses (two RNs and one EN), known only from the HCCC data as N17, N18 and N19, were accompanied by a NSW Nurses Association representative to meet with the General Manager of MHS, Jennifer Collins. During this meeting it was alleged that the nurses were involved in a series of incidents that had occurred over the preceding months, and in some cases more than a year previously, where they had been subjected to bullying and harassment by Quinn and Owen (HCCC, 2003, p. 168).

The internal investigation examined Owen's approach to implementing new work practices (using new sponge bags), the manner in which she had addressed a male orderly and, finally, and her behaviour towards Anaesthetist D1. In addition to her altercation with Anaesthetist D1, Quinn's conduct was also examined with a particular focus on an episode of communication with staff regarding the lack of attendance to an in-service session. At the end of the meeting, MHS General Manager Collins completed a one-page document as a record of the meeting that contained no specific details about the allegations and did not even identify which of the three nurses who attending the meeting had made the complaint (HCCC, 2003).

That same day 19 April, 2002, Collins consulted with the Manager of Human Resources, Greg Driver, and a decision was made to suspend both Quinn and Owen. Owen, who was working that day, was informed of the suspension in the afternoon. Quinn, not at the hospital at the time of the decision, was asked to come in, which she did, and was then informed that she was suspended. Each nurse was provided with an official letter:

Dear ……

> A number of bullying, harassment and victimisation allegations have been raised in regards to your behaviour. Macarthur Health Service considers these allegations serious and need to be investigated. I [Collins] have decided that these allegations will be investigated by an independent person to the organisation. Given the nature of the allegation, I consider that it is in your best interest and that of the Health Service that you not be on duty at this time. Therefore I now direct you not to report for duty until further notice by the Health Service. You will continue to be paid during the period of absence. In making the direction that you will not be reporting for duty does not nor should not imply that the allegations are true but rather that they need to be investigated. You are also directed to have no contact with staff either on duty or socially until this investigation is completed.
>
> (HCCC, 2003, p. 146)

At the end of their meeting and with the official correspondence provided to them, the Quality Manager escorted both senior nurses from the hospital. Their colleagues witnessed this escort removal of the two nurses from the OT. The Acting Director of Nursing was later to refute the claims and interpretation of the HCCC that the nurses were 'escorted off' the premises, and argued that the nurses were rather 'accompanied' by the Quality Manager because they were 'upset' (HCCC, 2003, p. 160). Owen's interpretation of the events on the day is as follows

> We were told that we were being stood down, given that there were serious allegations made against us. We were not to

> report to duty. We were not to contact our colleagues either socially or with regard to work related matters … Neither myself nor my colleagues had any clue about the detail of the allegations made against us …. We were prohibited from contacting our colleagues and we learned over time that in the absence of any accurate and concrete statements from management we had been regarded within the rumour mill of the work place as drug dealers, drug addicts, fraudsters, alcoholics, indeed very undesirable personalities.
>
> (Ms Owen, Evidence, 12 March p.1 in NSW Parliament 2004f, p. 49)

This suspension of two senior nurses from the OT occurred without consultation with Solarz (the NUM of the unit), who was informed of the suspension without being offered a rationale or insight into the allegations that led to the decision.

The suspension of Quinn and Owen continued for 77 days until 5 July, 2002. During those eleven weeks, Quinn and Owen requested, through their legal and union representatives, full details of the allegations made against them, including the identity of the complainants. Their requests were refused in writing by MHS General Manager Collins (HCCC, 2003). The MHS executive undertook to investigate the allegations against Quinn and Owen by commissioning Jan Stow, a retired senior nursing administrator, to undertake an independent review of the OT work environment (HCCC, 2003).

The Stow Review began in April, 2002, and included a survey of 60 staff who were assured that data collected in the survey were confidential. They were not informed, however, that the data would be used as a central piece of evidence in a disciplinary investigation involving other staff (HCCC, 2003). Neither Quinn nor Owen was given the opportunity to

complete the survey, nor were they interviewed by Stow prior to her tendering her report in May 2002 (HCCC, 2003). The report by Stow identified

> specific and serious allegations about named staff members and then [put forth]thirty-three recommendations. The first four recommendations specify proposed management action to be taken against both named and unnamed staff members in relation to allegations of bullying, harassment, discrimination, corrupt conduct and professional misconduct.
>
> (HCCC, 2003, p. 147)

On receipt of this report on 24 May, 2002, Collins forwarded it to the Internal Audit Services unit of SWSAHS and requested it be examined in relation to *alleged corruption*. On 4 June the Director of Internal Audit Services at SWSAHS issued a response that noted the report's inadequacies, particularly insofar as it contained significant emotional content and its 'use of the terms fraud and corruption were inappropriate' (HCCC, 2003, p. 147). Despite this, the Human Resources Manager and the Director of Aged Care and Rehabilitation at MHS used Stow's report to support evidence gained in a fact-finding investigation conducted between April and June 2002, into the allegations of bullying, harassment and corrupt conduct by the senior nurses (HCCC, 2003).

Also informing the fact-finding investigation were interviews with Quinn (conducted on 12 June, 2002), with Owen (4 June, 2002) and with Solarz (23 April, 2002). At the request of the General Manager, written statements were collected from N17, N18, and N19 – the three nurses who had raised the allegations against the senior nurses. Yet no interview was conducted with N17, N18, N19 or with Anaesthetist D1 (HCCC, 2003).

On 5 July, 2002, Quinn and Owen were both invited to attend disciplinary interviews at which they were advised that all the allegations made against them had been substantiated. Quinn received documentation stating that the findings were substantiated by two specific incidents of harassment that included 'obstructive and argumentative behaviour towards an anaesthetist CMO' and 'being verbally aggressive and intimidating towards staff about attendance at an in-service session' (HCCC, 2003, p. 148).

In addition,

> five other general reports of harassment and five general reports of abuse of power [were] identified within the operating suite report conducted by an external consultant [i.e., Stow].
>
> (HCCC, 2003, p. 148)

Owen's documentation similarly recorded two specific instances of infraction: one involved 'staff being pressured and intimidated into adopting new work practices (sponge bags) and her behaviour towards Dr [Anaesthetist] D1 on 15 January 2002'. It was noted that although her treatment of a theatre orderly did not constitute harassment, the general allegations were

> supported by six general reports of harassment and six general reports of abuse of power identified within the operating suite review report conducted by an external consultant [i.e., Stow].
>
> (HCCC, 2003, p. 149)

The documents concluded that for both nurses concluded that the 'findings constituted a breach of the SWSAHS Code of Conduct Section 4' (HCCC, 2003, p. 149).

This meeting on 5 July, 2002, was deemed to constitute the nurses' first and final warning for breach of the *Health Service Code of Conduct*. The punishment imposed upon Quinn and Owen was the removal of their Clinical Nurse Specialist status (a demotion in professional status) and substantive adjustment to their respective positions on staff within the OT. Efforts were made by MHS to reintegrate both Quinn and Owen into other positions at Liverpool and Bankstown Hospitals operating theatres during August of 2002. Both nurses, however, tendered their resignations in September 2002.

Quinn reflected on her experiences of dealing with management at MHS in a 2002 interview with the Legislative Council investigating complaints handling within NSW Health: 'Unfortunately, the pursuit of my concerns led me to being shackled by management and thrown on the scrap heap' (Quinn Evidence, 12 March 2004, p. 3 in NSW Parliament 2004f, p. 28).

6.6 Censure of Solarz

The disciplinary investigation and the Stow Report also resulted in censure for Solarz. On 31 July, 2002[90] NUM Solarz was asked to attend a disciplinary meeting with the Acting Director of Nursing and Acute Services (ADNAS) and the Quality Manager (QM). She took with her a representative from the Nurses Association for support. At the meeting Solarz was asked to justify not only her behaviour towards Anaesthetist D1, but also her 'management of an allocation of time in lieu, flexible work

[90] Just three weeks after her colleagues had been demoted and removed from her service.

practices, the signing off of time sheets, pay for staff and delegation of managerial duties to staff' (HCCC, 2003, p. 150). Despite strong assertions from Solarz and her accompanying union representative that her behaviour towards Anaesthestist D1 was as an advocate for the patient and her safety, and that there were serious flaws in the previous investigations, the final report from this meeting found that certain allegations were substantiated (HCCC, 2003). Solarz was sent a letter on the 5August, 2002, advising her that the outcome of the fact-finding and disciplinary process had been the substantiation of the allegations against her, and that the letter comprised her first and final warning.

The other nurses Nurse Z, Angela Perez, Vanessa Bragg – who had raised nine allegations regarding patient care at MHS and who were to provide evidence to the inquiries that followed, were not, however, subjected to any disciplinary actions. Still, they had completed incident reports and were disillusioned and disappointed by the lack of response. Given Nurse Z's continued anonymity throughout each inquiry, no data is available to determine her nursing history at MHS. More information is, however, available on the other nurses. Perez worked as a Registered Nurse for 13 years in a medical ward at Camden Hospital until her resignation in March 2001; Bragg worked as a Clinical Nurse Specialist in the Intensive and Coronary Care units at Campbelltown Hospital and had 17 years' experience as a Registered Nurse, 14 at Campbelltown Hospital (Dasey, Totaro, & Pollard, 2003; HCCC, 2003; ICAC, 2005b; NSW Parliament, 2004f; Sacre & Timms, 2003; Walker, 2004a).

The nurses who reported their concerns (as well as those who came forward in the later inquiries) were individuals representing a diverse range of positions and scopes of practice within MHS: from an AHNM to an EN and from specialty areas such as OT and ICU to a general medical ward. Their length of service at MHS also varied: Martin, the most recent employee, had only one year of service, while Quinn had a long-standing employment record of 19 years. These nurses had significant professional experience in a variety of settings within MHS and elsewhere and, as such, should have been seen to have been well-placed to 'identify deficiencies in patient care and to alert management of the hospitals to problems' (HCCC, 2003, p. 2). The nurses raised their concerns repeatedly between 1995 and 2002; however, the response (or rather, lack of response) from MHS management to their concerns, catalysed the nurses into taking the extraordinary step of reporting those concerns to someone outside the organisation; someone whom they perceived could bring about some action and resolution.

To more fully appreciate the culture of MHS management and to assess their reactions to reported episodes of substandard clinical practice, the discussion now turns briefly to an examination of the reporting avenues available to the nurses at MHS. Included are the nurses' views and experiences of using these channels, as well as of the perceived effectiveness of these avenues in changing practice and improving patient safety.

6.7 Internal reporting practices at MHS

The most common avenue open to staff at MHS for the reporting of substandard clinical practice during the period 1995 to 2002 was the completion and submission of incident reports. Other measures included the raising of verbal concerns or complaints through the relevant line manager, or the referral of clinical cases to the relevant peer review committee, such as the CCRC, or to the Perinatal Mortality and Morbidity meetings. Each of these reporting avenues was employed by the nurses to emphasise what they perceived to be deficiencies in clinical practice and episodes of substandard clinical practice. However, despite adopting various forms of internal reporting, the nurses perceived that their efforts to be both unwelcome and ineffectual in the changing of practice to improve safety.

Incident reports (also known as problem reports during the period 1995-2002) were recorded on pre-printed pro-forma documents. They were used by nurses and other health staff in the identification of 'deviations from expected or standard practice' that could have resulted, or did indeed result, in patient, staff or visitor injury (NSW Health, 2000, p. 72; Walker, 2004a). The data collected from these forms included details of the time and location of the incident, the department involved, the immediate action taken and any recommendations by the author of the report that could, in their assessment, prevent the incident recurring. The incident report document also provided space for comments on the incident to be provided by the immediate manager and, ultimately, the MHS Executive (Walker, 2004a).

Completed forms were provided to the manager of the department or unit in which the incident occurred, who then referred them to the Director of Nursing and Acute Services (Walker, 2004a). After1999, when a computerised data system was introduced, elements of the procedure for recording, reporting and analysing incidents changed. While the report still followed through the channels of the Unit Manager to the director, the Quality Manager was also tasked with the role of uploading the data from the original incident document to the new computer information management system (Walker, 2004a).

When Owen began working in the operating theatres at MHS, she brought with her 25 years of clinical experience with other healthcare services. Upon witnessing repeated substandard clinical practice, particularly by medical staff, she began completing incident reports. In evidence given to the Parliamentary inquiry into complaints handling in NSW, she recalls her experience:

> Within the first few months I came across an experience which horrified me and I submitted a complaint and on the advice of my Nurse Unit Manager I was told to withhold my name from this complaint because, You are now working in a small hospital and complaints, if nurses make complaints against doctors they stand a very high chance of losing their job.
>
> (Ms Owen, Evidence, 12 March, 2004, p7 in NSW Parliament, 2004f, p. 47)

Fraser recounts similarly dismissive comments from senior managers in response to her concerns over patient care: ‘Tell someone who cares,’ she was told; ‘You have to understand you are at Camden, they do things differently here’; and, ‘You’re the only one who thinks this is a problem’

(Walker, 2004a, p. 116). Martin began submitting many incident report forms in an effort to highlight instances of substandard clinical practice; when there was inadequate staff or skill mix to deal with patients.[91] As she was later to recall:

> I started filling in Incident Forms when people weren't being resuscitated or when a patient's blood pressure reached a level requiring mandatory emergency care and they didn't get it. I put the forms under the Nurse Unit Manager's door but she said I was making a lot of work for her.
>
> (Zimmer & Jones, 2004, p. 2 of 4)

On another occasion, during the same period, Martin submitted an incident report detailing the management and care of a 73-year-old male patient who had suffered a stroke, complicated by diabetes and hypertension.[92] On this occasion she had not been directly involved in the management of the incident, rather it occurred prior to her starting her shift. Nevertheless, she had heard from other staff that a medical emergency team (MET) call had not been initiated even though the patient had a recorded blood pressure of 70/42, significantly lower than the threshold required to initiate a MET call. In order to complete the details of this incident form, Martin accessed the patient's clinical notes. Rather than informing Martin that the incident would be investigated and referred to the CCRC, the NUM disciplined her for breaching patient confidentiality during the formulation

[91] After being informed in a disciplinary interview that her clinical practice had been investigated and that she had performed skills outside the scope of an Enrolled Nurse, Sheree Martin felt the need to provide MHS management with examples of other episodes of substandard clinical practice that were occurring in her ward, particularly those which highlighted inadequate staffing and skill mix. Thus she completed various incident report forms during July 2002 (many of which were not dated or signed) in order to support her claim that there were mitigating circumstances, i.e., inadequate staffing and skill mix that lead to her working outside of her scope of practice.

[92] This case known as Incident no 13 in the HCCC and SCICCH inquiries

of the incident report (HCCC, 2003). The NUM's written response to Martin's actions reads:

> Each of these problem forms [i.e incident forms] were completed by the same staff member (Sheree Martin) who was not on duty at the time so therefore was not privy to the issues and actions that took place. On writing these reports I feel patient privacy and confidentiality has been invaded by accessing of notes and the presumption that issues had not been dealt with or dealt with incorrectly.
>
> (Walker, 2004a, p. 118)

The lack of feedback following the analysis of incident reports and, more particularly, the absence of any relevant reforms to prevent further incidents was given as a justification by other nurses for disengaging with the reporting process. Bragg identified this as a mitigating factor for not continuing to complete incident report forms. In the Parliamentary inquiry into complaints handling in NSW, she commented:

> An incident form could be anything from a doctor misdiagnosing a patient to a nursing staff member giving an incorrect dose of medication. It can be something simple to something severe. I used to write out the incident forms initially, my first few years that I was there, and in my later few years I stopped writing incident forms. It was general talk that it did nothing anyway. Even though you still hoped that there was something being done, you knew that there was no action being taken because there was no change.
>
> (Ms Bragg, former Clinical Nurse Specialist, Intensive and Coronary Care, Campbelltown Hospital, Evidence, 12 March 2004. NSW Parliament, 2004a, p. 11)

Later, Bragg was to describe her frustration at the lack of resolution and implementation of reform after incident forms had been completed, she cited one case in which she was directly involved and where the distress that she experienced compelled her to complete an incident report. This case involved an example of substandard clinical practice that combined poor

management, poor communication, under-diagnosis and the bungled transfer/transport of a seriously ill patient to Liverpool Hospital from the ICU at Campbelltown Hospital. The case, known as Incident 44 in both the HCCC (2003) and SCICCH (2004a), involved a near-term pregnant women suffering from acute respiratory distress.[93] In her incident report, Bragg alleged that the patient's deteriorating condition had not been not taken seriously enough by the obstetrician VMO, that poor communication between the obstetrician and ICU registrar had resulted in a general duty ambulance transport being summoned rather than Care Flight, and that the patient should have been transferred to Liverpool Hospital earlier. At Liverpool Hospital, the patient's daughter was born with cerebral palsy [94] (HCCC, 2003; NSW Parliament, 2004f; Walker, 2004a).

Bragg's incident report did not result in this case being referred to the CCRC for peer review. It was, however, presented at the Perinatal Mortality and Morbidity meeting, where issues regarding communication during the incident were raised. Still, no changes were made to any of the hospital's protocols to prevent future incidents of this kind (HCCC, 2003). Bragg

[93] In the final HCCC investigation report into MHS, the outcome or final condition of the patient (known as Ms LG in the HCCC report) and the baby delivered of her at Liverpool hospital (Incident 44) was not known: 'It is understood that both mother and baby survived but we have been unable to confirm this'(HCCC, 2003, p. 331). In addition to the MHS investigation, this case was also independently reported to the HCCC by Vanessa Bragg one year after the HCCC published its final report into MHS. In 2004, four years after the incident occurred, a new HCCC investigation into the case began. Despite being identified as Incident 44 in the MHS investigation, the patient (a Mrs Flegg) was not even aware that she had been at the centre of an investigation into the management of her care at Campbelltown Hospital until she was contacted by the HCCC in 2004 (NSW Parliament, 2004f).

[94] Cerebral palsy is an umbrella term applied to a disorder that impairs development of movement and posture in children causing disability; it is believed that one cause may be an in utero disturbance such as neonatal encephalopathy due to intrapartum (the period of labour and birth) hypoxic injury (deficiency in the amount of oxygen reaching the body tissues) (Johnson, Blair, & Stanley, 2011).

viewed this lack of action as unacceptable, and stated as much in her deposition to the Parliamentary inquiry into complaints handling in NSW:

> Sara Flegg's case was a typical example. Although it was severe, it was a typical example of the poor decision-making that goes on at Campbelltown Hospital. She was in a critical condition when she arrived to me and shortly after she was intubated and ventilated, put on life support, and she needed to be shipped out. A doctor overrode that decision and cancelled the Care Flight, which delayed her transfer. The worst part about that was, after all was said and done, there was a meeting about it and I saw the minutes of the meeting afterwards and the outcome was that there be better communication between the registrar and the VMO, which actually had nothing to do with the incident itself. What happened in the incident was that it was poor management. It was under diagnosis. The outcome was a way of obscuring what actually happened and therefore it was never going to resolve anything, which is actually what used to happen all the time at Campbelltown.
>
> (Ms Bragg, Evidence, 12 March 2004. NSW Parliament, 2004a, p. 20)

Bragg's experience provides an example of the flawed process that resulted in this case not being referred to the MHS CCRC. The CCRC was a central safety and quality working group specifically tasked with providing analysis of such adverse events and reported incidents, and with the results of the analysis, making recommendations for system-wide improvement (HCCC, 2003; NSW Parliament, 2004f). The Committee also had within its terms of reference the monitoring of 'inter-hospital transfer of critically ill or injured patients between acute hospitals in the area network' (HCCC, 2003, p. 128). The serious nature and the location of the incident, as well as the emphasis on inadequate planning for transport to Liverpool Hospital reported by Bragg, meant that it should have been referred to the CCRC.

6.8 The Critical Care Committee/Critical Care Review Committee

The Critical Care Committee (CCC) was established in 1999 as part of the Acute Services Business Plan and was one of three committees that reviewed patient cases by employing quality control indicators such as unanticipated deaths, unanticipated ICU admissions, MET utilisation and referred incident reports (HCCC, 2003). In May 2001 the Committee was renamed the Critical Care Review Committee (CCRC) and at that time recognition was given by MHS that the structure of the Committee made it impossible for members to investigate cases fully when they also had fulltime duties in other roles within the organisation. Additionally, no dedicated funds were provided to support any implementation and evaluations of reform (HCCC, 2003). Consequently, the CCRC was overwhelmed with cases and unable to provide recommendations in a timely manner. The Director of Medical Services and CCRC member Dr Helen Parsons reflected on this situation in 2004:

> We rapidly realised that we just couldn't deal with all the cases and we weren't dealing with them in a coordinated way. We were dealing with them in – you know, people, staff raised complaints.
> You know, someone around the system, around the hospital may have thought we could have done things better, and it was all just being sent to the Critical Care Committee.
> (Inquiry interview 13 April 2004, p. 18 in Walker, 2004a, p. 113)

One of the central complaints to be raised by nurse Fraser in relation to the CCRC was the fact that some completed incident reports were not

forwarded to the Committee and, when they were, the implementation of recommendations for system-wide improvement were delayed.

To illustrate her concerns Fraser reported on the response of MHS to the death of a 52-year-old woman (known as Mrs T) who, following three days of severe flank pain, presented to Campbelltown Emergency Department in October of 2001. Mrs T's condition was treated as a urinary tract infection and, despite evidence of hypotension and tachycardia, she was discharged ten hours after presenting. Sixteen hours later she was returned by ambulance and was dead on arrival (HCCC, 2003).[95] Fraser, as the rostered AHNM at the time of the incident, was concerned about the management of the case and the lack of senior medical coverage to review the patient. In keeping with her concerns, she duly completed an incident form. In the space allocated for recommendations, Fraser proposed that the case be reviewed by the CCRC that the coverage of senior medical officers to the Campbelltown Emergency Department be evaluated and that the Emergency Department have a medical registrar available at all times – 24/7 – to ensure that patients in a deteriorating condition were not prematurely discharged (HCCC, 2003; Walker, 2004a).

On receipt of the incident report relating to Mrs T, a senior MHS manager was 'critical of the wording of the nurse's report and queried the need for medical registrar coverage' (HCCC, 2003, p. 293). Despite these

[95] Known as Incident No. 23 in both the SCICCH and HCCC investigations, the death of Mrs T required referral to the Coroner for autopsy, where the following finding was made: "Dissection of the thoracic aorta caused by aneurysm of left internal mammary artery, possibility of connective tissue disorder". Despite this finding and the fact that the case was reviewed by an internal reviewer as well as the CCRC, neither internal MHS investigation requested or received the autopsy findings. (HCCC, 2003, p. 293).

reservations on the wording of the report, the senior manager nonetheless referred the case to the CCRC. Twelve months after the original incident, the CCRC implemented a revised nursing assessment form to be used in the Emergency Department. Fraser did not view this action as in any way satisfactory:

> Now, that lady was presented to the critical care committee and you know what their findings were, I've got it here? Here we go, an official memo, her findings were that we just need better documentation in the patient's notes. They could not see beyond the clinical management of this lady. She left, meeting emergency criteria. She dropped dead at home, in front of her five children.
>
> (Nola Fraser Interview March 2003 p. 76-77 in Walker, 2004a, p. 19)

According to Fraser, the delayed and inadequate response by the CCRC, as well as the lack of support from MHS in the implementation of their recommendations, were not unique to this case. At least four other critical incidents were subsequently identified involving patients treated in the Emergency Department during 2001 (Incident no's 16, 66, 67, and 69 in HCCC, 2003). Fraser summarised her experiences to The Hon. Amanda Fazio, Member of the Legislative Council, during the General Purpose Standing Committee No. 2 Inquiry into Complaints Handling within NSW Health:[96]

> **The Hon. Amanda Fazio:** You say [you submitted] 70 incident notification forms. When each incident occurred in the hospital you filled in the notification form and you lodged it with the appropriate people. What happened generally that you came to feel that the complaints processes were not being dealt with appropriately at the hospital? What action was taken by them after you put in the notification?

[96] For ease of explication the lengthy and somewhat cumbersome title of General Purpose Standing Committee No. 2 Inquiry into Complaints Handling Within NSW Health will be referred to as Inquiry No. 2

> **Ms Fraser:** There appeared to be no action, in that there was no follow up, there was no feedback. The same dangerous practices happened over and over again. I sat on a committee called the Critical Care Committee at which a lot of these cases were discussed and they seemed to miss the root of the problem and seemed to blame everybody. It was more a thing about blaming rather than fixing.
>
> (NSW Parliament, 2004a, p. 10)

Fraser's perception that the CCRC's failure to review relevant incident reports, recommend changes in clinical practice, and ensure these were implemented, was a view shared by other members of the Committee. Leanne Lancaster, a Clinical Nurse Educator in the Campbelltown Emergency Department from October 2000 to October 2001, attended some of the CCRC meetings during 2001 and was questioned by Legislative Council Member the Hon. Dr Arthur Chesterfield-Evans. Because of the pertinence of the testimony given by Lancaster regarding the functions of the CCRC the quote below is been reproduced in full.

> **The Hon. Dr Arthur Chesterfield-Evans:** Ms Lancaster, I understand that you were on the critical care committee at Campbelltown.
> **Ms Lancaster:** I was on and off. I did not attend all meetings but I was at some of the meetings of the Critical Care Committee.
> **The Hon. Dr Arthur Chesterfield-Evans:** We have had conflicting evidence on Nola Fraser. I am told she was also on that committee.
> **Ms Lancaster**: Yes, she was.
> **The Hon. Dr Arthur Chesterfield-Evans:** Did you put in complaints through that committee?
> **Ms Lancaster:** Complaints were usually lodged from the clinical face via incident reports and I did lodge incident reports and sent them through the channels that they were supposed to go through, which was the nurse unit manager, who then forwarded them up the chain of command.
> **The Hon. Dr Arthur Chesterfield-Evans:** Did Nola Fraser do that also?
> **Ms Lancaster:** Yes, I am sure she did. We had discussed some incidents in the past. I cannot recall specific incidents where she was concerned but she did lodge incident report forms, as we all did.

The Hon. Dr Arthur Chesterfield-Evans: Were they discussed at the Critical Care Committee appropriately?
Ms Arthur Chesterfield-Evans: Some issues were discussed at the critical care meeting.
The Hon. Dr Arthur Chesterfield-Evans: Were any not discussed?
Ms Lancaster: I could not tell you how many incident report forms I would have put in or that I would have counselled my staff to put in.
The Hon. Dr Arthur Chesterfield-Evans: Would you say that the ones that you did put in were adequately discussed by that committee?
Ms Lancaster: To the best of my recall none made it to that committee.
The Hon. Dr Arthur Chesterfield-Evans: Does that mean that they were culled before they got there?
Ms Lancaster: I do not know the process once they hit senior management. I do not know what happened once they got there.
The Hon. Dr Arthur Chesterfield-Evans: But you were putting the incident reports in at one end and watching the committee work at the other. You must have been able to see the beginning of the process and what came through at the end of the process.
Ms Lancaster: I was not a permanent member of that committee. I went on occasion to that committee when the nurse unit manager was not able to attend or they felt that it was better that my education background would serve the meeting better.
The Hon. Dr Arthur Chesterfield-Evans: Do you think that committee worked adequately to look at the quality of critical care that it was set up to look at?
Ms Lancaster: When complaints came to the committee I felt that the committee worked to try to look at a solution and put in some measures to prevent a recurrence of a particular incident. Again, recommendations come from that committee. Were those recommendations ever put into practice? Not to my knowledge.
The Hon. Dr Arthur Chesterfield-Evans: So you are saying that the Critical Care Committee did generally take appropriate action in terms of the committee itself but it was not implemented. Is that when [*sic*] you are saying?
Ms Lancaster: Well, I did not see any implementation in the 12 months I was there.
The Hon. Dr Arthur Chesterfield-Evans: You mean you saw that they were not implemented or you did not? You saw nothing or you saw lack of action?
Ms Lancaster: I saw lack of action in the 12 months that I was there.
The Hon. Dr Arthur Chesterfield-Evans: So management was not supportive of the conclusions of the Critical Care Committee, is that your opinion?

> **Ms Lancaster:** In the timeframe that I was there they did not appear to be supportive. However, I was not privy to management meetings so I could not tell you the discussions that resulted from the recommendations from the committee or whether there was a plan of action from management side to be put into action at a later date.
> **The Hon. Dr Arthur Chesterfield-Evans:** But you did not observe the fruits of any action plan?
> **Ms Lancaster:** I did not observe the fruits of any action while I was there.
>
> (NSW Parliament, 2004d, pp. 60-61)

The CCRC was the central quality control body and the correct avenue within MHS through which to deal with incident reports generated by the nurses in medical/surgical wards, ED, ICU and OT. Rightly or wrongly, however, the nurses perceived that issues resting at the heart of many of the cases reported yet were not adequately addressed.

The perceived dysfunction of the CCRC was understood to be related to the large volume of cases presented to it, coupled with inadequate support and resources to ensure that its recommendations were adopted. MHS General Manager Collins attempted to justify the actions of MHS by noting that 'all but one of the cases were reviewed prior to these allegations being received' (NSW Parliament, 2004c, p. 2), but Fraser and the other nurses were far from satisfied. Particularly as measures to address the underlying problems had been inadequately identified and that none of recommendations for change had been or were being implemented. In an attempt to effect action and ensure no further episodes of patient injury or death, the nurses explored various avenues before resorting to their meeting with the Health Minister. The nurses' actions, the avenues they explored,

and the personal toll experienced during the period before meeting with the Minister are briefly outlined in the following section.

6.9 Exhausting every avenue

Prior to meeting with the Health Minister, all of the nurses who had previously raised concerns within MHS explored alternative sources beyond their immediate managers in order to effect action and make changes to the then current practice and clinical governance. Their reporting attempts, as well as their disappointment at the inaction with which they were met, were verbalised by the nurses in various subsequent inquiries, as well as in the media.

From October, 2001, until March, 2002, Fraser began searching for alternative reporting avenues to address her concerns. The demotion in position from AHNM to a NUM of a medical ward at Camden Hospital, resulted in her being excluded from membership of the CCC (Walker, 2004a). While justified by management as being due to her change in position, Fraser perceived this exclusion as yet another example of a campaign being waged against her (Walker, 2004a). During this period Fraser declared to colleagues such as Dr Hugelmeyer (Director of Emergency Medicine, MHS) that she was being 'accused of being untrustworthy and insane by senior staff for making complaints' (NSW Parliament, 2004e, p. 10). In a *Sydney Morning Herald* newspaper interview in 2005, Fraser explained how she felt at the time:

> I felt like I was an alien on another planet, [...] The rest of the staff didn't speak the same language and, no matter what I said and no matter what we all saw, there was no connection between me and them whatsoever… The personal effect was

> devastating: I couldn't sleep for two years; I cried myself to sleep to think that those patients could have been saved if somebody just cared [...] I walked away shattered [...] thinking this had all been calculated, this had all been deliberate from these people, this had all been a set-up.
>
> (Duffy, 2005a)

Fraser began an extended period of sick leave from March, 2002, claiming that the stress associated with the situation was affecting her health. She submitted two workers compensation claims in 2002; both were rejected. Fraser was then asked by management to attend a meeting that was to consider her future employment. Fraser asserted during an interview with journalist Michael Duffy from the *Sydney Morning Herald* (2005b) that

> this was a turning point in her life and that of many others, for she refused to attend and instead sought a very different meeting, with Knowles.

A full year prior to meeting with Health Minister Knowles, Fraser sought guidance in addressing her rising concerns about the status of MHS complaint management and the lack of organisational reform to rectify the underlying issues. First, she contacted the HCCC by phone:

> I phoned them and I told them the situation and they said they were not the appropriate body. They said they deal with a case. They will look at one case only, and as you can imagine this was far greater than one case, this was a whole culture, and they just told me that they were not the appropriate body to deal with it.
>
> (NSW Parliament, 2004a, p. 10)

Later she turned to the NSW Nurses Registration Board

> I decided to turn to the New South Wales Nurses' Registration Board because they do govern our practices, and they told me that they do not make nurses accountable, that nurses can practice in this fashion. I described some clinical incidents, and it is not their role to make nurses accountable. At that stage I was a little bit frustrated because I was dealing with the

> HCCC as well who said they do not make anyone accountable.
>
> (NSW Parliament, 2004a, p. 12)

Her labyrinthine journey through bureaucratic, governmental, institutional and professional channels was summarised by Fraser in the SCICCH public forum on 7 June, 2004:

> After exhausting every avenue, we went to the executive level at Macarthur Health Service. We then went to the area health service. We then went to the New South Wales Nurses Registration Board. We then went to the New South Wales Nurses Association. We then went to Work Cover. We also put a formal complaint to the minister, prior to visiting the minister. All those investigations were sent straight back to the area health service for them to investigate - even the complaint to the minister....our concerns were there was really no independent avenue that we could utilise for our concerns to be heard.
>
> (Walker, 2004b, p. 149)

These are sentiments echoed by Quinn who recalled the avenues she explored with Owen before reluctantly deciding to join Fraser in her meeting with the Health Minister:

> The steps of Parliament House were not the first place we went. The media was not the first place we went. We went through the processes. Our problems were bumped back to the area health service. The main issue was denial that there existed a problem. The area health service and New South Wales Health has distant management. They have huge bureaucracies that are distant from the clinical coalface. The clinical managers have a vested interest in finding favourable outcomes. They don't want to find an unfavourable outcome and say, “Yes, we let this clinician be in charge of these cases and now we're telling you this person is incompetent.” They will not find that. They will find, “Yes, this clinician is clearly competent because we are responsible for leaving that person in charge”.
>
> (Walker, 2004b, pp. 152-153)

Thus, the nurses recount their reporting actions through various levels of internal MHS management, as well as avenues outside MHS. Their

complaints of substandard clinical practice and inadequate systems to protect patient safety and quality of care at MHS were met with indifference or deferral. Each time the nurses reported their concerns to personnel within NSW Health, they were directed back to MHS management who denied that a problem existed. This Kafkaesque situation resulted in the nurses considering that their next course of action, although drastic, was unavoidable: to report to the Health Minister.

6.10 Investigations begin

On 5 November, 2002, Fraser, Martin, Owen and Quinn, together with their solicitor, met with the then NSW Health Minister Craig Knowles. In the meeting, they alleged that episodes of substandard clinical practice had been and were being mishandled by management at MHS and specifically by the CCRC. They also related their own experiences of intimidation and discipline by MHS management as examples of a culture that discouraged internal reporting of patient safety concerns (HCCC, 2003; ICAC, 2005a; Walker, 2004a).

Minister Knowles responded to the meeting with the nurses by requesting that the Director General of the Department of Health (DoH) investigate the allegations made. The Director General then requested that the Director of Audit of the DoH commence an initial investigation. This included interviewing Minister Knowles and each of the four nurses who had met with him, as well as three other nurses who had subsequently come forward to support the allegations made (Hindle *et al.*, 2006; Walker, 2004a). Thirteen days later, on 18 November, 2002, the Director General

referred allegations relating to 47 clinical incidents to the HCCC, and, in keeping with the *Health Care Complaints Act 1993*, followed this with a statutory declaration to the HCCC made on 21 November, 2002 verifying the complaint (HCCC, 2003).[97]

The HCCC investigation began with a focus on the standard of care provided to patients, on the adequacy of quality and safety systems at MHS, as well as on the 'allegations that management had intimidated and disciplined nurses who reported problems and errors' (HCCC, 2003, p. 2). The investigation resulted in the analysis of the 47 specific clinical incidents alleged to have occurred between June, 1999, and February, 2003; after thirteen months of investigation, the *HCCC Macarthur Health Service Investigation Report* was delivered to the Director-General of the DoH, and published on 9 December, 2003 (Walker, 2004e). The published report strongly supported many of the allegations made by the nurses, finding that 'in some instances the care was so poor that the patients suffered serious deterioration in health' (HCCC, 2003, p. 4 part 1). In spite of this, the report did not include any prosecutorial or disciplinary plans to be directed against any of the individual practitioners whose conduct it had brought into question.

This omission was seen by the new Health Minister, Mr Morris Iemma, as a failure on the part of the HCCC to discharge its statutory responsibilities (Cabinet Office New South Wales, 2004). Health Minister

[97] The complainant in the statutory declaration was the Director-General of the Department of Health, and not the nurses who made the original allegations to the Minister for Health. No individuals were named in the complaint, which referred instead to Campbelltown Hospital, and Camden Hospital. Because of their overall responsibility for the two hospitals identified, however, the MHS and SWAHS were also named (HCCC, 2003).

Iemma[98] reacted within two days of the Report's publication by sacking the SWSAHS Board and the HCCC Commissioner, Ms Amanda Adrian. On ABC Television's *7.30 Report* for 12 December, 2003, Minister Iemma stated:

> The [HCCC] report, whilst it roared incompetence, it whispered solutions. And that's just not good enough. To have outlined the lack of care, the substandard care, was one thing and then not to bring forward firm plans for action and accountability was where it fell down.
>
> (Bannerman, 2003)

The NSW Premier Mr Bob Carr responded to the perceived shortcomings of the HCCC Report by requesting that the Governor appoint Special Commissioner Brett Walker to conduct a Special Commission of Inquiry into the allegations of unsafe and inadequate patient care at Campbelltown and Camden Hospitals (Cabinet Office New South Wales, 2004; Hindle *et al.*, 2006; Walker, 2004e). The inquiry was to be carried out under powers and duties outlined by the *Special Commissions of Inquiry Act 1983* (Walker, 2004b).

Under the stewardship of its soon-to-be-dismissed Commissioner, Amanda Adrian[99] (who was at that time endeavouring to move the HCCC away from its traditional prosecutorial approach) the HCCC had applied a systems-orientated investigation. To assist an understanding of the rationale behind this strategic direction, and the negative public response to the HCCC's lack of action in holding individual practitioners accountable, the

[98] In a Cabinet reshuffle following the State election in March, 2003, Minister Knowles was moved to the Infrastructure and Planning and Natural Resources portfolio.

[99] Adrian was appointed as the Commissioner of the Health Care Complaints Commission from June 2000 until December 2003. Adrian was a hospital educated registered nurse and a graduate in Law, although she was never admitted to the Legal Practitioners Admission Board as a legal practitioner (Walker, 2004e, p. 81).

following section explores the origins of the HCCC as a statutory authority and its changing focus from the investigation of individual practitioners to a more systems-based approach.

6.11 The Health Care Complaints Commission

The Health Care Complaints Commission (HCCC) was established as a statutory authority in 1993 under provisions contained within the *Health Care Complaints Act 1993.* The Commission's role according to the Act was to: receive, assess and investigate the nature of complaints relating to health services and health service providers in NSW; to prosecute serious complaints; and to resolve or oversee the resolution of complaints. A decade before the *Health Care Complaints Act 1993* and the institution of the HCCC, the Complaints Unit of the NSW Department of Health had been established.[100]

Composed entirely of lay personnel, the Complaints Unit had the power to investigate and pronounce on medical professional conduct, and was intended to quell growing public concern regarding the Health Department's failure to investigate complaints and evidence of patient abuse, particularly in the wake of the Chelmsford Private Hospital deep sleep scandal (NSW Parliament, 2004f; Thomas, 2006).

Between 1993 and 2002, a change occurred in the manner in which human error management and patient safety failures were regarded and

[100] On 26 April, 1983, the then NSW Health Minister Laurie Brereton announced the establishment of the Complaints Unit of the NSW Department of Health; its first task was to investigate doctors at Chelmsford Private Hospital. This was the first non-peer institutional body to review medical professional conduct in Australia and was also the first time anywhere in the world that medical disciplinary autonomy had been challenged (Thomas, 2006).

investigated by the HCCC. From the traditionally prosecutorial approach of naming, blaming and shaming individual practitioners that emerged as a response to the Chelmsford scandal, the Committee moved towards the systems-based approach used during the MHS investigation. This new investigative approach reflected both a change in attitude and in contemporary research into human error management in healthcare by recognising that adverse events and problems in healthcare are rarely attributable to a single cause, and that holding individuals solely accountable for failures within healthcare *systems* was counterproductive (HCCC, 2003a; Adrian, 2002).

During 2002-2003, the HCCC investigated the allegations relating to the 47 clinical incidents that occurred between June, 1999 and February, 2003 at MHS. Under the stewardship of Commissioner Adrian, the HCCC interpreted the complaint as having been filed against the MHS (i.e the service as a whole) rather than the *individual* health professionals who could have been identified in the clinical incidents (Hindle *et al.*, 2006). As stated in the report itself, the 'approach was to identify the patients in the alleged clinical incidents and focus on the *systems* and *culture* at MHS' (HCCC, 2003, p. 3 part 1 Emphasis added), it was evident from the outset that the HCCC sought to investigate the allegations as adverse events and human fallibility resulting from a chain of error in a system. In the forward to her report, the Commissioner stated:

> The Commission's experience and the research show that many adverse events and problems that arise in the provision of healthcare are not merely attributable to one individual who was on the spot at the time the event occurred. They are often the result of a chain of errors or failures in the system of care

> that, unless identified and fixed, will lie latent until the circumstances occur again.
>
> (HCCC, 2003, p. i)

In short, the HCCC investigation attempted to find the errors in the system at MHS that contributed to incidents at the centre of the nurses' allegations. In the final HCCC report into MHS, recommendations were outlined to address the multiple systemic problems found in the investigation. In keeping with the notion that these events were 'not merely attributable to one individual' (HCCC, 2003) no clinicians (doctors or nurses) were named or referred to their respective registration authority to be held accountable for providing substandard care. The final HCCC report into MHS did make it clear, however, that future disciplinary action against individual practitioners, if warranted, would not be ruled out. Nonetheless, at the time that the first interim report was presented to the Health Minister and the Department Heads at SWSAHS, many of the individuals implicated in the allegations had yet to be interviewed by the HCCC staff or notified that an investigation was underway.

The first that many of the clinical staff knew of the allegations, and the implication that the HCCC had 'substantiated' deficiencies in clinical practice, was when the HCCC's Interim Report of the was leaked in September, 2003 (Walker, 2004a). The nurses, the politicians and the media, all of whom continued to look for someone to blame, deemed this stance unsatisfactory. Equally, the clinicians at the centre of the allegations reported their dissatisfaction through their professional bodies such as the Australian Medical Association.

6.12 The leaking of the HCCC report to the media September 2003

In September, 2003, three months before the final HCCC report was delivered to the Director-General of the DoH, details of the HCCC investigation, including some of the preliminary findings, were leaked to the media.[101] The media picked up the matter immediately with a series of headline stories. The key focus of the articles and news reports spawned by the leaks was that, despite 17 deaths being linked to 'unsafe, inadequate care or questionable care', no one was being held to account (Kidman, 2003c).

The media coverage of the leaked HCCC Preliminary Findings began as an exclusive by Fairfax journalist John Kidman in two of that media group's leading newspapers on 14 September, 2003. The *Sun Herald* in Sydney led with a frontpage headline declaration of 'Sick Hospitals'. This was followed by 'Report exposes the hospitals of horror' on page 4 and 'Mother who need not have died' on page 5 (Duff & Kidman, 2003; Kidman, 2003b, 2003c). The *Sydney Morning Herald* headlined with 'Report exposes hospital malpractice' (Kidman, 2003a).

The coverage was extended on the same day by an *ABC News Online* story: 'Report finds unsafe practices at Sydney hospitals' (ABC, 2003d). As was the case with the newspaper accounts, the ABC item immediately focused on the contention that 17 patients who had died at Camden and Campbelltown Hospitals deaths during the period of 1999 to 2003 had

[101] The source of the leak was not known. Commissioner Walker in the final SCICCH report identified that it was beyond the inquiry terms of reference for him to investigate the origins of the leak (Walker, 2004a). In the Parliamentary inquiry into complaints handling in NSW, Amanda Adrian reported that she was unable to locate the source of the leak however two copies of the interim report were provided to SWSAHS to be provided to the relevant clinicians and management to respond (Parliament of New South Wales, 2004c).

'received unsafe, inadequate or questionable care' (Kidman, 2003c). The Health Minister Morris Iemma was swift and direct in his response:

> I give them [the patient's families] this commitment - that there will be firm and decisive action.
> That people who need to be held to account will be held to account there'll be no sweeping anything under the carpet and secondly, that we put in place an action plan to lift the standard of care and safety at those two hospital.
> (ABC, 2003d)

During the first week that following the leaked report there was further extensive media coverage. An examination of this coverage reveals three themes. The first being the reaction of the families of patients who had died, the second, the response of the nurses and, lastly, was the response of the medical staff who worked at MHS, including some who had contributed to the care of some of the 17 patients. None were happy with the direction the HCCC inquiry was taking. The families reportedly wanted 'those responsible to be held accountable'(Duff & Kidman, 2003). It was reported that nurses believed 'additional patient records and incident reports collected by them had never been looked at' and 'called for an open parliamentary inquiry into the affair' (Kidman, 2003d). The medical staff at MHS meanwhile, threatened to resign over what they believed to be an unfair process by the HCCC, which concluded that allegations of inadequate care were 'substantiated', without offering those individuals an opportunity to make individual submissions to defend themselves (ABC, 2003b).

The spouses of two patients presented emotional stories in the *Sun Herald* of retelling how their wives had allegedly been mistreated at Campbelltown Hospital: Mrs Dawn Alexander 'Mother who need not have

died', and Mrs Marie Bently 'Marie was treated like a statistic'(Duff & Kidman, 2003; Wood, 2003). The national television current affairs program *60 Minutes* later picked up the stories of these women's deaths. On Sunday, November 2, 2003, *60 Minutes* presenter, Liz Hayes, interviewed Health Minister Iemma, the women's husbands, Peter Bently and Omar Alexander, as well as nurses Fraser, Martin and Bragg (Sacre & Timms, 2003).[102] The program aired one month before the final HCCC report was published on 9 December, 2003.

During the period of heightened publicity surrounding MHS, and in the wake of the leaked HCCC interim report, Professor Bruce Barraclough and a 'team of clinical experts' were sent in by the Health Minister. In October 2003, Professor Barraclough reported to the Health Minister that he had found 'significant shortcomings in the structures and practices of the South Western Sydney Area Health Service' and recommended changes to the leadership in both the clinical and administrative management areas (NSW Parliament, 2004b, p. 45; Pollard, 2003). The Health Minister responded with an additional allocation of five million dollars funding for MHS and what appeared to be a reshuffle of senior officials at SWSAHS (Pollard, 2003). Collins resigned her position in MHS to take up another position within NSW Health; the Deputy Director-General of NSW Health, Debora Picone, took over as Acting Chief Executive of the service; and the Chairman of SWSAHS Grahame Bush was stood aside following an allegation that he had 'described the nurses who made complaints as having

[102] Only Nola Fraser, Sharee Martin and Vanessa Bragg were quoted in media coverage examined after the leaked report in September 2003. It appears that the other nurses Valerie Owen and Yvonne Quinn did not engage with any print or television media.

psychiatric problems' (Pollard, 2003). This all occurred before the release of the much anticipated final HCCC report.

By 20 November, 2003 the HCCC inquiry was being called into question in the NSW Parliament. The Leader of the Opposition, John Brogden, called for an independent judicial inquiry. He argued that the HCCC statement declaring 'no findings to support any loss of confidence by the community in the Macarthur Health Service',[103] was not supported by the evidence which had come to light since the leaking of the Preliminary Report (NSW Parliament, 2003, p. 5477). The Health Minister attempted to assuage Members of Parliament by stating:

> As I have consistently said, if when the final report is handed down there is an adverse finding against an individual, no matter who it is or what position they occupy, they will be brought to account, as they should be, after due process has been exhausted.
>
> (NSW Parliament, 2003, p. 5474)

The stance taken by Members of Parliament calling into question the HCCC investigation was immediately picked up by media sources; the national broadcaster headlined its news bulletins with the story: 'Opposition calls for judicial inquiry into NSW hospitals' (ABC, 2003c) and followed up with a *Stateline NSW* TV program titled 'Hospital Deaths Enquiry Inadequate' (2003). Reporter Quentin Dempster discussed the parliamentary debate surrounding the HCCC inquiry before asking Health Minister Iemma on camera whether he could:

> give us an assurance that this HCCC Report won't be dropped [i.e., released to the media] at a media-convenient time, meaning that it won't be dropped when everybody's off on

[103] Made by a spokeswoman of the HCCC on February 25, 2003 to the Health Minister.

> Christmas holidays, it'll be dropped as soon as possible? Iemma replied 'Absolutely'.
>
> (Dempster, 2003)

The program also included an interview with Fraser who verbalised her lack of confidence in the HCCC investigation. Dempster concluded the program with the following:

> The credibility of the Health Care Complaints Commission now appears to be on the line. If its investigation does not convincingly get to the bottom of all the complaints at Camden and Campbelltown, pressure will build for a parliamentary or judicial inquiry into practices there and across the system.
>
> (Dempster, 2003)

The media output surrounding the issue focused on the State Opposition's call for a new inquiry and for the individuals responsible to be sacked. There is scope to suggest that this tactic could be construed as compounding political pressure on the Government to account for the crisis. It was just 20 days before the final HCCC report into MHS was to be released.

6.13 The reaction to the final HCCC Final Report

The HCCC Final Report into the Macarthur Health Service (HCCC, 2003), published by the Director-General of the DoH on 9 December, 2003, became the focus of the media reporting two days later, with the dramatic news that Health Minister Iemma had sacked both the HCCC Commissioner and the entire Board of the South Western Sydney Area Health Service (SWSAHS). Iemma also declared that former MHS General Manager Collins 'would be given a week to show cause why she should not be removed from her new post with the Central Sydney Area Health Service'

(Robotham, 2003).[104] At the same time the NSW Premier Carr announced the appointment of Special Commissioner Brett Walker to conduct a Special Commission of Inquiry into the 'allegations of unsafe and inadequate patient care at Campbelltown and Camden Hospitals'(Walker, 2004a).

Momentum was maintained with the announcement of further inquiries a week later, including the Legislative Council Parliamentary 'Inquiry into Complaints Handling Within NSW Health' to begin in March 2004, as well as an Independent Commission Against Corruption (ICAC) 'investigation into the alleged misconduct associated with the former South Western Sydney Area Health Service' (ICAC, 2005b, p. 6) which began in August 2004.

The media reception to the announcements of new investigations into MHS and the sacking of the HCCC Commissioner was mixed. Many newspaper reports were optimistic regarding the renewed opportunities these developments presented for the nurses and families to be heard. The *Sydney Morning Herald* ran reports declaring 'Avenue opens for health workers to speak out' (Pollard & O'Malley, 2003) and 'The search for truth starts now' (Totaro & Pollard, 2003). Other reports were not so enthusiastic and deemed the sacking of the HCCC commissioner to be the 'drastic and diversionary' response of a government seeking to shift the focus of blame ("Hospital deaths: too many cover-ups," 2003, p. 12; Robotham, 2003).

The sacking of the HCCC Commissioner provoked an immediate response from the Health Complaints Commissioners of Australia and New

[104] Jennifer Collins was later sacked on 20 December, 2003 (ABC News, 2003a)

Zealand. In a media release prepared by the Victorian Health Services Commissioner, Beth Wilson, on behalf of her colleagues, wrote that:

> Health Care Complaints Commissions must be able to investigate and report on patients' complaints without fear or favour, independent of the Government of the day. Commissions must be accountable for the quality of their work, but the sacking of a Commissioner – because the Government does not accept the message contained in a major investigation report undertaken by a Commission – sends a very unfortunate signal. The possibility of a Commissioner being removed from office by a Minister who doesn't like the outcomes of an investigation is inconsistent with the concept of independence…Shaming and blaming does not help to bring about cultural changes.
>
> (Wilson, 2003)

The sacking of the HCCC Commissioner had all the hallmarks of a political move by the Carr Government, aimed at deflecting attention away from its own level of accountability for the culture existing within MHS whereby inadequate quality and safety systems resulted in a failure to protect patients. The HCCC Final Report explicitly identified the 'flawed and underdeveloped system of organisational management at MHS' (HCCC, 2003, p. 6), which had failed to recognise that the concerns raised by the nurses were important signs of a system in distress. The HCCC found that MHS management responded to allegations by retreating into a defensive position, discouraging openness, and actively punishing any individuals wanting to shed light on the system that was responsible for the patient injury and death (HCCC, 2003).

The message delivered by the final HCCC Final Report suggesting deficits in MHS organisational management damaged the Governments standing, particularly in the wake of the State Opposition's repeated claims

that the MHS was merely one example among many in a systemically mishandled Health portfolio. It was much easier, politically at least, to divert the focus of attention onto a failing regulatory body than to face the reality that the system itself was in failure. Prophetically, in the forward of the Report appeared the following quote:

> Sometimes it is tempting to avert your gaze from a problem – particularly if it involves confronting deep seated issues within the organisation. To look away is almost always a mistake. The courageous route is to face up to it and resolve it despite the difficulties.
> (Liam Donaldson – CEO of the UK NHS in HCCC, 2003, p. ii)

The foreword of the HCCC Report included scathing criticisms of the MHS, which could have just as easily been levelled against the Government itself given its own response to the nurses' allegations following the Final Report:

> They [MHS] 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.
> (HCCC, 2003, p. ii)

Fraser reiterated this lost message during an interview on the *Sunday* program February 29, 2004: 'We did not blow the whistle on deaths. We blew the whistle on unsafe practices at Campbelltown Hospital' (Davis, 2004).

6.14 The Walker Special Commission of Inquiry

On 11 December, 2003, Commissioner Walker was appointed by the NSW Governor Professor Marie Bashir to 'inquire into and report on allegations of unsafe or inadequate patient care at Campbelltown and Camden Hospitals

and other relevant matters' (Walker, 2004a, p. 168). The scope of the Special Commission of Inquiry into Campbelltown and Camden Hospitals (SCICCH) as outlined in the letters patent[105] was modified twice. First, on 21 January, 2004, to 'encompass all the nurses who had made relevant allegations about patient care at the two hospitals', and then on 10 March, 2004, to 'include the treatment received by Vera Lalic and her baby Natalia Lalic' (Walker, 2004a, p. 168).

The SCICCH began its investigation amid expectation from the nurses, politicians, media and the public, that those responsible would be held to account. Early in the investigation, on 19 December, 2003, Commissioner Walker arranged a meeting with the ICAC Commissioner to ensure that the public became aware during the investigation process of each investigating agency's responsibilities.

In a joint statement it was noted that the SCICCH

> would focus on the adequacy and safety of patient care at Campbelltown and Camden Hospitals and the Health Care Complaints Commission processes, but the Inquiry [SCICCH] would not make findings on allegations of corruption.
> (Walker, 2004a, p. 170)

Three months into the investigation, on 31 March, 2004, Commissioner Walker issued an Interim Report, the purpose of which was to promote awareness that the SCICCH would provide conclusions and recommendations, which would prompt a resumption or commencement of formal investigations into the more serious allegations (Walker, 2004b, p.

[105] A requirement of the *Special Commissions of Inquiry Act 1983.* The letters patent "authorising or requiring the person to inquire into and report to the Governor on any matter specified in the commission" (Section 4 *Special Commissions of Inquiry Act 1983* No. 90, Part 2, Establishment of Special Commissions 4 Issue of Commission

11). It also recommended that in specific patient cases 'the conduct of certain doctors and nurses should be properly considered with a view to possible professional discipline, by the appropriate statutory bodies and procedures' (Walker, 2004b, p. 3).

At the time of the Interim Report's publication, Commissioner Walker had already formed the view that the conduct of twelve medical practitioners in relation to the treatment of ten patients required re-examination by the HCCC, and noted that five of these medical practitioners had already been referred by the HCCC to the NSW Medical Board (Walker, 2004a). In light of the high expectations surrounding the Inquiry, Walker also made it explicitly clear that:

> No Special Commission of Inquiry, including this one, could make operative decisions about the discipline of medical practitioners or nurses. That power quite properly resides with the Medical Tribunal, Nurses Tribunal and those who administer other forms of professional discipline. The law made by Parliament, relevantly the *Health Care Complaints Act 1993,* the *Medical Practice Act 1992* and the *Nurses Act 1991*, specifically provides for specialist bodies to carry out those important tasks. This Inquiry does not supplant the continued authority of the bodies and officers under those statutes, in relation to the alleged matters of poor care or misconduct at Campbelltown and Camden Hospitals.
>
> (Walker, 2004b, p. 3)

The SCICCH then convened six days of Public Hearings, the first of which, held on 26 March 2004 was to address the issues regarding those details which should be published in the Interim Report.

Day Two was convened on 8 April, 2004 and focused entirely on the testimony of former HCCC Commissioner Adrian, with particular reference to how the HCCC had complied with its statutory obligations under the

Health Care Complaints Act. On 16 April, 2004, Day Three of the Public Hearings, Commissioner Walker questioned two witnesses regarding the clinical governance processes in use by MHS at the time of the incidents as well as the manner in which MHS responded to the HCCC Inquiry. Director of Medicine, Associate Professor Bradley Frankum,[106] and Professor Jeremy Wilson, the Chairman of the SWSAHS Clinical Council. A line of questioning directed at Associate Professor Frankum focused particularly on his understanding of the meaning of the terms 'adverse events', 'unsatisfactory professional conduct' and 'professional misconduct'. Both witnesses professed ignorance of the statutory obligations of the HCCC to refer individual practitioners to the Medical Board, and stated that during the HCCC investigations they had been assured that the investigation was not 'interested in individual clinicians, so much as systems issues'(Walker, 2004g, p. 122).

The fourth day of public hearings, 5 May, 2004, heard further evidence from Associate Professor Frankum and Adrian. The former was quizzed on the end-of-life care management plans adopted by MHS, while Adrian was pressed on specific features of the initial MHS investigation. Of particular concern were the decision to characterise the complaint as against MHS rather than individual practitioners, and the process of investigation then employed which had resulted in 'allegations of substandard care against or directly involving certain doctors and nurses' being substantiated (Walker, 2004d, p. 228). Days Five and Six of the Hearing, on 7 and 4 May,

[106] It is important to note that the Director of Medicine, Assoc. Prof. Bradley Frankum did not take up this position at MHS until 13 January, 2003, long after the events under consideration here had taken place.

2004, respectively, continued an examination of the minutiae underlying decisions made by Adrian and the HCCC during the various stages of the investigation. Adrian was the only witness called and cross-examined on these days.

Further to the public hearings, the SCICCH convened two public forums: the first on 24 May, 2004, and the second over two days, on 7 and 8 June, 2004. At the first of these fora the operation of the *Health Care Complaints Act* and related health practitioner legislation was discussed; at the second, consideration of 'the inter-relationship between healthcare complaints, individual professional accountability and systemic improvement' came under detailed consideration (Walker, 2004a, p. 181). Each forum was attended by various stakeholders who came forward in response to advertisements placed in metropolitan and regional newspapers by the SCICCH. The SCICCH received 142 submissions between December 2003 and July 2004, conducted 13 interviews with the nurses and issued summonses for the provision of relevant documents[107] as evidence from MHS and SWSAHS (Walker, 2004a).

Much of the SCICCH investigation focused on a critique of the HCCC investigation, particularly regarding the questionable interpretation of its terms of reference, which allowed the HCCC to treat MHS as the central subject of the complaint. Adrian had significant difficulty in explaining how the HCCC could publish a report that contained substantiated complaints against specific clinicians, yet fail to refer those same clinicians for

[107] Such as medical records, minutes of various quality management committees such as the CCC, as well as incident reports.

disciplinary adjudication by their relevant profession boards, i.e., the Medical Board and the Nursing Board of NSW.

Full examination of the details of the *Health Care Complaints Act* and of the failure of the HCCC investigation into MHS to meet its statutory obligations contained therein, lies beyond the scope of the current study. In keeping with the aims of this thesis, the focus here turns to a summary of those SCICCH findings centred on the role of the nurses who brought forth the original allegations, and on the reaction of MHS to their expressed concerns.

In the final SCICCH report of 30 July, 2004, eleven of the 67 allegations made by the nurses were referred for further consideration by a newly convened HCCC[108] investigation; two were already under investigation by the HCCC and by the Coroner. In addition, Allegation 21- that managers had removed patient records - was at that time under investigation by ICAC. For various reasons, the bulk of the allegations were deemed to require no action by the SCICCH. In 23 of the allegations, the SCICCH found there to be a lack of evidence sufficient to identify the patient or incident in order to complete an investigation. Seven allegations lacked supporting evidence generally; a single allegation had previously been managed internally by the hospital; and 22 of the allegations were identified by the investigating team as requiring no referral to the HCCC at all (Walker, 2004a, pp. 202-206 Appendix I).

[108] The total number of practitioners referred to the HCCC included 15 doctors, 11 nurses and one physiotherapist, five doctors were then sent to the New South Wales Medical Board where "two of the five have been cleared of the complaints against them"(Hindle *et al.*, 2006, p. 54).

The SCICCH report contained details of three allegations made by Fraser[109] that members of MHS management and an HCCC legal officer had prevented or impeded the HCCC's investigation of patient cases. The first allegation was that the then Director of Medical and Clinical Outcomes at MHS, Dr Helen Parsons had asked a VMO in Obstetrics and Gynaecology Dr Mary Prendergast, to 'alter the notes of a patient' and that when the latter failed to do so Parsons accused her of not being a 'team player' (Walker, 2004a, p. 98). Upon investigation, the incident involved a request by Parsons for Prendergast to amend part of a statement that she had prepared outlining her management of a 32-year old pregnant (16 weeks) woman who presented to Campbelltown Hospital ED with symptoms of pre-eclampsia: extremely high blood pressure, shortness of breath, peripheral oedema and proteinuria.[110]

In her original statement Prendergast had remarked that '*there was a delay of over 3 hours before the O&G Department Staff were notified re this patient*' (Walker, 2004a, p. 98, emphasis in original). Upon receipt of the statement, Parsons asked Prendergast to remove the remark as it reflected poorly on the Emergency Department. Prendergast refused to do so and recalled Parsons saying: '*Well I wouldn't expect any more of you. This goes with your pattern of not being cooperative and working as a team member in situations*' (Walker, 2004a, p. 99, emphasis in original). Parsons denied that she had made the comment. The fact that no medical records were

[109] Chapter 7 of the SCICCH final report titled Cover-up allegations.
[110] Known as Incident 66 in the HCCC investigation.

altered and that the report by Prendergast was eventually sent unamended to the HCCC, led the SCICCH to deem the allegation to be unfounded.

The second allegation by Fraser, that managers had destroyed patient records was not investigated by the SCICCH, but instead directed to the ICAC. The third allegation chronicled the conduct of an HCCC legal officer, Sarah Connors, who Fraser alleged had, during a telephone interview in January 2003, refused to allow the referral of two additional incidents to the HCCC for investigation. In response to this claim, Connors denied that she had been given any specific details about patients and that her recollection of the conversation was that it was merely a general discussion about poor care at MHS. The two additional cases in question were subsequently raised in interviews by the HCCC with Fraser in March 2003 and had at that time been designated as Incidents 39 and 39. The SCICCH somewhat disingenuously labelled the conversation 'an unfortunate misunderstanding or crossed purposes between [Fraser and Conners]' (Walker, 2004a, p. 101).

Much like the HCCC, the SCICCH spent time examining the processes by which concerns regarding patient care were raised.[111] The nurses' main allegations concerned that fact that:

- a number of those completed incident forms have not been able to be located;
- feedback as to the action taken was not provided to the author of the incident report;
- the action taken as result of concerns raised in the forms, in particular the consideration by the CCRC, was a long time coming and the implementation of any recommendations by that Committee was delayed or did not eventuate; and

[111] The focus of Chapter 8 'Raising Concerns About Patient Care' in the final SCICCH report

- the response by certain managers to the concerns raised was not appropriate.

(Walker, 2004a, p. 103)

Since elements of the internal reporting practices at MHS have been described earlier in this chapter, a brief summary only is provided of the SCICCH response to these allegations. This deals specifically with the inability to locate incident forms, the lack of action and feedback from the CCRC or response by managers.

6.14.1 Incident forms unable to be located.

The SCICCH investigative team outlined its attempts to trace the incident reports allegedly submitted by the nurses. Like the HCCC, it had a great deal of difficulty doing so, although it did uncover 59 incident forms authored and requested by the nurses, of which 40 related to their allegations about unsafe or inadequate patient care. Despite these efforts the nurses claimed 'up to 74 reports have not been located' (Walker, 2004a, p. 106). Following a review of the processes that occurred at MHS from 1999-2002, the SCICCH concluded that the system of receiving, registering and processing data was flawed, as was the trending of information.

Additionally, although the early paper hard copies had now been moved to a computer-based system, the database was incomplete. The inability to locate incident reports was characterised as a consequence of a flawed system rather than being indicative of any sinister motivations. The suggestion that there was deliberate removal incident forms to cover up incidences of alleged unsafe patient care was ultimately rejected (Walker, 2004a).

6.14.2 Feedback on the action taken and the CCRC

While the SCICCH did find evidence that feedback to those who submitted incident forms was either slow or non-existent, it did not consider this lack of action to be deliberate. Senior MHS managers such as Director of Nursing and Acute Services Malcolm Masso readily acknowledged 'that there was no formalized system for providing feedback' (Walker, 2004a, p. 112). This admission led the SCICCH to declare:

> It is a basic principle of good complaint management to respond to those who take time to register their concerns, and advise them of the actions that have been taken as a result of the information they provided. Any systematic failure to do so will inevitably lead to a justifiable frustration by the authors of concerns, probably resulting in a disinclination to speak up in the future.
>
> (Walker, 2004a, p. 112)

The SCICCH was also critical of the functioning of the CCRC and supported the allegation that it 'did not examine all cases brought to its attention in a timely manner' neither did it 'operate as well as it should have. The time which elapsed between an incident and its consideration by the CCRC was unacceptable in a number of cases' (Walker, 2004a, p. 114).

6.14.3 The response by managers

Throughout the inquiry, the nurses asserted that there was a culture of discouragement towards the reporting of their concerns. The SCICCH response to this was somewhat ambivalent. Despite finding evidence of 'interpersonal conflict […] in some areas within the hospitals' (Walker, 2004a, p. 116) and 'some unfortunate patterns of communication in the workplace', it could not conclude that this revealed 'a deliberate and

concerted attempt by the managers in Macarthur Health Service to prevent issues being aired by the nurse-informants' (Walker, 2004a, p. 117). Accordingly, no recommendations for the individual or collective censure of members of MHS management were undertaken. Instead the SCICCH recommended 'a proper grievance system', which would not leave matters to fester but would deal 'promptly' with the issues raised 'by management through forums which are established and known' (Walker, 2004a, p. 117).

The SCICCH concluded that MHS management's reaction to the nurses' concerns would have been more suitably conducted using appropriate internal handling procedures, open collegial discussion and better disclosure to patients and families. Nevertheless the SCICCH also determined that there was no deliberate attempt to cover up 'adverse events or clinical incidents, or to stifle investigation about them'(Walker, 2004a, p. 2). Any of the allegations that were seen as having a potential for corrupt conduct were investigated by the ICAC. These included the allegations by Fraser and Martin that attempts had been made to cover up or suppress investigation by MHS management and by the previous Health Minister Craig Knowles. The findings of the ICAC investigation found that no public officials had deliberately and or intentionally committed an offense.

6.15 Conclusion

The nurses from Camden and Campbelltown Hospitals during the period 1995-2002 found that reporting concerns related to patient safety through the established channels did not generate the response that they were seeking. The organisational response was to increase surveillance on the

nurses' own practice and isolate the problem by implementing various forms of disciplinary action. The nurses efforts to highlight systemic inaction to deal with concerns about substandard clinical practice, and later the unjust management of their own cases, was each time drawn back to the Executive of the hospitals who appear to have been in denial that a problem existed. The circumstances surrounding this case raise a number of questions about the contextual effects of power, information dissemination and ethics related to the phenomenon of whistleblowing that will be addressed in the critical discussion section of this thesis in Chapter Eight.

CHAPTER 7

CASE STUDY 2 - THE BUNDABERG BASE HOSPITAL CASE

7.1 Introduction

This chapter has as its focus a recounting of the events which occurred at the Bundaberg Base Hospital that resulted in the Queensland Public Hospitals Commission of Inquiry. To this end, three key areas of the case are presented: first, attention is given to a description of Bundaberg Base Hospital (BBH), to the surgeon at the centre of all of the allegations of substandard clinical practice, and to the positions held by the whistleblowing nurses. Second, a summation is provided of the reports of substandard clinical practice made by the nurses and the approach taken by BBH management to deal with these reports. Finally, an account is given of the external investigations into the nurses' allegations, these being the Bundaberg Hospital Commission of Inquiry (BHCI) and, later, the Queensland Public Hospitals Commission of Inquiry (QPHCI).

7.2 Bundaberg Base Hospital

During 2003-2005, the Bundaberg Health Service District (BHSD) was comprised of the Bundaberg Base Hospital (136 beds), Gin Gin Hospital (18 beds), Childers Hospital (18 beds) and the Mt Perry Health Centre. These were the only public healthcare services supporting a district population of 87,933[112] and covering the 12,590km^2 area of the Wide Bay, Central and Northern

[112] 2004 Figures (Forster, 2005)

Burnett Regions of Queensland (FitzGerald & Jenkins, 2005; Forster, 2005; Queensland Government, 2004). The BBH provided emergency medicine, general medicine, general, orthopaedic and vascular surgery, as well as clinical services in renal dialysis, obstetrics, gynaecology, paediatrics, intensive care and coronary care, to the surrounding community. It also served as the primary referral facility for smaller health facilities in the area (FitzGerald & Jenkins, 2005).

According to Queensland Health, in 2001 the BHSD serviced a proportional population of older persons higher than the Queensland average, as well as a greater than average proportion of socioeconomically disadvantaged[113] persons (Queensland Government, 2004). Thus, although Bundaberg had two smaller private hospitals, there was a heavy reliance on public health services. Like many rural and regional hospitals throughout Queensland, BBH had difficulty recruiting and retaining suitably qualified and experienced medical staff, particularly surgeons. This impacted heavily on the workloads of existing staff (Forster, 2005).

7.3 The Director of Surgery 2001-2003

The difficulty in attracting and retaining senior surgical staff in regional hospitals in Queensland was acutely felt by the BHSD. In 2003, after advertising internally and nationally, the BBH Executive began a recruitment campaign to secure an overseas qualified Senior Surgeon under the Area of

[113] In 2001, BHSD recorded 49% of its total serviced population as living in areas of socioeconomic disadvantage, in comparison to the rest of Queensland at 20% (Queensland Government, 2004).

Need declaration.[114] This decision followed two turbulent years during which there had been conflict between senior surgeons and BBH management. This conflict resulted in the resignations of numerous senior surgeons (three from the position of Director of Surgery alone) and the depletion of surgical services at the hospital. Some preliminary details of the two-year period are provided here. The primary aim is to contextualise the situation at the hospital that resulted in the decision to appoint Dr Jayant Patel from the USA. Dr Patel initially recruited under the Area of Need declaration by an external agency to fill a senior surgeon position and, later, assumed the position of Director of Surgery.

In November, 2001, Bundaberg's Director of Surgery, Dr Charles Nankivell, resigned. In a confidential letter to Dr Rob Stable, Director General of Queensland Health, Nankivell stated that he had 'suffered enormous physical and mental exhaustion' due to the

> inflexible attitude of Queensland Health to surgeons doing private versus public work [thus suitably qualified private locums were unable to relieve him]; no support from management at Bundaberg Hospital or Corporate Office; not feeling valued and no job satisfaction because of lack of funding; and the excessive hours surgeons are required to work which leads to "burnout" and feeling that one is not able to do one's job properly.
>
> (QPHCI, 2005, Exhibit 212 p.4)

Nankivell also reported that during the two years prior to his resignation he had complained about the conditions at BBH to the District Manager, the Director

[114] The Area of Need declaration, during the 2002-2003, was made by the Health Minister in accordance with the *Medical Practitioners Registration Act* 2001. This could occur if the Minister considered that there were 'insufficient medical practitioners practicing in the State, or a part of the State, to provide the service at a level that meets the needs of people living in the State or the part of the State' (*Medical Practitioners Registration Act* 2001Section 135(3). The declaration was employed to allow international medical practitioners not qualified for general or specialist registration in Australia, to be allowed to practice under limited registration (Davies, 2005).

of Medical Services, the Zone Manager, the former Director General, the local Member of Parliament and to the Australian Council of Health Care Standards (QPHCI 2005 Exhibit 212). Little or no change had taken place to his workload, to the funding arrangements supporting elective surgery, to the specialist outpatient waiting list, to the endoscopy procedure waiting list or to the on-call rotation support enabling surgeons to receive a break from their work.

The training status[115] of the Department of Surgery at Bundaberg had been lost when Nankivell's surgical colleague, Dr Anderson, resigned in September 2000. Dr Anderson's resignation meant that the requirement that two Fellows of the Royal Australasian College of Surgeons staff the hospital could no longer be met and this training could no longer be offered. The repercussions of this included a loss of surgical registrars who could assist with workloads (Davies, 2005). Nankivell stated in his resignation letter:

> The concern I have with the surgeons' roster, and the key points of difference in the work-load of the city and country surgeons has been well communicated to Q[ueensland] Health both verbally and in writing. No effective response has been forthcoming .
>
> (QPHCI 2005 Exhibit 212)

Following Nankivell's resignation, the position of Director of Surgery at Bundaberg was twice temporarily filled: by Dr Sam Baker (November 2001 to August 2002), and by Dr Lakshman Kumar Jayasekera (August 2002 to

[115] In order to offer clinical training for future surgeons, the hospital required accreditation from the Royal Australasian College of Surgeons. Accreditation to attract registrars (medical officers in training for specialisation) required that the hospital have two supervisory surgeons who were Fellows of the College of Surgeons. According to Davies (2005), surgical trainee's (Registrars) had a greater level of competence than residents and as such were able to work in areas such as the ED and ICU, thus reducing the load on the surgeons. The training status also provided an auditing process of the competence of the supervisory surgeons.

December 2002).[116] Baker was appointed as temporary Director of Surgery for a 12-month period ending in January 2003, at which time the position was to be formally advertised. During this time, Baker reported that he had become 'more and more frustrated' due to a 'lack of funding, lack of staffing, and a shortage of anaesthetists' and nurses resulting from a restructured theatre roster (QPHCI, 2005, Transcript Day 17, p. 6349). He also raised concerns that junior doctors were being left unsupervised overnight in the Emergency Department (QPHCI, 2005, Transcript Day 17). After nine months as acting Director of Surgery, Baker resigned citing 'grave concerns about the management and their putting the budget in front of patient safety' (QPHCI, 2005, Transcript Day 17, p. 6348).

Dr Jayasekera, who had begun work at Bundaberg as a senior staff surgeon in January, 2002, took over the position of acting Director of Surgery in August of that year. He was one of two surgeons [117] who applied for the position when it was advertised in November, 2002. The position was initially offered to the other surgeon but he had turned it down. Even so, Jayasekera was not offered the position and reported that he was humiliated by this decision and consequently took up a position at Hervey Bay Hospital (Davies, 2005).

Senior surgical coverage at BBH had reached a critical stage by the end of 2002. The hospital now required two new senior surgeons, one as Director of Surgery (Davies, 2005). In December, 2002, the hospital's Executive applied

[116] Dr Jayasekera acted in the role of Director of Surgery from the time of Dr Baker's departure. He applied for the position advertised in the Courier Mail (14 November, 2002) and The Australian (16 Nov 2002) but was not appointed. He then tendered his resignation and left BBH in March, 2003 (Davies, 2005).

[117] The second surgeon, Dr Strekozov, was from Yugoslavia and, like Dr Jayasekera, was a Fellow of the College of Surgeons. Dr Stekozov was not employed at BBH (Davies, 2005).

for an Area of Need declaration and sought the services of several recruiting agencies to advertise internationally for a Senior Medical Officer; the position of Director of Surgery was not advertised (Davies, 2005).

7.4 Recruiting Dr Patel

Patel, a US citizen born in India, had been a staff surgeon for 12 years at Kaiser Permanente in Portland, Oregon, USA. Patel had not worked for 15 months and was searching online for opportunities to recommence his career (Davies, 2005). One of the recruiting agencies, Wavelength Consulting, received a request via their website from Patel who wished to explore options for working as a general surgeon in Australia (QPHCI 2005 Exhibit 41). Dr John Bethall, the Managing Director of Wavelength Consulting, was cognisant of the hospital's needs and so followed up by contacting Patel, who declared that he was an experienced general surgeon with expertise in paediatric, vascular and laparoscopic surgery (QPHCI, 2005, BHCI Transcript Day 7).

Bethall discussed the option of the position with Patel, who confirmed his interest in the position by sending his curriculum vitae (CV) for immediate forwarding to Dr Kees Nydam the Acting Director of Medical Services at BBH. Nydam reports that he regarded 'Dr Patel's CV to be comprehensive and took it at face value' (QPHCI 2005 Exhibit 51, p. 4). Patel indicated that 'he had the qualifications and experience necessary to perform clinical duties in general surgery for a 12 month locum position at the hospital' (QPHCI 2005 Exhibit 51, p. 4). Nydam then began the necessary administrative processes to ensure that an official offer was made to Patel. Meanwhile, with the support of both Nydam and Wavelength Consulting, Patel's registration through the

Queensland Medical Board and his visa requirements were expidited (Davies, 2005).

Patel's CV noted: Bachelor of Medical and Bachelor of Surgery between 1967-1973, and Master of Surgery between 1973-1976 at M P Shah Medical College and the Irwin Group of Hospitals affiliated with Saurashtra University (QPHCI 2005 Exhibit 24). In an effort to gain registration as a surgeon in the US, Patel had completed a surgical residency program at the University of Rochester (1979-1981) and the State University of New York Buffalo (1982-1984). From 1984, Patel's CV listed many positions in the US, beginning with Director of Surgical Education and Clinical Assistant Professor of Surgery in Buffalo New York (1984-1989) and ending with his twelve-year stint as a Staff Surgeon at Kaiser Permanente in Portland, Oregon (1989-2001).[118] He also recorded the other concurrent, associated positions he had held: Clinical Associate Professor (1992-2001) and Surgery Residency Program Director (1990-1998). Patel also noted his professional membership as a Fellow of the American College of Surgeons (QPHCI, 2005, Exhibit 46).

Patel provided six very positive written references from colleagues at Kaiser Permanente, all openly addressed 'To whom it may concern' and dated months (May-June 2001) before the end of his employment there in September, 2001 (QPHCI 2005 Exhibit 51 p. 4). He readily provided all the key documentation requested by the Queensland Medical Board and the Department of Immigration to expedite the process of his acceptance to the position of Senior Medical Officer offered by BBH.

[118] In Exhibit 46 Patel's CV noted that he was employed at Kaiser Permanente Portland Oregon until September, 2002. This was changed in a later version of the CV. Patel's employment actually ended in 2001(Davies, 2005).

In order to attain Queensland Medical Board registration Patel had to provide an original copy of his 'Verification of Licensure' from the Board of Medical Examiners of the State of Oregon. This document provided summary details about Patel's authority to practice as a medical physician and general surgeon in Oregon. Although it noted that were no limitations or extensions for practice, under the heading 'Standing' was the statement 'Public Order on File. See Attached' (QPHCI Exhibit 24-22), yet no attachments were provided. In the 'Fitness to Practise' section of the forms necessary to gain registration by the Medical Board of Queensland, Patel also declared that he had had no previous conditions imposed upon him, either suspensions or cancellations of registration. (Figure 7.1 provides an excerpt from this completed declaration).

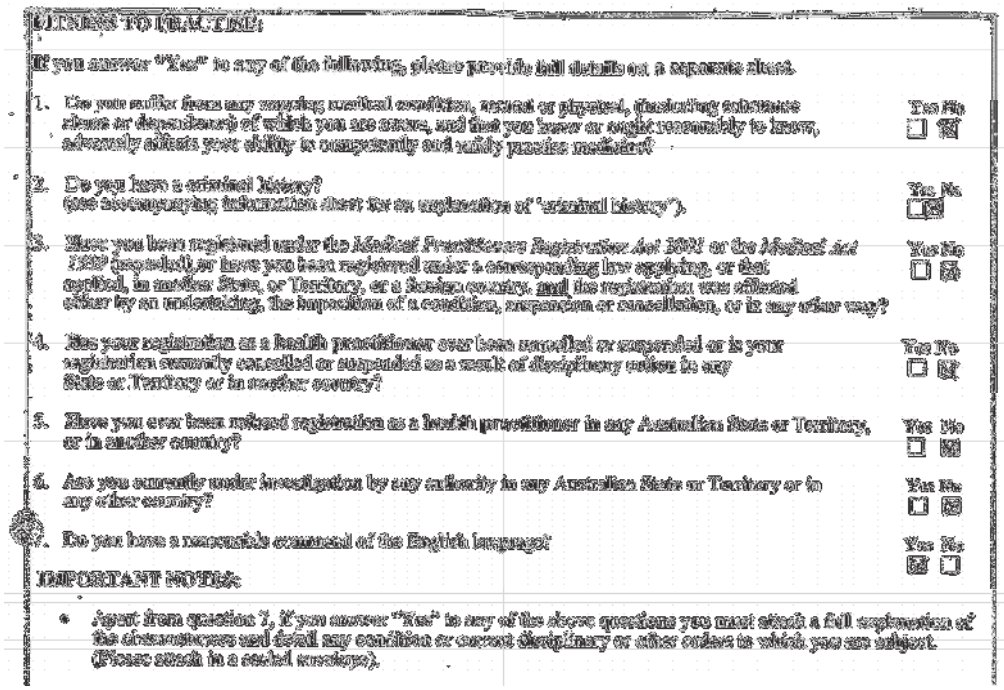


Figure 7.1: Patel's completed 'fitness to practise' form (QPHCI 2005 Exhibit 24-33).

By fraudulently answering 'No' to all questions on the form, Patel negated the need to provide details of the disciplinary actions taken against him by both the New York and Oregon Boards of Medicine (Dunbar, Reddy, & May, 2011). These included a six-month suspended license and three-year probation in 1984 by the New York State Board for Professional Medical Conduct for 'entering patient histories and physicals without examining patients, failing to maintain patient records and harassing a patient for cooperating with the New York board's investigation'(Oregon Medical Board, 2006, p. 1). In addition, the Oregon Board of Medical Examiners imposed a practice restriction 'from performing surgeries involving the pancreas, liver resections, and ileoanal pouch constructions' in 2000, as well as disciplinary action in response to 'gross or repeated acts of negligence and unprofessional conduct' (Oregon Medical Board, 2000, 2006).

Patel's Queensland medical registration and appointment to BBH proceeded without essential details that may have been evident in the missing attachments of the 'Verification of Licensure' from the Oregon Board of Medical Examiners. He was duly registered by the Medical Board of Queensland in accordance with the Area of Need declaration for the period 1 April, 2003, until 31 March, 2004. In 2004 Patel sought re-registration,[119] again making declarations that he had had no restrictions or disciplinary actions taken against him. He also indicated to the Board that he was now filling the Director of Surgery position at BBH (QPHCI 2005 Exhibit 24).

[119] The first registration was for a 12-month period as stipulated by the Area of Need declaration. Patel reapplied in December, 2003. Again the Area of Need declaration limited the timeframe to only 12 months, from 1 April, 2004, to 31 March, 2005 (QPHCI Exhibit 24-31 & 24- 36).

The glowing references and apparently unblemished reputation Patel presented to the Medical Board and to BBH went unexamined for a long time. That there may have been any deception on Patel's part was not countenanced, perhaps understandably so in a professional field driven by ethical considerations of honesty and capability. The full extent of Patel's deceptions, when they were ultimately revealed, were to be shocking and would call into question the vetting procedures of not just the BBH but also the Queensland Medical Board and the Queensland Health system in general. In the meantime, Patel arrived ready and apparently able to begin a new phase of his career in Bundaberg.

7.5 The nurses

Patel was employed at BBH between April 2003 and April 2005, during which time he saw 1457 patients, operated on approximately 1000 patients, and performed 400 endoscopic[120] procedures (Davies, 2005, p. 84 & 127). From as early as May, 2003, until his departure, nurses from the ICU, surgical wards, renal unit, infection control and OT, expressed concerns about Patel's surgical competence, rates of post-operative complications and lack of infection control measures, as well as his decisions to perform complex surgeries and to not transfer deteriorating patients to more adequately equipped hospitals in Brisbane.

The nurses completed incident forms, provided written as well as verbal complaints, raised concerns in management meetings, and collated evidence to

[120] Endoscopy is a medical procedure where a fine flexible fiberoptic tube with a tiny camera at the end is inserted into either an existing opening (eg. Mouth) or a created opening to visualise a body cavity. It is used for diagnostic and or interventional surgical procedures (Canard, 2011).

support their claims. Despite these actions, there was little effective reaction from the BBH Executive or from senior officials of Queensland Health. The following section discusses these nurses concerns, their experiences and the actions taken to protect patients.

7.5.1 Toni Hoffman and concerns related to oesophagectomies

Within six weeks of starting work, Patel performed an oesophagectomy – a complex surgical procedure[121] not usually preformed at BBH due to the lack of specialised post-operative facilities and staff (QPHCI 2005 Exhibit 4). The patient, designated as patient P34 in the QPHCI, had pre-existing renal failure and later died in ICU from post-operative complications. The decision to perform the surgery at BBH and the post-operative management of the patient were of such concern to Specialist Nurse Toni Hoffman that she made her first complaint.

Hoffman was employed at the BBH as the Nurse Unit Manager (NUM) of the ICU from June 2000. She had completed her nurses training at Princess Alexandra Hospital in Brisbane and was registered as a nurse in 1979 (Thomas, 2007). In 1981, she attained a specialist ICU Certificate from Kings College Hospital in London and from that time worked in ICU's in London, Saudi Arabia and in Tasmania and Queensland, Australia (QPHCI 2005 Exhibit 4). In 1997, Hoffman upgraded her qualifications by completing a Bachelor of

[121] Patient P34 had an oesophagogastric lesion/cancerous growth surgically removed (oesophagectomy) on 19 May, 2003. Pre-existing renal failure increased the complexity of P34's post-operative management. Oesophagectomy involves surgical resection of the oesophagus, part of the stomach, and at times may include removal of the lymph nodes and spleen. As such it is considered a technically demanding operation. Patients routinely recuperate in post-operative ICU for at least 24-48 hours (Mackenzie, Popplewell, & Billingsley, 2004).

Nursing and, while she was NUM of the ICU at BBH, also attained a Graduate Certificate in Management (2003) and a Masters in Bioethics (2003) (QPHCI 2005 Exhibit 4).

The post-operative management of patient P34, and later of a second patient, P18 (who also had an oesophagectomy[122] performed by Patel), prompted Hoffman to report verbally and in writing to both the Director of Nursing (DoN) Glennis Goodman and Director of Medical Services (DoMS) Dr Darren Keating. Her concerns related to Patel's competence and to his decision to perform such complex surgeries at BBH rather refer the patients to Brisbane, where there were greater post-operative intensive care resources and expertise (Davies, 2005). The ICU at BBH had only five combined intensive/coronary care beds and, according to the College of Intensive Care Physicians' classification system and its accompanying guidelines, was rated as a Level One Unit. This meant that BBH 'should only keep patients who require ventilation for between 24 and 48 hours before transferring them to a better equipped hospital' (QPHCI 2005 Exhibit 4, p. 2). Complex surgeries such as oesophagectomy require that the patient be managed in the ICU without complications for at least 48 hours, although this period can be considerably extended[123], if, as occurred in P18's case, post-operative complications do eventuate.

After the death of P34, Hoffman organised two meetings with DoMS Keating, one at which she was accompanied by DoN Goodman, and another in

[122] P18 had his surgery on 6 June, 2003.

[123] P18 was in the BBH ICU for 14 days and returned for further surgery three times to treat complications, before being transferred to the Mater Hospital in Brisbane 20 June, 2003 (QPHCI 2005 Exhibit 4 & Exhibit 218).

the company of Dr Jonathon Joiner, a locum anaesthetist[124] who shared her concerns (QPHCI 2005 Exhibit 4, p. 4). On both occasions, she expressed her concerns regarding: the lack of resources at BBH to undertake complex surgeries requiring prolonged ICU management, Patel's lack of collaboration with ICU medical and nursing staff, and the manner in which Patel charted in the medical record and communicated with the patient's family. Patel informed the family that P34 who's pupils were 'fixed and dilated' was 'stable, when in fact he was 'extremely ill and indeed the patient progressed to brain death' (QPHCI 2005 Exhibit 4, pp. 3-4). Hoffman later recalled Keating's response to her concerns and his directive that:

> Dr Patel was a very experienced surgeon and that we were required to cooperate with him and work together. He said that there was an expectation that the Bundaberg Base Hospital would continue to provide surgery to the people of Bundaberg and that Dr Patel was experienced and used to performing those types of surgery.
>
> (QPHCI 2005 Exhibit 4, p. 4)

Despite the concerns raised by Hoffman and Joiner, Patel scheduled a second oesophagectomy, to be performed on P18 on 6 June, 2003(Davies, 2005). As with patient P34, patient P18 developed post-operative complications, and was returned to theatre on three separate occasions (12, 16 and 18 June, 2003) (QPHCI 2005 Exhibit 4 & Exhibit 218). Upon review of the status of P18 in the ICU on the 19 June, 2003, Hoffman sent an email to Keating in which she clearly and emphatically outlined her concerns that the

[124] Dr Joiner was 'concerned about the type of procedure being performed at the Hospital because the Director of Anaesthetics was on holidays, the Hospital only has a level one intensive care unit, and recent studies had shown that this type of operation has a better outcome in a tertiary centre' (QPCH 2005 Exhibit 307, p. 1).

hospital was not equipped to manage such patients and, further, eluded to ongoing concerns about Patel's behaviour:

> I am writing to inform you of the situation that currently exists in ICU with the post –op patient [P18]. As you are aware [P18] underwent an oesophagectomy on the 6th June. He subsequently returned to theatre twice for wound dehiscence. He again returned to theatre last evening for repair of leaking jejunostomy[...]. I am writing due to my continuing concern over the lack of sufficient ICU backup to care for a patient who has undergone such extensive surgery. Both the RBH [Royal Brisbane Hospital] and PAH [Princess Alexander Hospital] have expressed concern about this surgery being done in our facility, without this backup. There remains unresolved issues with the behaviour of the surgeon which is confusing for the nursing staff. At present whist there is consensus regarding transferring this patient to Brisbane there are no beds to be found anywhere in the state. I am very worried that this patients care has been compromised by not sending him to Brisbane on Tuesday, and whilst I realise it is easy to be wise in hindsight, and I do not wish to make an issue of this I would like this to be noted. I believe we are working outside of our scope of practice. [...] The ongoing issues regarding the transfer of patients and the designate level of this ICU may need to be discussed in more detail at a later date. The behaviour of the surgeon in the ICU needs also to be discussed, as certain very disturbing scenarios have occurred. The current status is that we are awaiting a bed in a tertiary ICU, Regards Toni Hoffman.
>
> (QPHCI 2005 Exhibit 4-TH3)

Upon being transferred to the Mater Adult Public Hospital in Brisbane, P18 was accepted into the ICU by Dr Peter Cook, the Director of Adult Critical Care Services and a specialist in intensive care and anaesthesia. Following review of P18 and the surgical management at BBH, Cook expressed immediate concerns about the clinical practice at the hospital, specifically its capability as a Level One ICU to support such complex cases, as well as the accreditation and recent experience of the surgeon who had performed the operation (QPHCI 2005 Exhibit 218). Cook contacted Keating at BBH directly to outline his concerns and followed up with written correspondence to the

Mater Hospital's CEO, which was to be forwarded to Queensland Health Southern Zone Management Unit. Cook proposed a 'two-fold approach focussing on the role delineation of the hospital and the accreditation of the surgeon' (QPHCI 2005 Exhibit 218, appendix A2 p. 2).

Despite this, no action was taken by DoMS Keating to stop Patel from performing such complex surgeries. The final QPHCI report shows that Keating did not respond to either Hoffman or Cook regarding their concerns. Instead:

> the oesophagectomies continued. Two more surgeries would be performed by Patel at the Base [Bundaberg Base Hospital] (each with a terrible outcome) before the issue was re-visited.
> (Davies, 2005, p. 105)

Hoffman was not the only nurse alarmed by the increasing number of post-operative complications evident in patients treated by Patel, particularly with regard to the breakdown of surgical wounds known as 'wound dehiscence'.[125] Gail Aylmer, BBH's Infection Control Coordinator, and Dianne Jenkins, NUM of the Surgical Ward, each collected patient data during April 2003-April 2004 and attempted to bring to light the higher-than-normal incidence of wound dehiscence among Patel's patients. Their actions, the impact of the data they collected, and the reactions of both Patel and the BBH Executive are now examined.

[125] Wound dehiscence is a post-operative complication in which the suture line partially or completely breaks open as a result of either poor surgical technique or of wound infection (Bartlett & Kingsnorth, 2009).

7.5.2 Gail Aylmer, Dianne Jenkins and incidence of wound dehiscence

Gail Aylmer had 10 years' experience as a Registered Nurse and had achieved a Masters of Nursing and a Masters of Mental Health. She had been working at BBH since 1996. Immediately prior to her appointment as the Infection Control Coordinator at BBH in June 2003, she had been a Nurse Educator and had acted in the position of Nurse Practice Coordinator in the surgical ward at the hospital from April to May 2003 (QPHCI 2005 Exhibit 59).

Aylmer's first encounters with Patel occurred during surgical rounds at which Patel reviewed the progress of patients. She recalled that Patel 'did not wash his hands after attending to his patients, which often involved him touching patients, handling their dressings and in some situations their wound' (QPHCI 2005 Exhibit 59, p. 2). After a series of inconspicuous prompts, each to no avail, Aylmer resorted to:

> carrying a box of gloves during his rounds to try and encourage him to improve his practise to minimise the risk of cross infection to his patients. He did use gloves when they were placed in his hands.
>
> (QPHCI 2005 Exhibit 59, p.2)

Following Aylmer's appointment to the role of Infection Control Coordinator, a number of other nurses expressed disquiet over what appeared to be a higher-than-usual incidence of wound dehiscence (QPHCI 2005 Exhibit 59).[126]

Senior nurses at BBH, including Hoffman and the NUM of the OT, Jennifer White, recalled that in their own experiences full or total wound dehiscence were rare. Hoffman testified that she had previously only witnessed

[126] Abdominal wound dehiscence is a rare but serious complication occurring in 0.25%-3% of surgical cases and is linked to a high mortality rate of up to 45% (Bartlett & Kingsnorth, 2009; Van Ramshorst, et al., 2010).

one case in her whole career (QPHCI 2005 BHCI Transcript Day 1, p. 49) and White recalled that she had observed a 'wound dehiscence, complete dehiscence […] probably one or two [times] in 10 to 15 years' (QPHCI 2005 BHCI Transcript Day 12, p.1230).

On 3 July, 2003, in response to the concerns of her colleagues, Aylmer sent an email to ten other nurses including the NUMs of the ICU, OT, the Day Surgery Unit, and the surgical and medical wards:

> I am (as I know a number of you are as well) becoming increasingly concerned re the number of wound dehiscence that have occurred over the last 6-8 weeks. While it does not appear that the dehiscence is relating to infection, this needs to be investigated further to identify the cause/s[...] Can I ask you to gather any data you may have and come to the Seminar Room Monday 7 July at 0900hrs so we can investigate this situation further. At this stage I have not invited any medical officers.
>
> (QPHCI 2005 Exhibit 59- GA2)

Following this meeting on 7 July, 2003, Aylmer collated data from thirteen episodes relating to twelve patients (mostly Patel's cases), which she assembled into a report and delivered personally to DoMS Keating (QPHCI 2005 Exhibit 59 & BHCI Transcript Day 10). Later that same day, Patel visited Aylmer in her office with the report she had given to Keating in his hand and proceeded to provide explanations for each of the cases outlined (QPHCI 2005 BHCI Transcript Day 10). In an email to Keating the following day 8 July, 2002, Aylmer noted that, as a result of Patel's visit, she was 'able to exclude 6 of the 13 charts' from the original report (QPHCI 2005 Exhibit 198). Aylmer's response to the approach taken by Keating to this was as follows:

> I certainly did feel uncomfortable and, as I said, I did not expect that Dr Patel would be coming to see me. I felt that Dr Keating would arrange for somebody with the appropriate expertise to investigate these cases – another surgeon or some sort of review

> panel. But I certainly did not expect that Dr Patel would come to me and stand over me and – I mean, at that time, he was certainly letting – very clearly stating what all his accomplishments were, all his experience – that he worked in New York, that he was, you know, very experienced, and it was quite intimidating, and I, at no time, felt that I – I was well out of my depth and I knew I couldn't debate these things with him. So, I did not expect that would be the approach that would be taken.
>
> (QPHCI 2005 BHCI Transcript Day 10 p. 977)

The issue was raised at the Anaesthetic, Surgical, Pre-Admission and Intensive Care (ASPIC) clinical forum (Patel was an apology) held on 9 July, 2003, where the minutes note that the 'Definition of wound dehiscence [was] discussed' (QPHCI 2005 Exhibit 448-17). According to Keating, this resolved the issue. In his witness statement before the QPHCI, he stated his belief 'that the issue raised by Gail Aylmer had been openly discussed, researched and resolved to the satisfaction of all concerned' (QPHCI 2005 Exhibit 448, p. 18).

Nine months later the issue of wound dehiscence was raised again. This time Dianne Jenkins, the NUM of the surgical unit at BBH, attempted to bring to light the increasing numbers of wound dehiscence cases being observed by nursing staff in the surgical ward (Davies, 2005). Jenkins had been a Registered Nurse since 1969, and began working at BBH in1995 as a Clinical Nurses Consultant and as NUM of the surgical ward in July, 2003 (QPHCI 2005 Exhibit 494). She understood that part of her role was responsibility for 'the incident reporting process' which included 'taking action with respect to any adverse events which occur on the ward' (QPHCI 2005 Exhibit 494, p. 2).

With this responsibility in mind, she raised the perceived increase in the incidence of wound dehiscence and expressed her fears at the ASPIC clinical forum on 14 April, 2004, that data were not being 'picked up by the coders

when they were inputting data from the patient charts' (QPHCI 2005 Exhibit 494 p.5). White, the NUM of the OT, recalled Patel's response to Jenkins' concerns during this meeting:

> I do remember, because his response was he just laughed at us and said that we wouldn't understand what a wound dehiscence was, and, I mean, Di Jenkins, Gwenda McDermid from Day Surgery, myself, we had been nurses for 30 years and we do know what a wound dehiscence is and we know there is varying degrees of wound dehiscence, and he was – his instruction was that we needed to go off and do some research and find out what a wound dehiscence was.
>
> (QPHCI 2005 BHCI Transcript Day 12, p.1230)

Keating asked Jenkins to gather 'sufficient data to support the anecdotal evidence' and so she began performing a chart audit from January 2003 and continued her investigation until June 2004 (QPHCI 2005 Exhibit 494, p.5).

Jenkins' final wound dehiscence report was tabled at the ASPIC clinical forum 14 July, 2004. It detailed 29 incidences of wound dehiscence in 19 patients:[127] twelve of these cases recorded a full dehiscence resulting in the patient being returned to surgery for reclosure.[128] Ten incidents in nine patients were directly related to Patel, eight incidences in five patients were attributed to a Dr James Gaffield,[129] while each of the other five surgeons at BBH was linked to a single case (QPHCI 2005 Exhibit 494-02). The Minutes of this forum indicate that discussion took place around diagnostic related grouping (DRG)[130]

[127] Five cases had been raised by Aylmer twelve months earlier.
[128] Of the type that White had indicated that she had seen only once or twice in a decade (QPHCI 2005 Transcript Day 12, p. 1230).
[129] Dr James Gaffield a registered as a general surgeon with a special interest in plastic surgery in the USA. He applied for the SMO surgical position at the same time as Patel. He replaced Jayasekera as the second general surgeon and began work at BBH 28 April, 2003(Davies, 2005).
[130] DRGs previously discussed in Chapter 2.

classification of cases of dehiscence, the co-morbidities[131] of the patients in the report and the number of dehiscence and abdominal surgery. Patel and Kaye Ferrar from the District Quality Division Support Unit (DQDSU) were given responsibility for examining the DRG data (QPHCI 2005 Exhibit 494-02).

Both Aylmer and Jenkins had already expressed concern that the input of data contributing to the DRG's, data coded into the system by administration staff who relied on patient chart, were not capturing a true picture of the incidences of wound dehiscence. Compounding their fears were claims by Hoffman and other nurses, that junior doctors had been instructed by Patel 'not to use the word "dehiscence" in discharge summaries' (QPHCI 2005 Exhibit 4 p. 23).

At the following ASPIC clinical forum 18 August 2004, Patel produced his own report covering the period January, 2003 to July, 2004 that showed that nine of his patients had developed wound dehiscence and one a fistula near a colonoscopy (Davies, 2005). He also tabled two DQDSU wound dehiscence reports that reflected the coded DRG data captured during July 2002-June 2003 showing seven cases, and during July 2003-June 2004 showing four cases (QPHCI 2005 Exhibit 64). Patel argued that the number of wound dehiscence related to abdominal operations over the two-year period were within the expected range and that according to the DQDSU figures the incidences had in fact reduced (QPHCI 2005 Exhibit 494, Exhibit 494-02).

[131] While there is no universal definition of co-morbidity, it is commonly used to describe the presence of more than one condition (or diseases) in addition to the primary disease or condition and or the effect of such additional conditions or diseases(Valderas, Starfield, Sibbald, Salisbury, & Roland, 2009).

The figures and the methodology employed by Patel seem to have been accepted by Keating: 'It was apparent to me that there had been [a] reduction in the incidence of dehiscences' (QPHCI 2005 Exhibit 448 p. 19). Jenkins, however, had serious reservations about the validity of the doctor's argument, particularly given that

> he had compared the data over a two year period and not the 18 month period I had examined. The period Dr Patel had worked at the Hospital during this period was only 12 to 13 months, due to him starting in April 2003 and going on extended leave in April 2004, until the time of the report. Dr Patel did not produce any scientific data to back up his statements about the wound dehiscences being with the expected range.
>
> (QPHCI 2005 Exhibit 494, p. 7)

Hoffman's response at the clinical forum was to request that all future episodes of wound dehiscence be recorded on Adverse Event forms and documented on the theatre clinical indicator list[132] within 24 hours (QPHCI 2005 Exhibit 494-02). At the 13 October, 2004, ASPIC clinical forum minutes show no record of further discussion and that the item was closed with a note that 'Wards will obviously continue to report Wound Dehiscence as adverse event/outcome' (QPHCI 2005 Exhibit 494-02).

No further investigation into the increased incidences of wound dehiscence took place between August 2004 and Patel's departure from BBH in April 2005. This was despite the fact that Jenkins had completed two serious adverse event forms relating to two further incidences of full wound dehiscence following surgery performed by Patel (QPHCI 2005 Exhibit 494). Keating later stated that, after August 2004, he had received:

[132] An internal data base of the reasons patients are returned to theatre following their primary operation (QPHCI 2005 Transcript Day 12).

> only one wound dehiscence reported as an adverse event (Patient 127). Consequently I did not believe the issue required my intervention.
>
> (QPHCI 2005 Exhibit 448 p.19)

The database collated by DQDSU relating to all completed adverse incident forms shows the wound dehiscence incident filed on the 27 August, 2004, by Jenkins to be coded as high priority. Dr Keating is listed as the investigation officer, although no investigation process is noted, and only a brief comment is made: 'Recent study of dehiscence rates showed reduced incidence in last year compared to previous year [*sic*]' (QPHCI 2005 Exhibit 167 p. 32).

Nurses elsewhere in the hospital were also having difficulty getting the BBH Executive to acknowledge and investigate adverse incidences involving Patel. The nurses from the renal unit developed a strategy aimed at keeping patients from being treated by Patel, particularly for insertion of access catheters for dialysis. Their experiences in preventing Patel from performing surgery on elective renal patients and the strategies employed to reduce infections bear closer examination.

7.5.3 'Sister I don't have germs' – Robyn Pollock and the renal nurses

Robyn Pollock, the NUM of the Renal Unit, was first registered as a nurse in 1981. In 1996 she began her employment at BBH in the Renal Unit and after two years was appointed Charge Nurse, which was upgraded to NUM in 2002 (QPHCI 2005 Exhibit 70). The renal unit at BBH provided haemodialysis, peritoneal dialysis and follow-up care for renal transplant patients in the Bundaberg and the surrounding area (QPHCI 2005 Exhibit 70).

When Patel arrived at BBH, he made it known to the nurses and to Dr Peter Miach[133] in the Renal Unit that he was available to surgically place the renal catheters (i.e. Tenchoff and Central Venous Dialysis) (QPHCI 2005 Exhibit 70). Pollock recalled that initially Patel was a frequent and friendly visitor to the unit and her office until late in November 2003, when she reported to Aylmer and Keating an incident involving an alleged serious breach of infection control measures by Patel (QPHCI 2005 Exhibit 70).

The incident occurred on 25 November, 2003. Two patients in the renal unit had blood flow problems with their permacath[134] and a delay in commencing haemodialysis. Patel was called to review the patency (flow) of the line, which is performed by inserting a sterile saline and/or guide wire into the central venous catheter to dislodge a blockage and re-establish blood flow (QPHCI 2005 Exhibit 70). Joanne Turner, the registered nurse working in the unit on that day, prepared the two patients and set up their equipment ready for Patel to perform the sterile procedure (QPHCI 2005 Exhibit 197)[135]. Patel began by physically examining both patients without washing his hands or donning gloves (QPHCI 2005 Exhibit 70). Turner recounts what happened next:

> He then picked up the sterile syringe without having washed his hands or applying sterile gloves and flushed the line on one patient. I then observed him moving to toward the other patient with the same syringe and it was at that point I called to him and said words to the effect that *"this is this patient's set up"* to alert him to the fact that there were two separate sterile setups. I did not wish to appear rude to Dr Patel by stating the obvious which

[133] Dr Miach, a nephrologist, was the Director of Medicine at BBH from 2000 (Davies, 2005).

[134] A permacath is a large bore 2-3 line central venous catheter through which haemodialysis is performed. The term permacath appears to come from a specific trade mark brand Permcath by Quinton Kendall (Budruddin *et al.*, 2009)

[135] All attempts to access a permacath are performed with sterile gloves. Any direct contact with the patient's blood close to a large internal vein increases the risk of sepsis (blood infection). In immuno-compromised long-term renal patients sepsis can be fatal (QPHCI 2005 Exhibit 70).

> was not to cross contaminate the equipment. He put the syringe back on the first patient's setup. I asked him to put on sterile gloves and his response was *"Sister, I don't have germs"*… At first I thought he was joking but the look on his face demonstrated to me that he was not joking and that he was annoyed by my insistence that he put on sterile gloves. He continued to attend the patients but did not put on sterile gloves when attending to either patient and did not wash his hands after attending one patient and then moving to the other.
>
> (QPHCI 2005 Exhibit 197, p. 2, emphasis in original)

Two other nurses in the unit, Carolyn Water and Lynette Yeoman, witnessed the incident. Yeoman stated later that she was 'dumbfounded by what was unfolding before my eyes' (QPHCI 2005 Exhibit 196, p. 2). All three signed the completed incident report. Pollock then contacted Aylmer, the infection control nurse, by email relating Patel's refusal to follow the 'strict aseptic technique' required when 'accessing these catheters', and his dismissive comments. She concluded her message stating that the situation 'just isn't good enough!' and asking of the infection control nurse '[W]hat can we do [?]' (QPHCI 2005 Exhibit 70-RP1).

Aylmer and Pollack met with Keating on 27 November, 2003, to discuss their concerns. Keating informed them that he would speak to Patel and requested that Pollock provide statistical evidence to support her assertion that Patel had breached aseptic techniques (QPHCI 2005 Exhibit 59). Keating also informed Pollock that until he

> had data to support how often infections were occurring and how may infectious episodes there were in Dr Patel's patients, it was difficult for him to intervene in Dr Patel's practices.
>
> (QPHCI 2005 Exhibit 70, p.4)

Keating later reported to Aylmer that Patel refuted all the allegations by the renal nurses (QPHCI 2005 Exhibit 448). Aylmer reflected later that it was her

'impression that Dr Keating preferred the version given by Dr Patel over that given by the nursing staff' (QPHCI 2005 Exhibit 59, p. 8).

Aylmer responded in an email to Keating and forwarded a copy to the then Acting Director of Nursing Beryl Callanan. Her email addressed Keating's meeting with Patel by insisting that the '3 staff members that witnessed the situation obviously did not agree with [his] version' of events and relayed the information that Patel had announced that he wasn't going to do renal rounds anymore because he had 'had enough' of it (QPHCI 2005 Exhibit 59-GA7). In the forward copy of the email correspondence, to Callanan, Aylmer claims that Patel's denial of the accusations came as 'no surprise' (QPHCI 2005 Exhibit 59-GA7).

The amiable professional relationship that Pollock had enjoyed with Patel was severed. She later recalled:

> From that point in time onward Dr Patel did not speak to me directly. He would discuss issues through another nurse or would walk in and then out of the Renal Unit if only I was there.
> (QPHCI 2005 Exhibit 70, p. 4)

Keating was made aware of the strained relationship among senior staff at the hospital. His later response to this serious issue is somewhat disingenuous: 'My understanding was that subsequently Dr Patel only attended the Renal Unit if requested' (QPHCI 2005 Exhibit 448, p.26). Pollock directed the renal nurses in her charge to begin collecting data.

7.5.4 Peritoneal Catheters Insertion, the Baxter solution – Lindsay Druce

Lindsay Druce, a peritoneal dialysis specialist nurse at BBH, returned from maternity leave in November 2003. Almost immediately, she became

concerned about the number of problems patients were experiencing with their peritoneal catheters. As she reviewed all of the patients who had had a catheter placed by Patel during her absence, she noted that in every case the patient had experienced complications, including 'acute and chronic infections, migration of catheters requiring further surgery, and incorrect external positioning of catheters' (QPHCI 2005 Exhibit 67 p. 2). She raised her concerns with Miach and began to collate data to inform a written report.

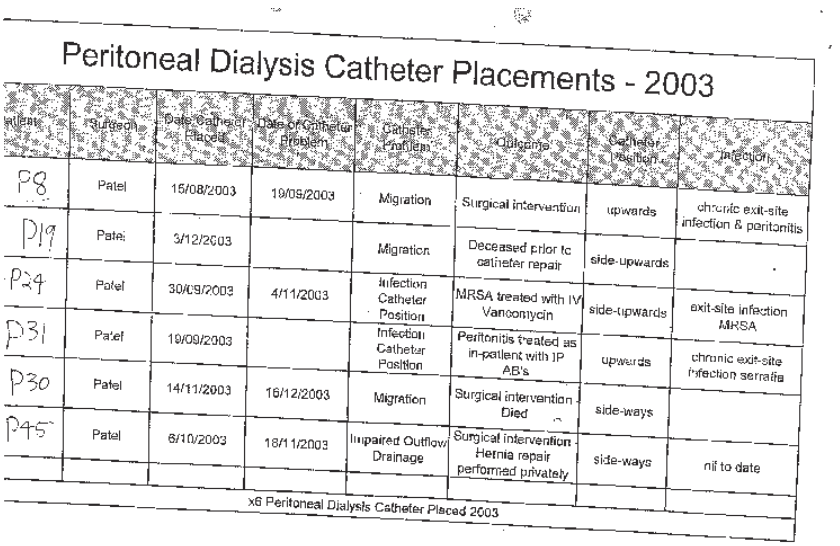
In December 2003, Druce 'hoping to deal with the catheter placement problems informally', approached Patel to discuss 'the positioning of the renal catheters and in particular the external tunnelling of the catheter' (QPHCI 2005 Exhibit 67, p. 2). Druce was to describe Patel's reaction as 'dismissive': he responded to her concerns by stating 'I'm the surgeon' and promptly left the Renal Unit (QPHCI 2005 Exhibit 67, p. 2). Druce recalled:

> He made me feel that I was stepping out of my place. I felt that this wasn't good enough so I continued to compile my findings so I could clearly show that there was a problem that needed addressing.
>
> (QPHCI 2005 Exhibit 67, p. 2)

Later the same month, on 17 December, 2003, one of Druce's regular peritoneal dialysis patients (P30) underwent surgical intervention to 'address the migration of his peritoneal catheter' (QPHCI 2005 Exhibit 67, p. 2). During the procedure to insert a permacath, Patel perforated the thoracic vein and, according to the autopsy report, the patient P30 died of a haemopericardium (QPHCI 2005 Exhibit 67 & 70, BHCI Transcript Day 10). The death of P30 distressed Druce, as she believed the permacath insertion would not have been required had Patel positioned the peritoneal catheter correctly in the first place.

In her eight years in the Renal Unit, she had never experienced a 'death of a patient because of the insertion of PermCath [sic]' (QPHCI 2005 Exhibit 67, p. 2, BHCI Transcript Day 10, p. 1110).

In January 2004, Druce completed her report into 'Peritoneal Dialysis Catheter Placements – 2003', presented in Figure 6.2 below. The table outlined the six procedures performed that year. The columns identified the patient, surgeon, date of procedure, date of catheter problem, catheter problem, outcome, catheter position and infection. It included details of the death of patient P30.



Peritoneal Dialysis Catheter Placements - 2003

[illegible]	Surgeon	Date Cather Placed	Date of Catheter Problem	Catheter Problem	Outcome	Catheter Position	Infection
P8	Patel	15/08/2003	19/09/2003	Migration	Surgical intervention	upwards	chronic exit-site infection & peritonitis
P19	Patel	3/12/2003		Migration	Deceased prior to catheter repair	side-upwards	
P24	Patel	30/09/2003	4/11/2003	Infection Catheter Position	MRSA treated with IV Vancomycin	side-upwards	exit-site infection MRSA
P31	Patel	19/09/2003		Infection Catheter Position	Peritonitis treated as in-patient with IP AB's	upwards	chronic exit-site infection serratia
P30	Patel	14/11/2003	16/12/2003	Migration	Surgical intervention Died	side-ways	
P45	Patel	6/10/2003	18/11/2003	Impaired Outflow/ Drainage	Surgical intervention Hernia repair performed privately	side-ways	nil to date

x6 Peritoneal Dialysis Catheter Placed 2003

Figure 7.2: Peritoneal Dialysis Catheter Placements – 2003 (QPHCI 2005 Exhibit 18)

She presented the report highlighting her concerns regarding Patel to Miach who responded by stating that 'he would not allow Dr Patel to operate on any

of his patients anymore' (QPHCI 2005 Exhibit 67, p. 2).[136] This was a decision with consequences for the Peritoneal Dialysis Service, since any future patient needing a catheter placed would have to travel to the Royal Brisbane Hospital. This was a fact that Druce wanted to bring to the attention of BBH Executive (QPHCI 2005 Exhibit 67, p. 3). Thus, on 4 February, 2004, when her manager Pollock returned from annual leave, Druce sent an email proposing a discussion regarding an 'alternative clinical area [in which] to perform Peritoneal Dialysis' in response to the 'cessation' of that procedure due to the 'recent high number of adverse catheter related events at the hospital (QPHCI 2005 Exhibit 70 RP4).

Pollock and Druce deemed that the best course of action was to bring the issue to the attention of the Patrick Martin, the Acting Director of Nursing at BBH from 15 December, 2003 to 7 March, 2004. He later recalled a meeting on 10 February, 2004 in which the renal nurses 'raised concerns in relation to the treatment that patients were receiving from Dr Patel. They specifically mentioned cases where he did not put catheters in correctly' (QPHCI 2005 Exhibit 138). Martin raised the allegations with Keating the same day. He recalled later that in the course of their discussions

> Dr Keating wanted data in relation to Dr Patel's adverse events for renal procedures compared to his non- adverse events […] Dr Keating then said the words to the effect, "If they want to play with the big boys, then they need to provide the evidence and bring it on"
>
> (QPHCI 2005 Exhibit 139, p. 4) [137]

[136] Miach reports that early in 2004 he hand delivered the report developed by Druce to Keating, however this is refuted by Keating, who also indicated he was never made aware that Miach had made a directive that none of his patients were to be treated by Patel (QPHCI 2005 Exhibit 21 and Exhibit 448).

[137] The data compiled by Lindsay Druce showed all six cases performed by Dr Patel in 2003 and all had adverse events, as such there was no existing data that showed non-adverse events to be compared to.

Martin then formulated an email to Pollock:

> I spoke with Darren [Keating] shortly after you left this afternoon and explained your concerns. I'll also speak with Peter Leck [District Manager], however, the long and short of it is that I need to see some stats regarding procedures undertaken by Dr Patel highlighting all renal related cases uneventful vs the number of adverse events which have occurred as a result of an intervention.
> (QPHCI 2005 Exhibit 139-PM3)

He also verbally relayed Keating's request to the nurses, including the statement made regarding 'playing with the big boys' (QPHCI 2005 Exhibit 138 p. 2).

Pollock believed that the 'Peritoneal Dialysis Catheter Placements – 2003' report had previously been provided to Keating by Miach. She therefore asked Martin

> why Dr Keating would want more data when we had already provided data and "What more proof did he need?" He [Patrick Martin] had no reply and we left the discussion there.
> (QPHCI 2005 Exhibit 70, p. 8)

Having failed to get the BBH Executive to address the key issue of who would surgically insert peritoneal dialysis catheters in the future, Druce and Pollock explored their options with a representative from Baxter Healthcare.[138] According to Pollock:

> In mid-February the position was that Dr Miach was still overseas, Dr Patel was not to operate on our patients, Brisbane would not accept our patients…Dr Keating was requiring more evidence to back up my concerns. I felt this was becoming a desperate situation. It was at this time that Lindsay Druce and I arranged to speak to Baxter Healthcare Pty Ltd.
> (QPHCI 2005 Exhibit 70, p.8)

[138] Baxter Healthcare was a medical supply company used by Queensland Health to supply renal dialysis equipment (QPHCI 2005 Exhibit 70 p.8).

Brian Graham, a renal product specialist from Baxter Healthcare, was aware of the difficulties at BBH and offered the renal nurses a solution whereby Baxter Healthcare would reimburse patients' expenses for having their catheters inserted by private surgeons at the Friendlies Private Hospital in Bundaberg, and then returning to the BBH's Renal Unit to continue peritoneal dialysis (Davies, 2005). Upon Miach's return from leave the arrangement was formalised and signed off by Keating.

Despite the fact that the 'Peritoneal Dialysis Catheter Placements – 2003' report provided to Keating indicated a 100% complication rate and two patient deaths related to the surgical insertion of peritoneal catheters by Patel, no action was taken. Meanwhile, the welfare of the renal dialysis patients was upheld by the efforts of the renal nurses who ensured that future catheter placements occurred at a private hospital by another surgeon.

7.6 Failure to transfer patients to Brisbane

Three patient cases from July 2004 to January 2005 resulted in nurses from ICU and the surgical ward completing high-rated adverse event incident forms and a sentinel event form for sending to DQDSU. Eleven nurses submitted written statements directly to the BBH Executive raising concerns about Patel's surgical practice and decisions not to transfer patients to tertiary hospitals in Brisbane. Seven of these written statements related to the care of a Mr Desmond Bramich[139] known as P11.

[139] During the Bundaberg Hospital Commission of Inquiry – which later became the QPHCI the family of Mr Bramich identified that they did not require his details to remain confidential. However in many of the exhibits prepared for the Inquiry before it began, Mr Bramich is coded P11.

7.6.1 Mr Bramich – P11

Mr Desmond Bramich, a 46-year-old man, was admitted as an emergency case to the ICU at BBH on 25 July, 2004. He had been working on his caravan when it fell on him causing a serious chest crush injury (Davies, 2005). After initially being stabilised in the ICU, Mr Bramich's condition improved and he was transferred the next day to the surgical ward. On 27 July, 2004, his condition suddenly deteriorated and he was transferred back to the ICU. Dr Carter, the Head of Anaesthetics, reviewed his case and decided

> to arrange for the patient to be transferred to a tertiary centre in Brisbane, where the capacity to provide thoracic surgery, long term ventilatory support and a blood bank with the capacity to provide products for massive transfusion were co-located.
> (QPHCI 2005 Exhibit 265A)

Following consultation with his primary surgeon Dr Gaffield, a decision was made to transfer Mr Bramich to the Princess Alexander Hospital. A further computed tomography (CT) scan was required to exclude intra-abdominal bleeding and inform the handover provided to the clinicians in Brisbane (QPHCI 2005 Exhibit 294).

While awaiting transfer to radiology for the CT scan Gaffield reviewed the patient's X-rays with Patel. On hearing from Gaffield that the patient would be transferred to Brisbane, Patel 'stated in a very loud voice, that the patient did not require transfer to Brisbane […] the patient did not need a cardiothoracic surgeon' (QPHCI 2005 Exhibit 4-TH21). Following the scan, Patel performed an ultrasound guided pericardiocentesis,[140] 'despite the evidence of the CT scan [which had] shown an absence of pericardial fluid' and informed the family that

[140] A procedure where fluid is aspirated using a needle from the pericardium (the sac enveloping the heart) (Inglis, King, Gleave, Bradlow, & Adlam, 2011).

Mr Bramich was now too unstable to be transferred (QPHCI 2005 Exhibit 265A Exhibit 265, p. 15-16). Mr Bramich died following cardiac arrest and unsuccessful resuscitation attempts (Davies, 2005).

Following this death, Carter recommended to Keating that the patient's management be audited. Karen Fox the RN who had accepted Mr Bramich back to the ICU on 27 July, 2004, submitted an adverse incident form regarding the absence of water in the underwater seal section of the intercostals catheter drain. Hoffman submitted a sentinel event form[141] with a two-page letter attached detailing her concerns about the management of Mr Bramich and the ongoing problems the ICU was experiencing with Patel. Five other ICU Registered Nurses added their written statements. In her letter to Keating, Hoffman stated:

> (a) Dr Patel had created a culture of fear and intimidation in the Unit;
> (b) On several occasions, Dr Patel has blocked the transfer of patients to Brisbane, even when they have stayed in the Base's Intensive Care Unit for more than 48 hours and a bed has been made available in Brisbane;
> (c) Dr Patel was doing operations which needed more post-operative support than the Unit was able to give;
> (d) All these problems had affected the care for Mr Bramich.
>
> (Davies, 2005, p. 123)

Despite the significant amount of data received by the staff involved in Mr Bramich's case, Keating argued that he had neither the resources nor the training to perform a root cause analysis[142] as required by the Queensland

[141] A sentinel event defined by in a Bundaberg Health Service District Policy and Procedure Document (2004) as 'An incident in which serious harm resulted to a person receiving health care' (QPHCI 2005 Exhibit 162-LTR6)

[142] Root cause analysis is an investigational approach that uses various methodologies and tools to retrospectively uncover systems-level causes and contributing factors behind sentinel events, incidents or near-misses (Card, Ward, & Clarkson, 2012; Mengis & Nicolini, 2011)

Health Incident Management Policy, and so conducted only a preliminary investigation (QPHCI Exhibit 448, p. 30; Davies, 2005).

Keating's preliminary investigation included asking each of the medical staff involved to provide their interpretation of the events. Keating also sent the sentinel event form and two-page letter prepared by Hoffman to Patel (QPHCI Exhibit 448, p. 29). Patel responded by stating:

> The sentinel event report form for the care of Mr. Bramich is based on mis-information, mis-representation, and personal bias.

He continued that a

> complete medical review of the case has been performed by me, Dr Gaffield and Dr Carter; and it has been reported that the patient was managed appropriately and he died from his injuries which were confirmed by the post-mortem findings.
>
> (QPHCI Exhibit 448 DK 46, p. 29)

This was despite the fact that Carter had outlined five areas of concern related to the case. He noted the six-hour delay in the arrival of a retrieval team and a lack of coordinated care between the two surgical teams that resulted in the family receiving 'mixed messages' regarding the 'advisability of transferring' Mr Bramich. Also noted was 'Poor triaging' resulting in a 'patient with a perforation of a prepped large bowel being prioritised ahead of a patient with catastrophic intra-thoracic bleeding'. He questioned the performance of a 'pericardial paracentesis' procedure when such a procedure was not indicated and also a 'lack of radiology support' in the form of a delay in receiving CT scan results (QPHCI 2005 Exhibit 265).

A verbal report to Keating from anaesthetist Dr Younis Iftikhar[143] on 18 October, 2004, also brought into question Patel's assessment of the events. Iftikhar was critical of Patel's 'volume and tone', which he described as 'very loud and inappropriate, especially with [Mr Bramich's] relatives in attendance'. He also felt that Patel had slowed 'the transfer of Mr Bramich who was stable enough for transfer' earlier and 'questioned the need for the CT scan'. He noted 'resistance from Dr Patel' and had spoken to other doctors about the case at the time. Patel was 'questioning' of what could be accomplished at Brisbane that could not be done at BBH, where he appeared to wish to 'keep the patients at all costs'. Iftikhar also observed that the 'multiple attempts at pericardiocentesis [had] distressed those involved in Mr Bramich's care' (QPHCI 2005 Exhibit 448 - DWK44).

Keating concluded that the issue was 'complex and not easily resolved'. Although he had concerns about Patel's

> multiple unsuccessful attempts at pericardiocentesis, his apparent failure to clearly establish himself as the clinician in charge after Dr Gaffield departed, and his communication problems with relatives and nursing staff.
>
> (QPHCI 2005 Exhibit 448, p. 31)

Still, he did not feel driven to take any action as 'None of these concerns caused me to restrict Dr Patel's surgical activities' (QPHCI 2005 Exhibit 448, p. 31).

[143] During the period of Mr Bramich's deterioration, Dr Younis Iftikhar, an anaesthetist involved in the case, was called away to deal with a 'less urgent case (a patient who had suffered perforation during a colonoscopy performed by the Director of Surgery [Patel])' (QPHCI 2005 Exhibit 265 A).

7.6.2 Feedback to the nursing staff re Mr Bramich

Despite the distress experienced by the ICU nurses in the wake of Mr Bramich's death (a number of nurses attempted to access the Employee Assistance Scheme for debrief counselling), no support was given by the BBH Executive (QPHCI 2005 Exhibit 4).[144] Hoffman recalls that she received no feedback regarding her sentinel event form for at least one month, and that was merely a verbal report from the Acting Quality Coordinator from DQDSU to the effect that Keating had downgraded the sentinel event (QPHCI 2005 Exhibit 4). Carter did send Hoffman his case report from the Bramich case. She was to recall later, however, that in discussions she had with Carter over the prospect of stopping Patel interfering in the care of patients in the ICU, his response was 'non-committal' (QPHCI 2005 Exhibit 4 p.32).

In email correspondence with DoN Linda Mulligan,[145] on 26 August, 2004, Hoffman reported that she was providing further information related to Mr Bramich. In the same email, she also expressed concerns about the lack of service by the Employee Assistance Scheme (EAS) for the ICU nursing staff and her fears over another complex surgical procedure booked by Patel that would take up a bed in the Unit. The response she received from Mulligan the same day shows no evidence of support, citing 'conflicting information, which at the best of times is difficult to sort out' (QPHCI 2005 Exhibit 4- TH22). In

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[144] One ICU nurse reported that the events she witnessed on 27 July, 2004, surrounding Mr Bramich – as well as other subsequent events at Bundaberg Base Hospital concerning Patel – caused a 'Major Depressive Disorder' and resulted in her taking workers compensation leave (QPHCI 2005 Exhibit 485 & Transcript Day 2).

[145] Linda Mulligan was employed as the DoN on 17 March 2004. Glenys Goodman the previous DoN retired in September 2003. During the period of Sept 2003- March 2004 a number of staff acted in the position including Patrick Martin (15 Dec 2003-7 March 2004, 25 Oct 2004 -31Oct 2004) and Toni Hoffman (3 March 2004- 20 March 2004) (QPHCI 2005 Exhibit 85).

the email, Mulligan reminds Hoffman of the 'issues/strategies with [regard to] communication that you and I have discussed previously' noting that 'further action needs to occur'. The email points out that Hoffman has been misinformed as to the nature of the contentious surgical procedure and that it would therefore proceed. She thanks Hoffman for 'this additional information' which she says 'will be sent on a[s] part of the review of the incident'. The EAS issue was not addressed at all, although Mulligan notes that since the matter does not involve 'nursing [she] will look at proceeding to involve others in discussing the issues at hand' (QPHCI 2005 Exhibit 4 – TH 22).

7.6.3 Hoffman's actions

Hoffman remained concerned about the repercussions of the Bramich case for her staff, particularly as she expected that there would be a Coroner's inquiry. She contacted the Queensland Nurses Union (QNU) representative to obtain legal advice and checked the coverage of her own indemnity insurance (QPHCI 2005 Exhibit 4).[146] In the days following Mr Bramich's death, Hoffman contacted the Coroner in Bundaberg, the local police and the Head Doctor of the Royal Flying Doctor Service Queensland (who performed most of the retrievals and transfers of critically ill patients to Brisbane). She undertook these actions to draw attention to the 'fact that we had the death of a patient in the hospital and that I believed that it was due to a doctor's negligence' (QPHCI 2005 Exhibit 4, p. 35).

[146] Members of the QNU benefitted from access to legal advice and professional indemnity insurance coverage.

On 3 September, 2004, two QNU representatives met, at the invitation of Hoffman, with ICU nursing staff who 'aired their grievances about the state of the patients coming though the ICU and the behaviour of Dr Patel' (QPHCI 2005 Exhibit 4, p. 38). One of these delegates, Kym Barry, later spoke to DoN Mulligan about the issues.[147] When Barry returned to Hoffman, she indicated that Mulligan had stated that she had received only one complaint related to Patel. Mulligan recalled telling Barry that she was 'aware that Ms Hoffman had issues with Dr Patel's behaviour', that 'no other issues had been raised with me by ICU staff or any Theatre/Surgical staff', but that she 'understood that the problem was only between Ms Hoffman and Dr Patel' (QPHCI 2005 Exhibit 180, p. 43).[148] According to Hoffman, 'Kym also ventured the opinion that she thought Linda Mulligan would try to discredit me' (QPHCI 2005 Exhibit 4, p. 38). Hoffman then proceeded to collect and collate a 12-month audit of all the patients who had died or suffered major complications due to Patel's surgery or intervention into care of patients in the ICU.

7.7 The Hoffman letter

On 18 October, 2004 Mulligan visited the ICU and met with Hoffman and other staff. She recalled that staff

> talked about the Mr Bramich matter and provided […] other examples of concerns they had about Dr Patel. All of the concerns (other than the Mr Bramich matter, which I reiterated as being investigated) related to Dr Patel's behaviour and not to any

[147] The dates of the meeting between Barry and Mulligan differ in their witness statements. Hoffman recalls the meeting was in September. Mulligan records meeting with Barry in October.

[148] There was an incident report form completed by ICU nurse Karen Fox earlier, as well as emails from Hoffman in August indicating that other staff had written reports with regards the Bramich case, and many were seeking EAS counselling over the issue. An incident report form P0392 was submitted on the 27 August, 2004, by Jenkins from the surgical ward regarding a wound dehiscence (QPHCI 2005 Exhibit 167).

> issue related to the standard of patient care. I strongly encouraged them to document the issues to me, so that the correct procedure could be followed and the matters investigated.
>
> (QPHCI 2005 Exhibit 180, pp. 44-45)

On the same day, Mulligan called an urgent meeting with District Manager (DM) Peter Leck and Director of Medical Services (DoMS) Keating in which she related the conversations she had had with the ICU nursing staff. She also stated that there was a need to 'progress the option of mediation between Ms Hoffman and Dr Patel in order to resolve the issues of behaviour/communication' as she was 'concerned that the matter was not resolving and [was] impacting on the smooth operation of the ICU'. It was also agreed at the meeting that 'data needed to be provided [...] from Ms Hoffman and Dr Carter in order to address the issues relating to transfers/ventilated capacity' (QPHCI 2005 Exhibit 180, p.45).

On 20 October, 2004, a further meeting took place between Hoffman and Mulligan in the Executive offices (QPHCI 2005 Exhibit 180 p. 46).[149] While Mulligan identified the fact 'that Dr Patel had agreed to participate in mediation', Hoffman indicated that the issue was not only 'about Dr Patel's behaviour/communication' (QPHCI 2005 Exhibit 180, p. 46), but also concerned other matters, too, notably:

> the level of complications those patients who were coming through to the Intensive Care Unit had after being operated upon by Dr Patel;
> a number of deaths which had occurred;
> Dr Patel's behaviour in the unit;
> the effect of the P11 incident upon my staff and that they were particularly suffering;

[149] Hoffman indicated in her witness statement that she called the meeting (QPHCI 2005 Exhibit 4, p. 41). This was refuted by Mulligan who indicated that Hoffman attended at her request (QPHCI 2005 Exhibit 180, p. 46).

> the lack of support for staff members and that I had sought but failed to obtain from the EAS debriefing for the staff;
> that Dr Patel had indicated to nursing staff that he was untouchable in that he had earnt a lot of money for the hospital.
> (QPHCI 2005 Exhibit 4, p. 42)

Mulligan was also to recall Hoffman's highlighting of how, in 2003, she and Dr Joiner had spoken with Keating concerning Miach's refusal to allow his patients to be treated by Patel, and relayed their further misgivings that other doctors had expressed concerns about the latter's competence and behaviour (QPHCI 2005 Exhibit 180, p. 47).

Later that same day, Hoffman was recalled to the executive offices to repeat her claims to DM Leck. Both Mulligan and Leck advised her that the allegations were serious and that they needed to be put in writing. Hoffman's three-page letter to the BBH Executive is too long to be included here, thus it has been reproduced in full in Appendix 3. It documents a series of incidents and patient cases that prompted Hoffman and other nurses to question the behaviour and competence of Patel, the scope of practice of the Level One ICU at BBH, as well as all previous attempts made by the ICU Nurses to have some level of investigation undertaken.

Leck assured Hoffman that these serious allegations would be investigated. He immediately forwarded her letter to Keating; however, the investigation proceeded at a slow pace. Keating and Leck interviewed Doctors Berens (29 October, 2004), Risson (2 November, 2004) and Strahan (5 November, 2004), who corroborated many of Hoffman's allegations (QPHCI 2005 Exhibit 464, p. 3). By November, 2004, Leck had settled on the need to have an external review undertaken, although this was not a view shared by

Keating. Exhibit 163 reveals that Keating was reluctant to agree to a review because he considered that the allegations related to a personality conflict and lacked substance. He felt Dr Patel's scope of practice should be addressed in the review but otherwise did not think any immediate action was required (QPHCI 2005 Exhibit 463, par. 52).

Nevertheless, in December, 2004, Leck and Keating began making enquiries for a suitable candidate to perform an external review, with Keating being keen to find 'someone with regional experience' (QPHCI 2005 Exhibit 463, par. 53). Meanwhile 'Dr Patel continued to operate without restriction or supervision', performing complex surgeries beyond the scope of the ICU resources, and delaying transfers of patients to Brisbane (Davies, 2005, p. 150).

The inquiry into Patel was progressing slowly, nonetheless the BBH Executive wasted little time bringing the nurses' actions of reporting outside the organisation to the attention of their representative body, the QNU. Hoffman recalls that shortly after sending her letter, three Queensland Health officers from the Ethical Standards Unit in Brisbane invited all senior nursing staff and heads of department to a seminar on the constraints on 'Queensland Health employees from disclosing confidential information to others' (QPHCI 2005 Submissions 25-1 QNU, p. 5). Hoffman recalled that the 'talk' dealt with reacquainting the senior nursing staff with Queensland Health's policies on confidentiality and whistleblowing. The talk also outlined the approved avenues staff were permitted to use to report concerns, and which ones they were not. She states:

> We were specifically told that it was impermissible for us to tell our Union anything about what goes on in the hospital or any

> hospital related business. We were told that this was illegal and that if we spoke about anything that happened at the hospital to our Union we would go to jail and lose our jobs... I distinctly remember that the talk scared the living daylights out of me.
> (QPHCI 2005 Exhibit 4, p. 44)

She understood the arranged seminar as a direct response to the statements in the later stages of her allegation letter in which she indicated that the QNU had been advised of the concerns within the hospital about Patel.

7.8 Waiting for a response, complaints continue Mr Kemps and P26

Bookings continued to be made to perform complex surgeries at BBH and the staff observed no changes in Patel's behaviour. Tension between the ICU nurses and Patel would soon reach a further crisis point, leading to further written complaints. While waiting for a response to the serious allegations made in October 2004, the nurses at the hospital learned that Patel had been named by the Executive as 'Employee of the Month'[150] for his efforts during November and the management of a tilt train accident (Davies, 2005, p. 160).[151]

The case that upset the ICU nurses occurred late in December 2004 when Patel demanded that a patient be urgently removed from life support to make room for his next oesophagectomy surgical case planned the following day. Mr Kemps, the oesophagectomy surgical case from December 2004, also became the focus of a written complaint by three perioperative nurses. Meanwhile, just

[150] This accolade occurred during the same month in which Jenkins submitted a adverse event form P0540 with a high rating for analysis of complications that arose following a laparascopic cholecystectomy (surgical removal of the gallbladder) performed by Patel. As the nominated investigator Mulligan added: ' Note, this is a medical issue, situation to query surgical technique. DMS [Keating] has received, not appropriate for other action at this time' (QPHCI 2005 Exhibit 167).

[151] Just after midnight on 16 November 2004, the Spirit of Townsville Tilt Train travelling from Bundaberg to MacKay derailed, 60km north of Bundaberg. There were 157 passengers and crew on board. No fatalities resulted, however injured passengers were transferred to local and regional hospitals (Australian Government, 2005).

days after Mr Kemps' operation, the surgical ward nurses were dealing with the repercussions of Patel's decision to perform a series of vascular surgeries (with complications) on a young motorbike victim, P26, rather than send him to Brisbane.

7.8.1 ICU, OT nurses and Mr Kemps (P21)

On 20 December 2004, ICU nurse Vivian Tapiolas was caring for patient P44, a 63 year-old lady who had suffered an extensive sub-dural haematoma[152] following a fall at home on 18 December 2004. Patient P44 was admitted to the ICU, intubated and ventilated. However, her fixed and dilated pupils indicated that there may have been brain death (QPHCI 2005 Exhibit 4-02 TH41, Exhibit 156). The previous evening Patel requested that P44 be removed from the ventilator at midnight, as he had an oesophagectomy case the next day and required the ICU bed. Dr Jonothan Joiner, the anaesthetist on call that night refused, indicating that he had 'not dealt with the patient and no formal brain death tests had been conducted' (QPHCI 2005 Exhibit 307, p. 3). At 8am, Dr Carter reviewed P44 at the insistence of Patel who was still looking to secure a bed (QPHCI 2005 Exhibit 265). Carter, Patel and ICU nurse Tapiolas held discussions with the family of P44 and a decision was made to withdraw treatment. Tapiolas recalled: 'As we walked back up the corridor Dr Patel said; "now I can perform the oesophagectomy". Treatment was withdrawn from P44 and she consequently passed away' (QPHCI 2005 Exhibit 4-02 TH41).

[152] Acute subdural haematoma is a collection of blood on the surface of the brain that compresses brain tissue. It is a serious complication of head injury, with a high mortality rate of from 50 percent to 80 percent (Leung, Ng, Ho, Hung, & Yuen, 2011).

Mr Gerard Kemps (P21) a 77-year-old local Bundaberg man attended BBH to have investigated a lump that was contributing to a difficulty in swallowing. Initially treated by the Department of Medicine under the care of Dr Dawid Smallberger,[153] Mr Kemps underwent a series of tests, including endoscopy, CT and biopsy, the results of which showed that he had a large 40cm cancerous mass (malignant tumour) in his oesophagus (QPHCI 2005 Exhibit 133). Smallberger informed Kemps of his condition and indicated that 'the best further management of the problem was likely to be a combination of the use of a stent (to keep the oesophagus open) and/or radiation and/or chemotherapy'. He advised that Kemps 'be transferred to the Royal Brisbane Hospital' (QPHCI 2005 Exhibit 133, par. 5). In order to progress a transfer, the protocol required a referral from a BBH surgeon. Smallberger had already decided that, due to its limitations, BBH was not the right hospital for Kemps' continued treatment. He expected that the surgical referral would support his plan and a transfer would be arranged for Mr Kemps to continue treatment in Brisbane (QPHCI 2005 Exhibit 133).

On the 19 December, 2004, Patel reviewed Kemps and informed him and his wife that the 'keyhole surgery'[154] was only

> 'patch up work' and that the best course of action was to 'have part of the stomach and oesophagus taken away and then join them back together. [Patel] did say, "It is a big operation but it is nothing because I've done hundreds of them"
>
> (QPHCI 2005 Exhibit 126, p. 4).

[153] Dr Dawid Smallberger, a South African doctor was first registered as a doctor in Queensland in 2003. He worked in the Department of Medicine at BBH under the direction of Dr Miach, the Director of Medicine (QPHCI 2005 Exhibit 133).

[154] Inserting a stent to keep the oesophagus open.

Mr Kemps then was discharged home to spend time with his family over the weekend and return to the hospital on the day of his operation, the following Monday. Near the end of Kemps' operation the anaesthetist and nurses involved in the surgery[155] raised concerns about the volume of 'blood coming through the various drains that had been inserted', which to them suggested 'that there is bleeding somewhere in the abdomen'(QPHCI 2005 Exhibit 128 par. 17).

Despite their protestations that Kemps may be bleeding, Patel completed the operation and left the theatre, leaving the more junior staff to close the incision (QPHCI 2005 Exhibit 146). The anaesthetist, Berens, noted the continued flow from the drain, as well as the low blood pressure and elevated heart rate, and requested that Dr Kariyawasam (the junior surgical staff member) have Patel review the patient before transfer out of the theatre. Nurse Damien Gaddes later recalled:

> Dr Kariyawasam returned and informed us that Dr Patel's orders were to admit the patient to ICU. All the staff present including myself expressed disbelief as to this response from Dr Patel. It was clear that all present believed that the patient was haemorrhaging. Dr Berens stated *"This patient will be back to theatre tonight"* […] and the patient was transferred to the ICU.
> (QPHCI 2005 Exhibit 146, p. 8, emphasis in original)

At the conclusion of the operation at 2pm, Patel rang Mrs Kemps to inform her that 'the surgery was a total success only a little bit of bleeding but that was nothing' (QPHCI 2005 Exhibit 126, p. 5). It was only when Mrs Kemps arrived in the ICU that she was informed by the staff of the gravity of her husband's condition. Nurse Tapiolas, who accepted Mr Kemps back into

[155] Katrina Zwolak Damien Gaddes and Janelle Law.

the ICU, reports that the initial four hours of post-operative management for Mr Kemps

> was a period of intense acuity, requiring 3 staff members at the bedside for fluid management, in order to maintain a BP 80 and Hb70. Mr Kemps' abdomen was now distended with bright blood flowing into his bellovac [surgical drain]. Numerous telephone calls were made regarding his condition… a staff member was constantly running to the Blood Bank for blood products…The relatives were extremely distressed regarding his deteriorating condition … and kept asking when he would be going back to Theatre.
>
> (QPHCI 2005 Exhibit 4-02, TH41)

Mr Kemps was returned to the Operating Theatre at 6.30 pm. Patel informed Mrs Kemps at 6pm that her husband was bleeding internally and that 'I have to take him back to theatre again. It can only be the spleen. I'll take it out because he doesn't need it any way' (QPHCI 2005 Exhibit 126, p. 6). Later, after the repeat surgery, Patel took Mrs Kemps and her son

> to the area where the theatres are and told us there, "I have taken the spleen out but it was all right. I had a look at the lungs and they were all right so the bleeding must have come from the heart". He went on to say, "I can't do anything about it but he will be lucky to last the night"
>
> (QPHCI 2005 Exhibit 126, p. 6).

Mr Kemps continued to bleed overnight at died at 9.45am the next morning. Patel assigned a junior medical officer to complete the death certificate and indicated to the ICU nurses that 'there would be no need for a coroner's case as he knew what [Mr Kemps] had died from' (QPHCI 2005 Exhibit 154, par. 12). ICU nurse Martin Brennan recalled that he was 'unhappy with this and spoke to Dr Dieter Berens, consultant anaesthetist, and Dr Martin Carter, ICU Director' (QPHCI 2005 Exhibit 154 par. 12).

In the days following Mr Kemps death, Carter performed research into the 'acceptable survival rates for oesophagectomies' and discovered that '90% of patients should survive at least 1 year after the oesophagectomy. As 2 of Dr Patel's 4 patients had died' Cater felt 'sufficiently concerned to raise this with administration' (QPHCI 2005 Exhibit 265, p. 10). On 23 December, 2004, Berens and Carter met with Keating to outline their concerns about the case, about Patel's conduct and about the lack of a referral to the Coroner for autopsy. Keating advised them that they were witnesses to the management of this patient and if they believed that an autopsy was required, that they should contact the Coroner urgently, as Mr Kemps' funeral was being held within an hour of their meeting (QPHCI 2005 Exhibit 265 & 448). Carter then decided that 'the family has suffered enough and that stopping the funeral would only add to their stress and grief' (QPHCI 2005 Exhibit 265 p. 10).[156]

Keating did inform the doctors that 'Dr Patel would not be permitted to perform any more oesophagectomies' and advised that they were to inform their fellow anaesthetists of this decision (QPHCI 2005 Exhibit 448, p. 60).

In the meantime, Mulligan had returned from leave during the Christmas period to learn that the ICU and perioperative nurses were deeply distressed over Mr Kemps' death. On 5 January, 2005 Jillian Jeffery the newly appointed Chief Nursing Advisor visited BBH and met with Mulligan and approximately 20 senior nurses, to outline the 'new' role of the Chief Nursing Advisor (QPHCI 2005 Exhibit 335 – SMB5). Jeffery outlined the 'special reporting relationship' of the Chief Nurse Advisor and encouraged the nurses to raise any

[156] On 15 April, 2005, one month after Patel's actions became public. Mr Kemps' death was reported to the Coroner by Keating and Nydam (QPHCI 2005 Exhibit 448, p.60).

issues that they felt may need to be reported to the Director-General of Queensland Health. Jeffery also provided the nursing staff with her contact details and reiterated her accessibility if staff needed to raise concerns (QPHCI 2005 Exhibit 335 – SMB5).[157] Despite this knowledge, neither Mulligan nor any of the other senior nursing staff present at the meetings with Jeffery raised any concerns related to Patel.

On 7 January, 2005, Mulligan met with the OT staff. Her file note summarises the meeting and is reproduced here in full:

> Three staff from Theatre, Katrina Zolak [*sic*] RN, Janelle Law EN, and Damien Gaddes RN made an appointment to see me today with respect to issues with Dr J Pattel [*sic*] in Theatre. The issues surrounded the areas of clinical practice, and professional behavior as follows:
>
> - Questioning of clinical expertise with certain surgeries, and two recent examples provided where they believed Dr Pattel practiced beyond his capabilities.
> - Questioning surgical skills/training of Dr Pattel and belief that patients are having poor outcomes, including unnecessary deaths as a result.
> - Alleging clients not being transferred to Brisbane when they should have been. They believe Brisbane hospitals able to cope better with the level of surgery that has been occurring by Dr Pattel
> - Alleging falsifying of documents by Dr Pattel, and threatening/intimidation of other medical staff to keep quiet about certain patient outcomes
> - Alleging unprofessional behavior-yelling at staff, intimidating staff by threatening their jobs, making derogatory comments about staff in front of others, bullying of staff to not take action by suggesting that he has a close relationship with DM/executive and using exclusion as a tactic with staff if they raise any concerns against him.
>
> (QPHCI 2005 Exhibit 147)

[157] On 29 April, 2005 Jillian Jeffery reported in a memorandum to Dr Steven Buckland, Director General the details of her visit to BBH on 5 January, 2005. She indicated that she attended the hospital for 'about half of the day' and held meetings with senior nursing staff. She also reported that 'no concerns or complaints were raised neither directly with me that day nor since that time' (QPHCI 2005 Exhibit 335 – SMB5).

Staff were encouraged to document their concerns immediately, and as they expressed fear of retribution,[158] or of no action occurring at all, were re-assured that the issues would be dealt with. Clarification was sought by the representatives from the Queensland Nurses Union who explained that staff were entitled to access their advice if they so choose. EAS information was provided as all three staff who displayed distress at the events – 'two were teary/crying and one stated it was affecting their ability to sleep at night' (QPHCI 2005 Exhibit 147). Reassurance was given that action would occur and explanations provided on the process surrounding complaint management. Staff were told confidentially that a particular surgical procedure over which they had raised concerns would no longer be occurring at the BBH, and thus they should be assured that their concerns would be taken seriously (QPHCI 2005 Exhibit 147).[159]

On 20 January, 2005 Hoffman forwarded the written complaint from Tapiolas, the ICU nurse involved with both P44 and Mr Kemps, to Mulligan. Mulligan reported sending all the statements onto Leck (QPHCI 2005 Exhibit 180).

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[158] The three operating theatre nurses Janelle Law, Damien Gaddes and Katrina Zwolack requested protection and anonymity under the Whistleblowers Protection Act 1994. Gaddes specifically writes 'My request is for the purposes of avoiding bullying (from Dr Patel) and staff speculation' (QPHCI 2005 Exhibit 281).

[159] Janelle Law reports her trepidation at making a written complaint: 'It took me quite a while to work up the courage to hand it in after I had written it as I feared for my job' During her meeting with Mulligan, Law was informed that since they had seen Mulligan they were 'obliged to hand in any written statements'. She then recalls 'I gave my statement to Gail Doherty [acting NUM of Operating Theatre]. She took it up to Linda Mulligan. While I received support from Gail and David Levings, the other Acting Nursing Manager, I received no feedback or support from Linda Mulligan or anyone else from Executive after handing in my statement'. (QPHCI 2005 Exhibit 160, p. 4).

7.8.2 Surgical Ward Nurse Michelle Hunter and P26

On the same day, that Cater and Berens were consulting with Keating about Patel's competence to perform complex surgery and about the death of Mr Kemp, a 15-year-old male, patient P26, was air lifted by ambulance helicopter to BBH following a serious motorbike accident. While riding his motorbike, P26 hit a tree stump and was bleeding from his groin. On arrival at BBH, he was rushed to surgery (QPHCI 2005, Exhibit 137). Patel performed the trauma surgery, first by exploring the laceration, then repairing the left femoral vein. The wound was debrided[160] and washed, a drain was placed, the wound closed with sutures and staples before Patient P26 was then transferred to the ICU (QPHCI 2005 Exhibit 146). Patel met with P26's mother and informed her that she was fortunate as he was

> a great doctor [...] that he had run the ER [emergency room] section of a New York Hospital for 10 years', and 'that he had stopped the bleeding and that my son would be alright.
> (QPHCI 2005 Exhibit 137, p. 3)

On arrival at the ICU from the OT nurse, Martin Brennan reports that he was unable to find a pulse in P26's left leg. He immediately contacted the Surgical Registrar, Dr Anthony Athanasiouv, and expressed his concern that the patient 'couldn't be managed in Bundaberg and needed to be transferred' (QPHCI 2005 Exhibit 154, p. 1). Athanasiouv examined P26 and could not find an arterial pulse and suspected compartment syndrome (QPHCI 2005 Exhibit

[160] Removing dead or damaged tissue.

142).[161] According to Brennan, Athanasiouv had begun exploring options to transfer P26 to a tertiary hospital in Brisbane to ensure specialised vascular management when Patel intervened and gave 'instructions to keep the patient in Bundaberg and he would take him back to theatre himself' (QPHCI 2005 Exhibit 154, p. 1).

Back in OT, Patel performed a fasciotomy[162] on P26's left leg to relieve pressure (QPHCI 2005 Exhibit 146). Gaddes, one of the perioperative nurses, recalls discussing with Patel the potential causes of P26's compartment syndrome, and inquired if it was related to bleeding or perhaps a fractured femur and even 'suggested that we do an on table angiogram or a portable x-ray. Patel's response was to the effect of "*No it is not necessary to do it now. I am happy with my anatomy and we have haemostasis*" (QPHCI 2005 Exhibit 146, p. 10, italics and emphasis in original). No peripheral pulse was found in the left leg, which was 'mottled and extremely stiff'. Patel informed the team that 'the patient's circulation would return after the swelling went down' and P26 was once more returned to the ICU (QPHCI 2005 Exhibit 146, p.11).

An ultrasound performed at 8pm by Athanasiouv showed an intimal tear of the femoral artery and the on-call surgical team, including Gaddes, was called back to the Theatre, where P26 was once more returned to investigate the lack of arterial pulse in his left leg (QPHCI 2005 Exhibit 142). Gaddes expressed surprise, as he had expected that after the fasciotomy P26 would be

[161] Compartment syndrome is a serious condition that can occur following limb trauma or surgery. It occurs when there is an increase in pressure (usually from swelling) within a muscle compartment, because the fluid cannot escape it compresses and compromises the circulation to the tissues within that space. The condition is most commonly found in the muscular compartments of the limbs, and in particular those of the leg (Wall *et al.*, 2010).

[162] Fasciotomy involves a long incision being made in the skin and fascia to release pressure or tension caused by compartment syndrome (QPHCI 2005 Exhibit 146).

transferred to Brisbane (QPHCI 2005 Exhibit 146). This time Patel noted that the femoral artery was damaged and he 'repaired the artery with a goretex bypass and removed a clot'. Yet, while Patel reported feeling a 'good palpable post-tibial pulse', Gaddes was unable to locate such a pulse (QPHCI 2005 Exhibit 146, p. 12). Again, P26 was transferred to the ICU and Patel left for a vacation in New York.

Patient P26 remained in ICU until the 27 December, 2004, when he was transferred to the surgical ward. Dr Gaffield took over care of P26 and indicated that in his opinion 'the patient was making slow, but appropriate progress' (QPHCI 2005 Exhibit 294, p. 5). Despite the patient's mother's repeated requests to transfer her son to Brisbane to see a vascular surgeon, she was reassured that 'he was doing well and everything was fine' (QPHCI 2005 Exhibit 137 p.6). However, by 1 January, 2005, P26's condition had deteriorated, and Gaffield found that 'he was confused, not eating and one of his leg wounds had developed a superficial infection'. The decision was made to transfer the patient to Brisbane (QPHCI 2005 Exhibit 294, p. 5).

Michelle Hunter, a surgical ward Clinical Nurse, looked after P26 for two shifts during his stay at BBH, and on both occasions reported the patient's serious condition to the surgical team and questioned why he was not transferred to Brisbane for review. Upon learning that P26 had finally been transferred on 1 January, and had subsequently had his leg amputated, she felt she had to act:

> On Sunday 2 January 2005, I heard from the nursing staff in the ward and from Dr David Risson, who was on call, that Brisbane has performed a through knee amputation and that during the procedure they had found the patient's femoral vein had been tied off. From that moment on I felt that Dr Patel had been

> incompetent and I was determined to voice my concerns as how the care of this patient was managed.
>
> (QPHCI 2005 Exhibit 141, p. 3)

Hunter's first intention was to 'write to the Health Rights Commission because I felt management wouldn't do anything about the incident, as I felt Dr Patel was protected' (QPHCI 2005 Exhibit 141, p. 4). She was dissuaded from following this option by DoN Mulligan, who suggested that this 'was not the right way to go about it and I should write a letter to her about P26 and about any other issues relating to Dr Patel' (QPHCI 2005 Exhibit 141, p. 4).

Hunter consequently wrote a comprehensive letter outlining all her observations of P26's condition during the two days he was under her care, as well as the lack of action by the medical staff. She concluded her letter by stating:

> My concerns are with the surgeon that performed his initial 3 operations whilst in the care of the Bundaberg Health Service. I am concerned that if the patient had been transferred to Brisbane initially he may not of lost his leg or be in such a grave condition. I would like his treatment at this hospital investigated as I fear his health and well-being has been compromised by inadequate, substandard treatment by the medical team. Your urgent assistance in this matter is greatly appreciated.
>
> (QPHCI 2005 Exhibit 180 – LMM22)

The letter was sent to Mulligan on 4 January 2005, who reported that she forwarded it to Leck.

Although Keating did not receive any of the nurse complaints about P26, he did receive direct and damaging feedback in the form of an email from Dr Steve Rashford, Director of Clinical Co-ordination and Patient Retrieval Services for Queensland Health on 4 January, 2005. Rashford had examined P26 on his arrival at the Royal Brisbane Hospital and recalled:

> I was struck by his condition. He was about 6ft 4 inches and well built. His leg was unbelievably swollen. It was disgusting. The wounds were full of pus and he was very, very unwell. In my opinion, the fact that the patient held it together was in no small part due to the more robust physiology of a 15 year old […] I was struck that warning bells had not gone off earlier in Bundaberg, and that the patient had not been transferred to Brisbane […] I decided that it was appropriate to make a complaint and I wrote an e-mail to the Medical Superintendent at Bundaberg Base Hospital, namely, Darren Keating […] I sent a copy of my e-mail to Dan Bergin (Zonal Manager) and the District Manager (Peter Leck). I did that just to make sure that the e-mail reached the right levels.
>
> (QPHCI 2005 Exhibit 140, par. 9-13)

The issue of poor management of P26 was no longer a mere allegation made by the nurses. It had now become a call by a senior medical authority from higher levels of Queensland Health for the case to be considered a sentinel event.

The seriousness of the complaint by Rashford and his referral to Bergin from Zonal Management required that Keating provide a report regarding Patel's practice to a source outside the immediate BBH Executive. Keating's report raised 'issues as to Dr Patel's judgement with respect to the need to transfer patients', particularly those that required specialised vascular surgery (QPHCI 2005 Exhibit 448, p. 34). However, it did not raise any 'issue as to his technical skills as a general surgeon' (QPHCI 2005 Exhibit 448, p. 34). Keating also identified that BBH would 'institute a policy of transfer to tertiary facilities of patients with emergency vascular conditions'(QPHCI 2005 Exhibit 448, p. 34). Even so, it did not address any of the previous complaints about Patel. Keating also advised Leck on 5 January, 2005, [163] on submission of his brief report into the management of P26 that he was 'not sure in the circumstances that an external review [was] warranted' (QPHCI 2005 Exhibit 448- DWK51).

[163] Just one day after receiving the email from Rashford, Keating sent his brief report to Leck to be forwarded to Bergin from Zonal Management.

7.9 Dr FitzGerald and the Queensland Health clinical audit investigation

In mid-January, 2005 following further complaints subsequent to the Hoffman letter in October 2004, particularly regarding the clinical management of P26 (which gained the attention of Zonal Management), Leck expedited his search for a candidate to perform an external clinical review. The clinical review, identified as an audit, was undertaken by Dr Gerard FitzGerald the Chief Health Officer of Queensland Health.[164]

The clinical audit into general surgical services at BBH began on 17 January, 2005,[165] and was completed on 25 March, 2005. This section examines the approach taken by the BBH Executive to secure FitzGerald to perform an investigation into the services at the hospital, the terms of reference of the clinical audit, the level of information and access to staff provided to FitzGerald, and finally the perceptions and reaction of the nurses to the depth and outcome of the investigation.

7.9.1 Finding an investigator

In early January 2005, the BBH Executive received additional complaints, incident reports and requests for sentinel event review concerning patients treated by Patel. While Keating remained resolute that the issue could be solved by introducing new policies and informing Patel that he was no longer to

[164] The Chief Health Officer is a statutory position related to the *Health Act* 1937. The position involved membership on the Medical Board of Queensland and also required advising the Health Minister and Director-General of Queensland health on the 'quality and standards of health care' (Davies, 2005, p. 507). FitzGerald held this position from January 2003(Davies, 2005).

[165] Although FitzGerald received information concerning Patel's performance from the executive of BBH and Ms Rebecca McMahon (Director of Internal Audits) on the 17 December 2004, no immediate action was taken to follow up. The rationale for the lack of immediate action by FitzGerald was that he and other senior Queensland Health officials were dealing with the aftermath of the January 8, 2005 earthquake and resulting tsunamis in Indonesia (QPHCI 2005 Exhibit 225).

perform complex oesphagectomy surgeries, Leck sought advice from Dr John Scott, the Director-General of Queensland Health. Leck was no longer merely relying on the verbal assurances of Keating. In an email to Scott on 13 January, 2005, Leck outlines his emerging concerns. Despite the fact that, by this date, he had received numerous written statements by nurses,[166] corroborating evidence from interviews with doctors,[167] and the Peritoneal Dialysis Catheter Placements – 2003 document reporting a 100 percent complication rate, Leck alludes only to *a single member* of the nursing staff making a complaint. The email correspondence from Leck to Scott reads as follows:

> Sorry we have missed each other over the last week.
> I was really trying to catch up about Dr Patel, our Director of Surgery, who undertook the procedure on the 15yo male who had initial surgery in Bundaberg and subsequently transferred to Brisbane where he had a leg amputation. You will recall that Steve Rashford raised some concerns.
>
> I was just wanting to flag that I actually do have some concerns about the outcomes of some of Dr Patel's surgery. Late last year I received some correspondence *from a member of the nursing staff* outlining a number of concerns about outcomes for patients (including some deaths). This is coloured by interpersonal conflict between Dr Patel and nursing staff – particularly in ICU.
>
> Until the last week, my medical superintendent did not believe the complaints were justified and were completely driven by the personality conflict – however, he has now expressed some concern although he still believes most of the issues are personality driven.
>
> Late last year I made contact with Mark Mattiussi for advice about who could conduct a review of the concerns – and particularly of elective surgical ICU cases. My med super is keen not to have a professional 'boffin' from a tertiary hospital undertake such a review for fear that they might not relate to 'real' world demands of surgery in regional areas.
>
> Mark suggested Alan Mahoney from Redcliffe. I flagged this also with Audit and Operational Review seeking some assistance for the review. They have referred me to Gerry FitzGerald.

[166] From the surgical ward, Intensive Care Unit and Operating Theatre.
[167] Berens, Risson and Strahan.

> Unfortunately, Gerry has been away (back next week) – I was really ringing to flag this with you as I am becoming increasingly anxious about the need for a swift review process and wasn't sure I could wait until next week to get something going (now I think that this is OK – sorry!).
>
> A few of the nursing staff have advised that they reported the matter to the QNU before coming to management (thankfully the QNU advised them to report to us).
> Peter.
>
> (QPHCI 2005 Exhibit 449, emphasis added)

Leck's correspondence to Director-General of Queensland Health Scott, indicated a desire to have a swift review of the clinical competence of Patel conducted by FitzGerald.

7.9.2 Dr FitzGerald

Six days later, after a telephone discussion with FitzGerald requesting an appropriate review of the cases in which concerns had been raised about the performance of Patel, Leck sent a follow-up memorandum to FitzGerald (QPHCI 2005 Exhibit 281). This memorandum, dated 19 January, 2005, included the attachments listed below:

- The Hoffman Letter (22 October, 2004)
- Notes from the meetings Leck and Keating had held with doctors Berens (29 October, 2004), Risson (2 November, 2004) and Strahan (5 November, 2004).
- A file note of a meeting between Hoffman, Mulligan and Leck, dated 20 October, 2004.
- A completed Adverse Event Report Form by ICU Nurse Fox regarding Mr Bramich.
- Email correspondence from Rebecca McMahon, the Assistant Manager of Investigations Audit and Operational Review Unit, Queensland Health, indicating that the 'matter involves issues of clinical practice and competence, rather than allegations of misconduct'.
- The letter sent by surgical nurse Hunter to Mulligan about the management of patient P26.
- Three statements prepared by operating theatre nurses Law, Gaddes and Zwolack related to the management of Mr Kemps sent to BBH executive on 14 January, 2005.
- A statement - 'ICU issues with ventilated patients' - prepared by Hoffman on 25 October, 2004.

- A statement prepared by ICU nurse Stumer on 21 October, 2004 outlining concerns regarding 'Dr Patel's indiscrete behaviour concerning fellow colleagues and clinical management'.
- Statements prepared by ICU nurses Fox, Tapiolas raising concerns about Patel's role in the medical management of Mr Bramich on 27 July, 2004.
- Email correspondence (26 August, 2004) between Mulligan and Hoffman related to ICU nurses concerns about the medical management and death of Mr Bramich.
- A 'Report on incident on 4-5th March' prepared by ICU nurse Kay Boisen, on 28 March, 2004, which outlined concerns about the management of P40, the behaviour of Patel and the limitations of the ICU to manage complex long-term ventilated patients [168].
- A letter by ICU nurse Boisen to Hoffman 3 August, 2004, reporting on a confrontation with Patel regarding the capacity of the ICU to manage too many ventilated patients and the transfer of patients to Brisbane.
- A written complaint prepared by ICU nurse Karen Jenner (not dated) that Patel had discussed confidential patient information, namely the autopsy report of Mr Bramich, 'over the top of' another conscious patient.
- The Sentinel Event Report Form prepared by Toni Hoffman on 2 August, 2004, regarding the death of Mr Bramich.
- The Peritoneal Dialysis Catheter Placements report of complications in cases performed in 2003.

(QPHCI Exhibit 281)

Despite the 40 pages of attachments listed above, FitzGerald advised Leck of his decision to proceed only with a 'clinical audit into general surgical services at Bundaberg Hospital'. The rationale given by FitzGerald was that

> there was at the time insufficient information to direct enquiries at any individual. Such an investigation would require a significantly different methodology and in particular the opportunity for the individual about whom the complaints were made to be provided with copies of all the material relevant to the complaints.
>
> (QPHCI 2005 Exhibit 225, par 61)

[168] No other background details of P40 or the incident surrounding ICU nurse Kay Boisen's concerns could be found. Kay Boisen did not submit any statements into evidence to the QPHCI, nor did she present to give testimony to the inquiry.

In an email correspondence to Leck on 8 February, 2005, FitzGerald further stated:

> I have reviewed all the material to date and while it is appropriate to proceed with the clinical audit it is too early to be able to document any particular concerns regarding any individual. To that end we would appreciate the opportunity to meet with a variety of staff including Dr Patel with a view to identifying their concerns and views regarding the quality of services provided at Bundaberg. At this point we will be simply collecting information and not seeking to validate or evaluate any particular concerns raised.
>
> (QPHCI 2005 Exhibit 225 – GF 12)

On 14 February, 2005, FitzGerald and Susan Jenkins, Manager of the Clinical Quality Unit, arrived at BBH. They stayed two days to collect relevant data and interview staff for the clinical audit.

7.9.3 Terms of reference for the Clinical Audit

The Clinical Audit investigation into general surgical services at BBH was described in the final confidential report as a 'systematic review and critical analysis of recognised measures of the quality of clinical care', conducted in order to benchmark and identify areas for improvement. Additionally, it was 'designed to complement accreditation surveys and focus on the outcomes of care rather than structures and processes' (QPHCI 2005 Exhibit 230, p. 2). The purpose being, to 'measure quality and safety of the general surgical services at Bundaberg Base Hospital and identify areas of improvement' (QPHCI 2005 Exhibit 230, p. 2).[169]

[169] FitzGerald and Jenkins identify the catalyst for the Audit was the request from Leck as well as 'a level of concern raised by a number of staff at the hospital in regard to some patient outcomes. In addition, some staff members expressed a level of distress about a number of staff interactions' (QPHCI 2005 Exhibit 230, p. 2). No indication of any specific relationship between the issues and Patel is made in the final report despite the significant amount of written complaint data presented to the Audit team prior to the investigation.

The data sourced to inform the Audit were Queensland Hospitals Admitted Patient Data Collection, interviews with staff managers, and patient records collected from BBH itself. The methodology used to inform the interviews that were conducted with BBH staff was not outlined in the final report. Nevertheless, it was reflected in Fitzgerald's statement to the QPHCI.

> The methodology used was to collect all their [staff at Bundaberg Base Hospital] personal impressions of issues of concern and not to collect 'evidence' for any particular disciplinary or other process. It was made very clear to staff that met with us [FitzGerald and Jenkins] that we wished for them to provide frank and open information and that at that point details of the individuals would not be disclosed or details of information collected. Any such investigation if relevant would need to be undertaken subsequently by an appropriate body with due process.
>
> (QPHCI 2005 Exhibit 225, par 63)

FitzGerald identified his main concern during his visit to Bundaberg as being that:

> Dr Patel was conducting surgical procedures which were not within the reasonable scope of practice of a hospital of Bundaberg's size and that patients were being retained at the hospital when they would be better cared for in a large hospital.
>
> (QPHCI 2005 Exhibit 225, par 65)

As such, he sought verbal assurance from both the DoMS, Keating and Patel himself, that in future, no further complex surgical procedures would be conducted at BBH and that Patel 'would refer on to major hospitals any critically ill patients' (QPHCI 2005 Exhibit 225, par 65). FitzGerald and Jenkins returned to Queensland Health's Brisbane office to analyse the data collected. No actions were taken other than eliciting verbal assurances from Patel and Keating that the scope of surgical procedures undertaken by Patel would be reduced and reflect the capacity of BBH.

7.9.4 Response to the Audit investigation

The decision not to collect evidence for a disciplinary outcome, or at least one that would investigate Patel's scope of surgical practice was not welcomed. Particularly so by Hoffman and the other nurses who had already provided documented complaints, incident reports and sentinel events forms to the BBH Executive. Hoffman recalls that the meeting

> lasted for at least $1^{1}/_{2}$ to 2 hours and that Dr Fitzgerald took notes of our conversation in a book. He told me that he wasn't conducting an investigation, only a fact finding mission to decide whether or not an investigation should be carried out. […] I told Dr Fitzgerald of all the general concerns that I had regarding Dr Patel at that time, including giving him specific examples and elaborating as required in response to the questions that he asked me. I recall that towards the end of the meeting he asked me what I thought should happen in respect of Dr Patel and I told him that I wanted to see him stood down until the conclusion of an investigation. He then said to me words to the effect that it was better to have a surgeon rather than no surgeon at all and essentially asked me to put forward a solution to the problem that would be posed if the Director of Surgery was stood down. […] I genuinely believed that the information that I imparted to Dr Fitzgerald during the meeting should have resulted in the surgery performed by Dr Patel being suspended, however, I am aware that the only thing that happened is that Dr Fitzgerald's team took the charts of the patients identified [in] my letter dated 22 October 2004 back to Brisbane with them.
>
> (QPHCI 2005 Exhibit 4, p. 50)

The Clinical Audit investigation into general surgical services at BBH continued, but no feedback was provided to the nursing staff who had submitted written complaints and reported verbally reports to FitzGerald (QPHCI 2005 Exhibit 4, p. 50).

7.10 The beginning of the end of Dr Patel's contract

Late in December 2004, aware that Patel's contract was due for reassessment on 31 March, 2005, Keating began considering the future of the Director of

Surgery position at BBH. Keating recalled Patel demanding that an offer of an extension to his contract be made prior to Christmas, which he would consider while on leave, during which time he was returning to the US (QPHCI 2005 Exhibit 448, p. 53). Despite the receipt of Hoffman's letter in October of that year and the death of Mr Kemps on 23 December, 2004, that had resulted in both ICU nurses and senior medical staff questioning Patel's capacity to perform complex surgery, Keating drafted and sent a letter (dated 24 December, 2005) to Patel offering an extension of his contract for the position of Director of Surgery until 2009. This offer breached Queensland Health's guideline that required that 'a formal merit based assessment' was required for temporary appointments that exceeded one year[170] (QPHCI 2005 Exhibit 448 p. 53). Keating's letter began:

> Dear Jay,
>
> I have pleasure in confirming the offer of the Temporary Full Time position of Director – Department Surgery with the Bundaberg Health Service District. This is an extension of your current contract from 1st April 2005 to 31st March 2009.
>
> (QPHCI 2005 Exhibit 448, DWK65)

The letter then outlined all the conditions and provisions of employment and concluded with a section for Patel to sign in agreement of the terms and conditions there. Patel did not accept the offer as the conditions and scrutiny of his performance had tightened after his return to BBH in January 2005. Keating

[170] In Keating's witness statement he states that at the time he was unaware of this provision (QPHCI 2005 Exhibit 448 p.53). Keating also began preparing the documentation required to renew Patel's medical practitioners' temporary visa. He justified his actions at the time stating 'Renewal of Dr Patel's contract would not prevent any necessary disciplinary or remedial action being pursued including termination of his contract' but was necessary to ensure that the hospital would not 'find itself without a senior surgeon' (QPHCI 2005 Exhibit 448 p. 53). Nevertheless in none of the documentation to any external body required to progress the process of extending the contract did Keating indicate that questions had been raised about Patel's competence (Davies, 2005).

and Leck informed Patel on the 13 January, 2005, that due to clinical issues and complaints by nursing staff [171] there was to be an investigation by FitzGerald (QPHCI 2005 Exhibit 448). Keating recalls Patel then stating that 'he felt that his position was untenable and that he did not intend to renew his contract' (QPHCI 2005 Exhibit 448, p. 54).

Keating accepted Patel's decision not to sign the contract to remain as the Director of Surgery. However, knowing that the hospital would now need to recruit a new Director of Surgery and that the timeline for doing so would run into months rather than weeks, Keating explored with Patel the option of extending his current contract ending on 31 March, 2005, until 31 July of that year (QPHCI 2005 Exhibit 448). On 2 February, 2005, Patel accepted this compromise and signed the offer of a Temporary Full Time Locum Director of Surgery position effective from 31 March to 31 July, 2005 (QPHCI 2005 Exhibit 448 – DWK69). In none of the associated documentation was any reference made to the verbal agreement that no further complex surgical procedures would be conducted by Patel at BBH.

Keating's perceptions of Patel's performance at the time he was pursuing an extension of contract can be seen in two briefings into Patel's performance at BBH, which he prepared at the request of DM Leck in January 2005. In the first briefing Keating refers to the oesophagectomy cases, the complaints of wound dehiscence, wound infection rates, the Renal Unit, the Bramich case, the tilt train disaster and various staff complaints about Patel's behaviour. Near the end of the briefing, under the heading 'consistent concerns', Keating writes:

[171] No mention was made of corresponding concerns raised by senior medical staff .

> At times, Dr Patel overextends himself performing a limited number of certain major sub-specialty operations – oesophagectomies, thoracic cases and emergency vascular cases, when appropriate level of intensive clinic al support isn't available for prolonged periods. Dr Patel delays transfer of seriously ill patients to Brisbane. Dr Patel's manner is perceived by many staff at all levels as very arrogant, abrasive, rude and potentially abusive.
>
> (QPHCI 2005 Exhibit 448 – DWK 66, p. 5)

In the final summary of the five-page briefing report, Keating outlines his interpretation of the conditions and circumstances that have led to the complaints regarding Patel. The first two paragraphs of this final summary are here reproduced in full:

> Dr Patel is a very knowledgeable surgeon with many years experience of general surgery who was probably very good to excellent technically in his career in USA. He is now good to very good surgeon technically, who has not maintained currency in some major thoracic and abdominal procedures or all aspects of care of critically ill patients. This situation has been exacerbated by a lack of professionalism amongst staff in supporting Dr Patel in the care of critically ill patients. He has a very positive attitude to work, which combined with cumulative work stress and fatigue plus multiple responsibilities contribute to a specialist surgeon who has more potential to make errors of judgement in clinical care, particularly in relation to seriously ill patients.
>
> These situations combined with interpersonal behaviour as noted by many staff leads to a situation where Dr Patel is unpopular and potentially without the support of many clinical staff, possibly affecting patient outcomes. I am uncertain that Dr Patel will be able to would be willing to change and/or modify his behaviour to reduce associated tension that has developed over the period of his employment at BBH. Nevertheless find the lack of professionalism (particularly bringing forwards concerns at very late notice or when the specialist is on leave) and overt emotion displayed by many senior staff as regards Dr Patel very concerning. I believe there is a large number of staff actively undermining the continuing efforts of Dr Patel to provide a general surgical service to the people of Bundaberg.
>
> (QPHCI 2005 Exhibit 448 – DWK66, p. 5)

Keating then recommends that the best option for dealing with the issue is to recruit a new Director of Surgery as soon as possible, stating that he would

> take a more proactive approach in dealing with complaints from the NUM in ICU and nursing staff from OT [Operating Theatre] in order to engender staff confidence in process.[172]
> (QPHCI 2005 Exhibit 448-DWK66 p. 5)

The second briefing paper prepared by Keating (just one page long) is a glowing reference of Patel's contribution to the hospital. Keating describes Patel as 'very hard working, conscientious and enthusiastic', with a 'strong eye for detail' and a 'role model for junior medical staff' (QPHCI 2005 Exhibit 448- DWK 67).

Accolades are then given for his contribution to increasing the surgical activity levels, outpatients scheduling, and endoscopy procedures, and for excellence in achieving the extra elective surgical targets (QPHCI 2005 Exhibit 448- DWK 67). Patel's performance in managing the tilt train incident are described as 'outstanding', and he is described as being 'calm, realistic and able to direct a multitude of activities' (QPHCI 2005 Exhibit 448- DWK 67).

This report contains only two substantive references to Keating's views as to potential flaws in Patel's behaviour. The first being that Patel 'isn't always tolerant of individuals who aren't willing to apply themselves to their job or willing to learn', resulting in confrontations to 'individuals and the processes they manage, which at times made these individuals very uncomfortable and defensive' (QPHCI 2005 Exhibit 448- DWK 67). The second states that Patel 'doesn't accept questioning by peers of his clinical judgement or decision making process' resulting in an unwillingness to 'discuss alternative diagnoses, options for management or accept recommendations for transfer of patients to a

[172] No mention in this briefing about liaising with medical staff in the proactive approach to dealing with the process of complaints.

tertiary facility' (QPHCI 2005 Exhibit 448- DWK 67). Keating concedes that these issues led others to view Patel as 'dogmatic, overbearing' and 'very arrogant', but these were not views he shared. He reports that his interactions with Patel have all been positive ones, and that Patel, far from being 'argumentative or dismissive, accepted advice readily', 'willingly' and proactively implemented 'suitable arrangements for follow-up management in relation to the complaint' (QPHCI 2005 Exhibit 448- DWK 67). No mention is made in either of these reports about the calls by Rashford for investigation into the poor medical management and delayed transfer of P26, nor of the request for a sentinel event investigation into the case.

7.11 Waiting for action and the last straw

By early March 2005, many of the nurses who had provided written statements, and who had been interviewed by FitzGerald for the Clinical Audit investigation, were waiting for some sign that action was being taken to deal with Patel. The nursing staff in the ICU and OT were informed that Patel was restricted from performing further complex surgical procedures. They began to look 'forward to the end of all the problems Dr Patel had been the cause of', under the impression that his contract at BBH was to end on 31 March, 2005 (QPHCI 2005 Exhibit 160, p. 6). Their expectations that the problem would be resolved with Patel leaving the hospital at the end of March, were scotched when they learned that his contract had in fact been extended to the end of July 2005.

Janelle Law, one of the perioperative nurses who submitted a statement regarding Mr Kemp's death and had requested whistleblower protection, later

recalled being appalled upon hearing Patel 'bragging that Darren Keating has extended his contract for 3 months, and he would be getting paid as much money for the 3 months as what he had got for the year' (QPHCI 2005 Exhibit 160, p. 5). She recalls her disbelief and inability to comprehend this decision made by the Executive, given the number of complaints made and 'despite his practice being questioned' (p.6). Hoffman recalled Patel informing ICU staff that 'he'd received a $10,000 bonus and his contract was extended by four months, [...] and this came back just like a big huge slap in the face to us [...] he was getting rewarded and we were getting ignored' (QPHCI 2005 BHCI Transcript Day 2 p. 184).

The news that Patel's contract had been extended was the last straw for Hoffman. After two years of submitting complaints related to the management of patients treated by Patel to a host of people within the healthcare sector [173] whom she believed would act, she decided that she must do 'something drastic to stop him from operating and treating patients' (QPHCI 2005 Exhibit 4, p. 53). Hoffman decided to take her concerns to Mr Rob Messenger, Member of Parliament (MP) for the seat of Burnett.

7.12 Blowing the Whistle

Hoffman's decision to take her concerns to Messenger was framed by her knowledge of the Minister's past involvement in advocating for BBH staff

[173] In her witness statement Hoffman writes: 'By this time I has tried to alert the following people to the problems with Dr Patel: The other doctors in the hospital Dr Carter, Dr Miach, Dr Strahan and Dr Berens; The Director of Medical Services, Dr Darren Keating; The Director of Nursing, Linda Mulligan; The District Manager, Mr Peter Leck; Dr Gerald Costello, the head doctor for the RFDS [Royal Flying Doctor Service]; Senior nurses from the RFDS; The Acting Coroner; The Queensland Police Service; and the Chief Health Officer for the State of Queensland, Dr Gerald Fitzgerald. I had told all these people the concerns that I held, the concerns that were held by nursing staff, and the level of distress experienced by nurses' (QPHCI 2005 Exhibit 4, pp. 53-54).

when there had been a human resources error that resulted in an overpayment of wages. Hoffman recalled that she had hoped that his position as 'the representative of his constituency' would empower him to stop any future complex operations being performed by Patel (QPHCI 2005 Exhibit 4 p. 54). Following a short telephone briefing, she was asked by Messenger to attend a meeting with him in his electoral office on 18 March, 2005. At the meeting Hoffman requested 'whistleblower status' and expressed a desire to remain anonymous. She then outlined all the difficulties that she had faced, the series of complaints made to the Executive and, finally, her perception that following the FitzGerald Audit there was nothing further to be investigated. She also provided a copy of her letter from October 2004, her statement 'Issues to deal with Ventilated Patients', and requested that Messenger anonymise any patient-related data before using it (QPHCI 2005 Exhibit 4 p. 54).

Messenger assured Hoffman that he was attending Parliament during the coming week and that he would act on her revelations. After his meeting with Hoffman, Messenger rang Dr Strahan to ascertain the validity of Hoffman's claims and was informed that the local medical fraternity was aware of the problems with Patel but hoped that all would be resolved when his contract ended (QPHCI 2005 Exhibit 4).

On 22 March, 2005, Messenger tabled Hoffman's letter in a Matters of Public Interest speech in the Queensland State Parliament. During the same Legislative Assembly, in Questions Without Notice, the Shadow Health Minister, Stuart Copeland, asked Health Minister Gordon Nuttall three questions. First, whether 'the fact finding process conducted by Dr FitzGerald,

the Chief Health Officer, into serious allegations made about the clinical and surgical competence of Dr Patel' would be released. Second, whether the allegations were to be independently investigated. Third, whether Dr Patel would be stood down during such an investigation (Queensland Parliament, 2005, p. 611). The Health Minister responded by stating that he was unaware of the allegations tabled and that whilst he considered these matters the purview of the Medical Board, he was 'more than happy, as the Minister responsible to investigate' (Queensland Parliament, 2005, p. 611). The concerns raised about Patel's surgical competence and the lack of action by the BBH Executive had now entered the public domain.

7.13 Reaction and repercussions

On the 23 March, 2005, Health Minister Nuttall responded in the Queensland Parliament to the questions raised by Messenger with a Ministerial Statement indicating that Queensland Health was aware of the complaints and that these were the subject of an ongoing audit into surgical services. He expressed his disappointment at not being previously advised of the audit, but suggested that this was because it was 'not yet complete' (Queensland Parliament, 2005, p. 691). Minister Nuttall then accused the Messenger of presenting 'inaccurate' and 'deliberately misleading' allegations, and of 'circumventing all natural justice processes'(Queensland Parliament, 2005, p. 691). According to Minister Nuttall, Messenger had 'vilified a health professional' before the audit investigation was completed, thus 'denying the person named the ability to defend himself' (p. 691).

The theme that Patel had been denied natural justice was employed often in the days and weeks that followed the public airing of allegations against him. It was used by DM Leck [174] in a letter to the local *Bundaberg News Mail* on 28 March, 2005, headed 'Backed by executive', in which he stated:

> The fact that a number of allegations have been made public without the completion of a review process designed to ensure the application of natural justice is reprehensible. At this time I have received no advice indicating that the allegations have been substantiated […] Dr Patel is an industrious surgeon who has spent many years working to improve the lives of ordinary people in both the United States and Australia. He deserves a fair go.
> (QPHCI 2005 Exhibit 473)

This stand was soon supported by the Australian Medical Association Queensland President, Dr David Molloy, who, on 1 April, 2005, lamented in a media release that the approach taken by

> Rob Messenger' in using 'State Parliament and the protection it wields to air concerns' regarding Patel, was irresponsible, and that the Parliament was 'not an appropriate forum for these allegations to be made.
> (QPHCI 2005 Exhibit 15)

This was particularly so since 'the Medical Board was competently investigating the allegations regarding Dr Patel's performance' (QPHCI 2005 Exhibit 15).

7.13.1 Back at the hospital in Bundaberg

The tabling of the Hoffman letter in Parliament prompted Dr Martin Strahan to meet with Leck to inform him that Messenger had indeed contacted him in the

[174] Leck testified that this letter of support for the local *News Mail* was drafted at the request of Patel who threatened to leave within 24 hours if support was not provided (QPHCI 2005 Transcript Day 26, p. 7203). Leck also outlined Patel's threats to leave to Bergin (Zone Manager) and expressed concern that since the Easter long weekend was imminent, Patel's departure at this point would 'be critical to service delivery' as he was the only general surgeon in Bundaberg (QPHCI 2005 Exhibit 474).

days prior to its release in Parliament. He informed Leck that Messenger had indicated in their telephone conversation that it was 'a nurse [who] had provided him with some information' about Patel. He assured Leck that 'no doctor would have done this sort of thing' (QPHCI 2005 Transcript Day 26, p. 7247). Strahan also reiterated to Leck that he had advised Messenger at the conclusion of their telephone conversation not to 'take it anywhere' (p. 7247). At the same time, Strahan sought out Hoffman with the warning: 'You'll be lucky to keep your job after this' (QPHCI 2005 Exhibit 4, p. 56).

Acting on the information provided by Strahan, and with renewed suspicions that it was an ICU nurse who had leaked the confidential documents, Leck asked the Acting DoN Deanne Walls (relieving from Rockhampton Hospital) to arrange a meeting with all nurses who had complained about Patel. At first Hoffman considered that this might finally be debriefing to provide support for her staff and invited all the ICU nurses who had submitted complaints to attend, even some who were not rostered for duty that day (QPHCI 2005 Exhibit 4).

The ICU nurses assembled in their Unit tea room on the 23 March, 2005, to be confronted by a 'visibly furious' Leck, who claimed 'that he had it from "very high sources" that the information given to the Member of Parliament' had been provided 'by a member of ICU staff and then to the media' (QPHCI 2005 Exhibit 4, p. 57). He further stated that he was 'appalled that such a senior surgeon of the hospital could be treated in such a way that denied him natural justice' (p.57). He claimed it was an action that 'would divide doctors and nurses; that it would stop patients coming to the hospital; and that it would

erode community confidence in the hospital' (p. 57). The nurses in attendance later recalled that during his tirade Leck waved a number of photocopied documents, including the Queensland Health Code of Conduct, an Industrial Relations manual document, a CMC [Crime and Misconduct Commission] leaflet and a copy of the PowerPoint presentation given by the Queensland Health officers from the Ethical Standards Unit in Brisbane in 2004. These were apparently displayed to add weight to his claim and veiled threat that staff 'who breached confidentiality could get 2 years jail and lose their jobs' (QPHCI 2005 Exhibit 4, p. 56; Exhibit 508). Before the nursing staff had an opportunity to respond, he left.

Karen Jenner, an ICU nurse present at the meeting, recalled her reaction to Leck's behaviour:

> When he finished speaking he quickly up and left denying us a right of reply. I was frustrated as I had never met Mr Leck previously and he had not offered any support to me concerning my complaint about Dr Patel. It was belittling that he came down to the ICU unannounced, poured out a tirade, gave us no opportunity to respond and left. It was extremely disappointing that he spoke to us about patient confidentiality and the Code of Conduct as if we were ignorant of these matters.
>
> (QPHCI 2005 Exhibit 508, p. 6)

The following day on 24 March, 2005, despite the public show of support provided by DM Leck, Patel resigned. He informed Leck that his resignation was effective immediately, and that he planned

> to take legal action against a variety of staff as well as Q[ueensland] Health for failing to stop the leak of confidential material and for not providing [him with] definitive support in relation to all allegations.
>
> (QPHCI 2005 Exhibit 475)

In the week that followed, Leck approved the payment of Patel's airfare back to the US and received email correspondence from FitzGerald containing the final confidential Clinical Audit of General Surgical Services at BBH.

Despite the details outlined in the audit report, [175] Leck continued to focus on measures to address the leaking of confidential documents. Instead of facilitating a more thorough investigation of the individual patient cases at the centre of the allegations, or instituting changes to the governance structures outlined in the audit report. Leck's thoughts and plans on the issue are evident in an email sent on 7 April, 2005, to the Zonal Manager Dan Bergin:

> Bottom line is that regardless of whether an investigation is held or not, I don't believe the culprit who leaked this information will be found. While on one hand I would like to send a strong message to the person(s) concerned that they are on very dangerous ground – I am concerned that such an investigation could prove very destructive in nurses and doctors going after one another. Perhaps we have the Audit team come up and deliver some training sessions around the Code of Conduct and deliver some firm and scary messages?[176]
>
> (QPHCI 2005 Exhibit 447)

[175] The audit report noted concern about the 'performance of complex procedures without the appropriate level of support services' at Bundaberg as well as increased rates of unplanned admissions, complications and wound dehiscence when compared with state and national average (QPHCI 2005 Exhibit 235, p. 11). Despite this no direct reference was made to indicate these were the result of Patel's performance. Instead when references were made about the 'divisional director' of surgery, these were predominantly couched in positive terms such as: 'accessible to GPs and easy to contact', 'had a good work ethic and a heavy workload', 'carried out excellent work triaging in ED following the tilt train disaster', 'committed to teaching', 'created efficiencies' in the elective theatre waiting list (QHPCH 2005 Exhibit 230, pp.5-6). When negative comments were made, they were applied in general terms e.g.'staff do not always comply with infection control policies and procedures, including wearing OT attire outside OT, hand washing between patients and appropriate use of instruments' (QPHCI 2005 Exhibit 230, p. 6). When cross examined at the QPHCI about the tone of the report and the significant lack of direct reference to Patel, FitzGerald states: "we were trying to keep to the style of clinical audit which is to really not focus on individuals and on their performance and behaviour but rather that look at the systems and structures which underline the events that have occurred"(QPHCI 2005 Transcript Day14, p.6115).

[176] A course of action previously used by the Executive to discourage nursing staff from consulting with their union following the Hoffman letter in October 2004.

In the end Leck did not, himself, need to use an audit team to 'discourage staff from raising complaints about clinical issues' outside the organisation. This message was delivered by Health Minister Nuttall and the Director-General of Queensland Health, Dr Stephen Buckland in a forum attended by approximately 150 BBH staff (Davies, 2005, p. 170).

7.13.2 The Health Minister's visits

On 7 April, 2005, Health Minister Nuttall and Director-General Buckland visited BBH. An invitation was sent to all staff to attend a forum at 3pm to address the 'the Patel incident' (QPHCI 2005 Exhibit 507, p. 3). Nuttall identified the purpose of the visit as a meeting 'with staff regarding the uncertainly they felt following the resignation of Dr Patel and the adverse publicity about the hospital' (QPHCI 2005 Exhibit 319, p. 5). Both Nuttall and Buckland claimed the meeting was called to support staff in the wake of adverse publicity related to Patel (QPHCI 2005 Exhibits 319 & 335). In countering these claims at least three nurses recalled the that the main contention of the 'meeting took a similar line to that taken by the District Manager' and centred on the disappointment that Patel was not afforded natural justice following the leaking of confidential hospital documents (QPHCI 2005 Exhibit 59, p. 19; Exhibits 507, 508; Transcript Day 30). The staff was then informed that the 'release of material in Parliament and Dr Patel's departure to America' meant that the FitzGerald Audit would not be released (QPHCI 2005 Exhibit 507, p. 3).

Gail Aylmer, one of the nurses attending the meeting, recalled the aggressive nature of the message's delivery and the perception that 'the nurses

were being punished for what had happened and were being characterised as troublemakers and responsible for the bad situation in Bundaberg' (QPHCI 2005 Exhibit 59, p. 19). Another nurse, Margaret Mears, concluded that the 'whole tone of the meeting was condescending and belittling […] like we were all at fault and that we were not working together which was not the case' (QPHCI 2005 Exhibit 507, p.4). Registered Nurse Karen Jenner, in both her written statement and testimony given on Day 30 of the QPHCI, recalled Buckland as saying that he had '100 per cent support in Queensland Health staff and he wouldn't have his staff tried by the media' (QPHCI 2005 Exhibit 508, p. 7, Transcript Day 30, p. 7384). Jenner then asked Buckland:

> if he had 100 per cent support in all of his staff, where was the support for the nurses, because there was only one letter leaked, but multiple formal complaints had been made. His response was words to the effect – he sort of said to me, "Well, what part of 'there's going to be no inquiry don't you understand?'", that – once again, that Dr Patel wasn't in the country and he couldn't – he didn't have a right of reply, and he hadn't been given natural justice, so that was it. There was nothing more that they [Nuttall and Buckland] could really do regarding Dr Patel.
>
> (QPHCI 2005 Transcript Day 30, p. 7385)

The visit, rather than providing support for the staff at BBH, in fact 'inflamed and upset' many (QPHCI 2005 Exhibit 59, p. 19). Director-General Buckland later conceded that:

> it was clear from the mood of the meeting and the level of frustration and anger verbalized by some staff that there were more significant issues with Dr Patel than the Minister and I had been briefed about.
>
> (QPHCI 2005 Exhibit 337, p. 2)

Buckland's perception that he had not been fully briefed, and that there were, indeed, other significant issues linked to Patel was an accurate one.

7.14 Patel's prior deregistration and restricted practice come to light

After the difficult meeting with the BBH staff, Buckland waited in the hospital canteen for Nuttall, who was attending a private engagement outside the hospital. Buckland was there approached by Keating who requested a private audience (QPHCI 2005 Exhibit 335). The previous evening at home, Keating, now curious 'because of the controversy which had arisen', had conducted an internet search on Patel and discovered the 'restrictions on Dr Patel's registration in Oregon and the cancellation of his registration in New York' (QPHCI 2005 Exhibit 448, p. 57). Keating was immediately aware of the implications of such a discovery and informed Buckland the following day. According to Keating, it was only after the address to all BBH staff that he had found the first opportune time to inform Buckland of his findings (QPHCI 2005 Exhibit 448).[177]

Dr Keating was not the first at BBH to perform an internet search into Patel's background. In mid-2004, surgical ward nurse Michelle Hunter 'began to wonder if Dr Patel had been involved in any negligence cases' previously, particularly after observing 'a number of disasters involving Dr Patel', such as the increasing incidence of wound dehiscence and other surgical complications (QPHCI 2005 Exhibit 141, p. 6). Given Patel's constant reminding of his subordinates that he had worked in Oregon, Hunter began her investigation with 'a Google search for the Oregon Medical Examiner's Board'. There she 'found that "Jayant Patel" had been involved in negligence cases and he wasn't

[177] Dr Buckland was later to reflect: 'From the moment Dr Keating passed on the fact of his [Patel's] restricted registration I began to believe that the problem was more extensive than was known. If I had known this before speaking to the staff at Bundaberg, I would have consulted with the CHO [Chief Health Officer FitzGerald] and had a very different approach to the staff meeting in Bundaberg' (QPHCI 2005 Exhibit 335, p. 8).

to perform certain types of surgeries' (p. 6). Hunter found it difficult to believe that this could be the same surgeon, particularly as Patel had gained registration by the Queensland Medical Board. She mistakenly assumed the Board must surely 'know about this' and consequently dismissed her discovery out of hand (p. 6).

The news that Patel had had his practice restricted and his registration cancelled in the United States was not passed on by Buckland to Health Minister Nuttall during the flight back to Brisbane. Nevertheless, Buckland did recall informing Nuttall 'that Dr Patel may not be everything that we had heard […] "There is more to this guy [Patel] than we know – I'll have a look at it"' (QPHCI 2005 Exhibit 335, p. 7). He also discussed with Nuttall the possibility of 'putting together an investigative team to be able to go into Bundaberg and have a look' (QPHCI 2005 Transcript Day 6, p. 5554).

On his arrival home, Buckland, using his own computer and internet connection confirmed the details of Patel's registration restriction that had just been relayed to him by Keating. The same night Buckland contacted Chief Health Officer FitzGerald by phone, delivering the news about this new evidence and recommending to FitzGerald that 'he should advise the MBQ [Medical Board of Queensland] as a matter of priority' (QPHCI 2005 Exhibit 335, p. 7). On the following day, 8 April, 2005, the news of Patel's chequered disciplinary past spread rapidly. Buckland now informed Nuttall and requested a comprehensive review of both Patel and the safety and quality of services at

BBH (QPHCI 2005 Exhibit 335).[178] FitzGerald contacted Mr Demy-Geroe from the Queensland Medical Board with these revelations about Patel's registration cancellation and his 'undisclosed disciplinary history in the United States' (QPHCI 2005 Exhibit 24, par.14). The latter then began an investigation that would form the basis for a report on the 'Registration of Dr Jayant Patel' (QPHCI 2005 Exhibit 24-MDG3).

The surprise uncovering of Patel's previous registration and disciplinary history prompted further investigation into his appointment to, and performance as, the Director of Surgery at BBH. The Health Minister publicly announced a comprehensive Queensland Health review headed by Dr Mattiussi on 9 April, 2005. The announcement did not include any details of the most important factor informing the very decision to investigate further, namely the recent revelation of Patel's failure to disclose past disciplinary action against him in the US (Davies, 2005). The public only became aware of the anomalies in Patel's registration when Hedley Thomas published the details of Patel's past on the front page of the *Courier Mail* on 13 April, 2005 (Davies, 2005; Thomas, 2007).

Thomas' (2005b) article in the *Courier Mail* made much of the fact that a simple Google search had uncovered Patel's past medical board disciplinary

[178] The review of clinical services at Bundaberg Base Hospital was performed by a panel consisting of Dr Mark Mattiussi (District Manager of Logan-Beaudesert Health Service District), Dr Peter Woodruff (Vascular Surgeon Princess Alexander Hospital), Dr John Wakefield (Acting Executive Director of Queensland Health Patient Safety Centre) and Associate Professor Leonie Hobbs, Acting Executive Director Women's & Newborn Services, Royal Brisbane and Women's Hospital) (QPHCI 2005 Exhibit 353-MPM2) . The terms of reference included examining the appointment, credentialing and management of Patel, review of Patel's cases where there was an adverse outcome, analysis of clinical outcomes and quality of care at BBH, review the Risk Management and Service Capability frameworks in operation at BBH and any other clinical service matters referred by the Director General (QPHCI 2005 Exhibit 353- MPM2).

action, registration restrictions and cancellation. It also emphasised that Patel's deception had not been picked up earlier, by either the Queensland Medical Board or the BBH Executive, with devastating results. These revelations increased media interest, and new stories about Patel began to emerge from Bundaberg, Oregon and New York (Thomas, 2007). Reporters from state, national and even international news outlets descended on BBH seeking interviews with hospital staff and patients, and with Rob Messenger MP. Thomas characterised the revelation about Patel's past as being as if a 'match had been struck and the fuse was well alight. It hissed angrily and headed steadily to the powder keg: the Beattie Government' (p. 277).[179] The State Opposition and the health unions called for an immediate independent inquiry. Talkback radio commentators and writers of letters to the editor called for sackings of the BBH Executive and senior members of the Queensland Medical Board.

7.15 The inquiries begin

On 26 April, 2005, the Queensland Government announced two new inquiries into Queensland Health and Dr Patel. The Review of Queensland Health Systems was to be headed by Mr Peter Forster, and second, the Bundaberg Hospital Commission of Inquiry, by Mr Tony Morris QC (Dunbar *et al.*, 2011).[180]

[179] Hon Peter Beattie was the Queensland State Premier.

[180] The Bundaberg Hospital Commission of Inquiry was terminated by the Supreme Court on September 2, 2005, after an appeal by District Manager Leck, and Director of Medicine Keating, who accused Commissioner Morris of an 'reasonable apprehension of bias' (Davies, 2005, p. 1). Commissioner Geoffrey Davies continued the investigation with broader terms of reference in the Queensland Public Hospitals Commission of Inquiry from 6 September, 2005 (Davies, 2005).

7.15.1 The Forster Queensland Health Systems Review

The Forster Review, headed by Mr Peter Forster of The Consultancy Bureau,[181] was supported by a team of consultants from the Department of the Premier and Cabinet, Queensland Treasury, Queensland Police Service, Department of Public Works and Queensland Health, as well as from health professionals in the form of two advisory panels. The inquiry team gathered evidence from:

> direct observation, assessment and discussion with several thousand staff about the performance of systems within Queensland Health and from consultation with the broader community, former patients, consumers of community health services, and some 1,300 formal submissions.
>
> (Forster, 2005, p. iii)

The final 480-page report outlined the challenges faced by contemporary healthcare organisations such as Queensland Health, where demand for services was fuelled by an increasing population, technological advances, staff shortages, infrastructure shortages (in Emergency, OT and ICU) and a lack of indigenous and mental health capability (Forster, 2005). The report also noted that Queensland had a comparatively higher rate of 'obesity, smoking and suicide' and identified the need to focus on primary care solutions to decrease the associated risks and 'limit the number of admissions to acute hospitals' (Forster, 2005, p. iii).

The final Forster Report included a whole chapter focused on the organisational culture of Queensland Health, where strong negative themes of 'bullying', 'intimidation' 'blaming and avoiding responsibility' were found in

[181] The Consultancy Bureau is a Queensland management consultancy that was founded in 1988. Practising in the public and private sectors its consultants provide 'innovative, lasting, practical solutions to the many challenges confronting executives in today's complex and rapidly changing workplace environment'(The Consultancy Bureau, 2011).

addition to such positive themes as 'dedication towards patient care and wellbeing' and having pride in service provision (Forster, 2005, p. 56). Clinical teams and individual doctors and nurses reported feeling disempowered, and that their initiative and ability for independent decision-making was suppressed by a bureaucratic style of leadership where

> the balance of power within acute hospitals has moved too far to the side of formal authority and administration, driven largely by financial imperatives around budgets, measurement of throughput and economising in the use of staff resources and materials.
> (Forster, 2005, p. 56)

According to the report, the impact of economic rationalism had increased work pressure for individuals with staff reporting that they were 'experiencing a higher than usual rate of dysfunctional interpersonal relationships' (Forster, 2005, p. 57). Forster also found that staff claimed the Code of Conduct had been perversely misused as a tool with which to bully and intimidate Queensland Health staff, rather than to inspire a 'patient or consumer centred [*sic*] approach' to service delivery (p. 58). The protection of patient rights and of patient-related data or privacy was deployed as a device to cover-up and control the flow of information.[182]

A culture of secrecy resulted in the avoidance of the release of any data which would otherwise have been considered in the public interest (Forster, 2005). Additionally, staff reported either inaction or delay in dealing with those who exhibited unacceptable behaviour, such as bullying, and many

[182] In Forster's investigation Queensland Health staff reported that when they wrote comprehensive reports about organisational deficiencies which included adverse performance related data such factors that limited community access to services or increases in surgical complications or infection these were 'modified or suppressed at higher levels in the hierarchy' (Forster, 2005, p. 59). The rationale provided was that the data contained patient-related information.

perceived that such incidents were ‘managed’ by transferring or promoting the offender, rather than tackling non-performance (Forster, 2005). All of the listed features resulted in staff recording ‘unfavourable scores on many of the organisational climate variables’ and that further eroded morale within the organisation (Forster, 2005, p. 57).

The Forster Report outlined many areas in which Queensland Health would require change in order to meet the future challenges and respond to the findings of the investigation. In essence, the investigators concluded that while no single, perfect solution would be found, ‘the way forward must involve a building of trust’, where clinical leadership and decision-making were linked to accountability for patient and financial outcomes (Forster, 2005, p. 62). According to Forster, health professionals would need to expand their leadership models, using examples based on expert knowledge, to focus on system and service improvement, prioritisation of the needs of the population under a constrained economy, as well as the individual needs of patients (Forster, 2005). The scope of the current work does not allow for the majority of these areas to be addressed, however, some further elements outlined in the Forster Report, such as clinical governance and risk management, are addressed in Chapter Eight.

7.15.2 Morris and Davies Commissions of Inquiry

The Bundaberg Hospital Commission of Inquiry, that was announced at the same time as the Forster Review, began taking evidence on 23 May, 2005. Commissioner Tony Morris QC and his deputies, Sir Llewellyn Edwards AC

and Ms Margaret Vider,[183] presided over 50 days of hearings for 84 witnesses in Bundaberg, Brisbane and Townsville, before the Inquiry was terminated. District Manager Leck and Director of Medical Services Keating appealed to the Supreme Court to uphold accusations of a 'reasonable apprehension of bias' on the part of Commissioner Morris. Their appeal was upheld on September 2, 2005 (Davies, 2005, p. 1; Hamer, 2006).

Immediately following the Supreme Court decision to close the Morris Inquiry there came calls from the Bundaberg Patients Support Group,[184] Toni Hoffman and the media for it to continue (Christiansen, 2005; Thomas, 2005a). Initially, the Queensland Premier, Mr Peter Beattie, rejected these pleas, instead deciding that the issues raised over the 50 days of hearings be referred to existing investigations by other agencies such as the Forster Review and the Crime and Misconduct Commission (Christiansen, 2005). After five days of media and public pressure to continue with a new inquiry, Premier Beattie announced a new re-established Commission of Inquiry headed by Mr Geoff Davies QC (AAP, 2005; Odgers & Watt, 2005; Thomas, 2007).

The Queensland Public Hospital Commission of Inquiry (QPHCI) continued the work of the BHCI, collecting evidence from previous witnesses, as well as testimony and depositions from 37 new witnesses, over 30 days between 8 September and 27 October, 2005. A further 200 exhibits and 29 submissions were also entered into the Inquiry. Commissioner Davies and his

[183] Sir Llew Edwards, a graduate of Medicine and Surgery from University of Queensland and former Minister for Health in a Queensland Coalition Government from 1974-1978 and Margaret Vider, Director of Mission, Holy Spirit Northside, a former Director of Nursing at Holy Spirit Hospital, Wickham Terrace, and Nurse Surveyor on the Australian Council on Health Care Standards (Beattie, 2005).

[184] A support group of former Patel patients set up by Beryl Crosby (Thomas, 2007).

legal team then used the 7000 pages of witness transcripts, 511 exhibits and 29 submissions to inform the findings in the Final Report. While a full summary of the QPHCI findings lies beyond the scope of the current chapter, it is cogent to note here that Commissioner Davies outlined four factors that he considered guided Patel's 'path of injury and death at Bundaberg Base Hospital':

> - the hospital budget,
> - the failure to check Patel's background,
> - the failure to have him credentialed and privileged [185]
> - and, ultimately, the failure of any adequate complaint system to operate
>
> (Davies, 2005, p. 6).

Davies discerned that Patel had adopted a series of practices that allowed him to avoid scrutiny of his work. These practices included: dealing severely with anyone who questioned his performance, dismantling the surgical audit processes, working predominantly with junior staff, limiting his contact with other surgical staff in the Bundaberg region, resisting collaborative approaches to patient treatment, delaying or denying the need to transfer patients to tertiary hospitals, subverting Mortality and Morbidity meetings to sessions where he taught junior staff about a given topic rather than case discussion, and finally, falsifying patients clinical notes to omit adverse outcomes (Davies, 2005).

When coupled with the fact that no formal inquiry into Patel's past performance in the US had been conducted, and that no process to ensure he was credentialed to meet the position requirements of a Director of Surgery had been undertaken, these obfuscatory practices coalesced to allow him to operate at BBH in 'splendid isolation' (Davies, 2005, p. 135) .

[185] A process by which a doctor will have his or her competence assessed by a committee of peers eg. in Patel's case the Royal Australasian College of Surgeons (Davies, 2005).

Thus, despite at least 20 serious complaints mostly by nursing staff to management over the two-year period of Patel's appointment, the Executive repeatedly failed to act. This lack of action in dealing with Patel resulted in the Inquiry's adverse findings against the then Acting DoMS at BBH, Dr Kees Nydam (who had originally appointed Patel to the position of Director of Surgery) as well as against Keating and Leck. While no recommendations were made by Davies against Nydam, Keating and Leck did not fare so well. Davies recommended that Keating's conduct in making the application for a four-year visa for Patel be referred to both the Australian Federal Police (for the giving of false or misleading information to the Department of Immigration and Multicultural Affairs) and to the Queensland Police Service (for the giving of false or misleading information to the Medical Board) (Davies, 2005). He also referred Keating to the Crime and Misconduct Commission to face a charge of official misconduct, and to the Director-General of Queensland Health under the accusation that he had performed his duties incompetently (Davies, 2005).[186] Leck was also referred by Davies to be prosecuted by the Crime and Misconduct Commission for official misconduct and to Queensland Health for incompetency (Davies, 2005). Both Leck and Keating were ultimately dismissed from Queensland Health.

Davies (2005, p. 190) detailed nine separate findings against Patel including:

- misleading the Medical Board of Queensland,

[186] Keating did not lose his medical registration, however he has one condition placed on his current registration, as indicated on the Australian Health Practitioner Regulation Agency 'The registrant may not practise as a Director of Medical Services, or in any similar administrative position, in any public or private hospital'(AHPRA, 2011).

- performing surgical procedures restricted by previous medical boards,
- performing surgical procedures outside his scope of practice,
- negligent treatment of 13 patients who died and others who suffered adverse outcomes,
- adverse outcomes from delayed patient transfer,
- inadequate recording in patient files (in particular omitting details about complications arising from surgery),
- failure to perform surgical audits and effective morbidity mortality meetings,
- failure to report 13 deaths to the Coroner, and finally
- working as a general surgeon without specialist registration in Queensland.

Davies (2005, p. 191) recommended that Patel be investigated by the Queensland Police Service for 'fraud', 'assault', 'assault occasioning bodily harm', 'grievous bodily harm', 'negligent acts causing harm' and 'manslaughter' and that the matter also be referred to the Medical Board of Queensland for 'further investigation in relation to *s158 Medical Practitioners Registration Act 2001'*.

Patel was extradited back to Australia from the US in July 2008 to face charges of fraud, grievous bodily harm and manslaughter. Just under two years later, on 29 June, 2010, Patel was convicted of three counts of manslaughter, one count of grievous bodily harm and one count of negligence causing harm and was sentenced to seven years jail (Dunbar *et al.*, 2011). After two years in jail, on 24 August 2012, Patel appealed to the High Court of Australia and was

granted bail after it was found that the 2010 trial was tainted by 'highly emotive and prejudicial evidence'(Owens, 2012, par. 5). On 20 December 2012, the Crowns appeal to the 'Supreme Court to have Patel's manslaughter charge for the death of an elderly patient permanently stayed' was dismissed (Elks, 2012, par. 2). Patel did plead guilty in the Brisbane District Court to four counts of fraud for failing to disclose the limitations on his practice and deregistration in the US prior to being employed at BBH. On 21 November, 2013 Patel was given a two-year suspended sentence and flew out of Australia to his home in Portland, Oregon in the US the very next day (Calligeros, 2013).

7.16 Conclusion

The BBH story began with the hospital facing a challenge that can all too easily be found in many contemporary Australian and overseas health services: the desperate need to source adequately skilled health professionals to meet unrelenting clinical demand. Patel's appointment as the Director of Surgery at BBH was made in haste and with no measures in place to review or credential his performance. It was the nurses at BBH who were first to question and then to constantly and consistently report instances of Patel's continuing incompetence. Their efforts in the face of systemic inaction by the BBH Executive ultimately led to Toni Hoffman's whistleblowing event, are outlined in this chapter. Why this occurred, indeed *how* it possibly could occur, are matters that are investigated further in the following chapters, where a focus on the contextual effects of power, information dissemination and the ethics of reporting, will elucidate the motivations and impetuses underlying this sorry saga.

CHAPTER 8

ANALYSIS AND DISCUSSION OF THE FINDINGS

8.1 Introduction

This chapter has as its focus an analysis of the data obtained from the Macarthur Health Service (MHS) and Bundaberg Base Hospital (BBH) inquiries, using Fay's Critical Social Theory (CST) as an interpretive frame. To this end, attention is first given to Fay's Theory of false consciousness and, specifically, the MHS and BBH nurses' false consciousness underlying their expectations that their formal complaints of substandard clinical practice, unprofessional and/or unethical conduct would be investigated and appropriate action taken. Attention is then directed to Fay's Theory of crisis and the structural bases that contributed to the emergent crisis at the two health services. The propensity to cast blame, the wilful blindness displayed by service executives, the network of hierarchical observation, and disciplinary action to which the nurses were subjected and, finally, the use of confidentiality as a mechanism for trying to silence the nurses' dissent and prevent their disclosures being made to authorities external to the organisations. The focus then turns to using Fay's Theories of education and transformative action in order to explain the events that occurred in both the Bundaberg Base Hospital (BBH) and the Macarthur Health Service (MHS) cases.

8.2 Fay's Theory of false consciousness

Fay (1987) defines false consciousness as a manner of thought that precludes the thinker from comprehending the true nature of their social situation, characterised as self-misunderstanding. False consciousness is systemic, shared and deeply rooted in the ideology of a whole group or community and is also 'causally operative' for the maintenance of the social order (p. 29). Others, such as Marcuse (1964) have also linked the maintenance of social order in a system to the false consciousness of individuals or groups within it. Marcuse asserts that it is the extent to which an individual within a system, through their 'thought and behavior' becomes 'unwilling and perhaps even incapable of comprehending what is happening and why', that prevents change (p. 145).[187]

False consciousness is a term which has also been applied to describe the nature of hierarchical social relations and specifically of the 'cognitive distortion' and 'concealment of social contradictions' that take place in such relations (McCarney, 2005 para.1). In the cases considered in this thesis false consciousness can be recognised in the nurses' expectations that the systemic and organisational processes were 'on their side'. They believed that there was in place a system of checks and balances within their respective hospital organisations. They had faith in the existence of 'technical apparatus',[188] such as sentinel reporting procedures and feedback mechanisms, and that their messages of complaint would be given credence and would result in active support for their attempts to protect patient safety. The nurses from BBH and

[187] If a need for change remains unidentified or unexposed then change will not occur. Individuals will contribute 'to the preservation of a false order of facts' (Marcuse 1964, p. 107).

[188] For Marcuse (1964) 'this false consciousness... become[s] embodied in the prevailing technical apparatus which in turn reproduces it'(p. 145).

MHS each shared the 'false consciousness' that their internal reporting of substandard practice would result in three specific, predictable outcomes:

1. That the reports that they had made of substandard practice would be fully investigated;
2. That if the investigation found that an individual practitioner had violated the standards of practice, the outcome would be censure;
3. That should an outcome of substandard practice be the result of an error rather than a deliberate violation, a change in the processes and factors which had contributed to that event would result.

8.2.1 Substandard clinical practice and censure

Substandard clinical practice can result from either an error or a violation, the difference lying in the degree of intent of the individual responsible for the breach. An error, is generally taken as referring to the '*unintentional* use of a wrong plan to achieve an aim, or failure to carry out a planned action as intended' (Runciman *et al.*, 2003, p. 975 emphasis added) and is thus explicitly non-deliberate. A violation, on the other hand, is considered to be deliberate in that it entails an act or acts that intentionally deviate from the known and accepted rules or regulatory practice (Runciman *et al.*, 2009; Runciman *et al.*, 2003). It is important to note that not all patient harm results from substandard clinical practice. Some patient harm results from iatrogenic causes, i.e. 'unintended or unnecessary harm or suffering arising from any aspect of healthcare management' (Runciman & Moller, 2001, p. i).[189] For each of these

[189] An example of an iatrogenic adverse event or harm may be sterility that results from the administration of a chemotherapy agent to treat cancer(Blumenfeld, 2012).

definitions, when it comes to apportioning blame, the focus is on the psychological state of the individual performing the action, that is, on their level of *conscious intent*, rather than on the *outcome or outcomes* of that action.

The notion of censure is one based on the principle of retributive justice and has as a focus on the delivery of punishment designed (in this formulation at least) to make an example of the violator and to ensure his/her compliance with expected standards. Such censure would be expected to come as a formal 'adverse judgement [...] expression of disapproval or condemnation' (OED Online, 2012a) from a judicial or legal authority that would serve as a public reprimand of (and punitive response to) those deemed responsible.

The aim of retributive justice is the maintenance of behavioural standards. Actions such as censure are important symbolic representations of the value of conformity to accepted behavioural standards (Victor *et al.*, 1993). Durkheim (1964) and others such as Miler and Vidmar (1981) identify the importance also of transparency since members of the social group watch very carefully the action taken against a rule violator. Censure is thus justified by accepting that the failure to impose a punishment leaves 'the social order unbalanced and raises questions about the group's belief systems, norms and values' (Victor *et al.*, 1993, p. 255).

8.2.2 Lack of investigation and no feedback

The nurses in the MHS and BBH cases believed that if episodes of substandard practice were formally reported, particularly those that had resulted in actual harm to patients, then those episodes would be thoroughly investigated. However, as can be seen repeatedly in the case material, no action was taken

following the submission of incident reports or other formal written and submitted communications. The nurses stated several times that they had not been provided with any feedback and that no follow-up had occurred. They inferred from this that existent problems and the need for consequent change in practice had been left unchallenged. Nurse Owen from MHS was particularly forthright and explicit in her concerns:

> What is the point in all of these committees where people sit down and assess where complaints should go and who should deal with them if it doesn't get back to the floor, if the staff are still frustrated by the same issues happening…
>
> (Walker, 2004c, p. 152)

The expectations of these nurses (that an investigation would follow the submission of an incident report and that feedback would be provided) were reasonable. An effective incident reporting system, one that provides feedback of an investigation and opportunities to learn from failure, is regarded as best practice in healthcare (Benn *et al.*, 2009). Incident reporting in healthcare is however, 'only of value if it leads to a constructive response' that 'provides feedback of the findings from an investigation' (WHO, 2005, p. 10). The reality facing the nurses in the cases presented in this thesis was that both the system of reporting and the investigatory capacity of each hospital were under-resourced and poorly constructed. It was later shown that the staff performing the investigations also lacked the skills necessary to undertake the required processes adequately.

Former General Manager Collins reported to the Commission of Inquiry that at MHS, feedback provisions had not formed part of the Service's complaints management system (Walker, 2004a). The uncoordinated manner in

which the under-resourced Critical Care Review Committee investigated complaints resulted in a backlog, further delaying the already insufficient action (Walker, 2004a). The HCCC and SCICCH found that, in her role as after-hours nurse manager, Nurse Fraser had repeatedly completed and submitted incident reports and had written to the MHS management outlining her concerns regarding patient safety and substandard patient care.[190] Despite her repeated reporting via existing internal channels no action was taken, this was later taken as indicating 'a lack of clarity at a number of different levels in management about responsibilities and the available pathways for incident management' (HCCC, 2003, p. 133).

Inadequate reporting processes were also deemed to have undermined the efforts of the Bundaberg nurses to initiate an investigation in response to their formal notifications of substandard clinical practice. Rather than instituting an investigation and providing feedback to the nurses, the then Director of Medical Services at BBH, Keating, gave the data related to the reports directly to Patel, the subject of the complaint. Patel was then able to provide, unchallenged, alternative data, explanations and opinion for consideration. This action was contrary to the expectations of the nurses, who believed that the matters would be placed in the hands of someone with 'appropriate expertise to investigate these cases – another surgeon or some sort of review panel' (Nurse Aylmer in QPHCI, 2005, BHCI Transcript Day 10 p. 977).

A review by another surgeon or by a panel of Patel's peers would have been consistent with Queensland Health policy, whose procedures specified

[190] See the example of the death of Mrs T in Chapter 5 pg. 146.

that independent medical opinion should be sought to review adverse incidents and undertake root cause analysis[191] of sentinel events. However, neither of these procedures took place (Davies, 2005). In BBH, at the time of the case, feedback related to the initiation and progress of investigations was not provided. Even though it was 'the intention of the District Quality and Decision Support Unit to provide feedback to staff who were reporting adverse events' no such action was forthcoming and, due to a lack of resources 'feedback ceased' (Davies, 2005, p. 438; QHPCI 2005 Exhibit 169).

The provision of prompt feedback to nurses and other healthcare professionals who report substandard practice and error via an incident reporting system is credited with being one of the cornerstones for the establishment of trust in that system (Shaw & Coles, 2001; WHO, 2005). Feedback provides evidence that issues of concern are being investigated and demonstrates a level of seriousness and commitment on the part of management regarding the value and importance of the reporting effort itself (Shaw & Coles, 2001). Nonetheless, despite the near ubiquitous recommendation that feedback is essential to reporting systems, research (including large scale inquiries into serious allegations of substandard practice and misconduct) shows that feedback still is not always provided (Evans *et al.*, 2006; Firth-Cozens, Redfern, & Moss, 2004; Fitzgerald, Cawley, & Rowan, 2011; Hindle *et al.*, 2006; Mahajan, 2010; Thomas *et al.*, 2011). Evans *et al.* (2006) report that in South Australia, the most frequently stated barrier to future incident reporting behaviour (cited by 186 doctors and 587 nurses) is the lack of feedback on

[191] Root cause analysis is a structured process used to identify system level causal or contributing factors that underlie adverse events or other critical incidents, for the purpose of informing risk evaluation and risk reduction (Card *et al.*, 2012; Wachter, 2012b)

previous reports. Similar findings have been recorded in other, international studies investigating barriers to incident reporting (Benn *et al.*, 2009; Fitzgerald *et al.*, 2011).

Even when internal incident forms have been completed, there are also limitations to their capacity to generate accurate analysis and to inform measures for improving processes (Anderson, Kodate, Walters, & Dodds, 2013; Shojania, 2008). Investigation by Thomas *et al.,* (2011) into the utility of the incident reporting systems currently used in Australian hospitals has found that many systems have been designed and administered in ways that do not allow the collection to facilitate systematic analysis of incidents and error. Instead, the incident reporting system provides a reviewer with only a brief 'description of the incident as it unfolded' (p. 638), without sufficient detail about causal or contributory factors that could assist with the analysis of the incident and identification of measures that would prevent similar incidents and related adverse events in the future.

A systematic review by Lawton *et al.* (2012) examining the factors contributing to patient safety incidents in hospitals has likewise found that incident report data lack the quality necessary to effectively elicit those situational factors proximal to errors and that instead they focus attention on the individual who has erred. That is, even in organisations that value and promote incident reporting, there can be such a paucity of evidence to be gleaned from incident reports that the causal data generated is not strong enough to bring about significant change in practice.

In the case of the MHS incident reporting, processes were found to be inadequate. Nurse Fraser, responding to the Parliamentary Inquiry, stated that

> There appeared to be *no action*, in that there was *no follow up*, there was *no feedback*. The same dangerous practices happened over and over again. I sat on a committee called the Critical Care Committee at which a lot of these cases were discussed and they seemed to miss the root of the problem and seemed to blame everybody. It was more a thing about blaming rather than fixing. (NSW Parliament, 2004a, p. 10, emphasis added).

In most instances, neither the manager responsible nor the safety committees involved seemed to have the time or available resources necessary to adequately revisit the incident. Nor did they consider any possible mitigating intentions or offer the individual named an opportunity to justify their actions.[192] When it became apparent to the nurses that no action was to be forthcoming at a level which would satisfy them, they began to explore avenues for reporting to an external authority.

8.2.3 Reporting violations of the standards of practice requires censure

The nurses at MHS and BBH expected that when a standard of practice which resulted in a breach to patient safety or an adverse outcome occurred, the practitioner would be subjected to official censure to ensure a change in practice. In the BBH case it was as early as May 2003, just one month after Patel began his practice at the hospital, that Hoffman reported what she believed to be a violation of standards. Patel had performed his first oesophagectomy and the patient had died following complications. Hoffman

[192] There was only one instance of a member of the Executive approaching the individual at the centre of the complaint during an investigation phase of the events at the heart of this research. This occurred at BBH when Keating afforded Patel the opportunity to justify his actions. At MHS Solarz was asked to justify her actions in the treatment of Anaesthetist D1. However this only occurred at the final meeting when she received the findings of a formal investigation into the matter.

expressed her concern that neither Patel nor the ICU had the requisite skills and resources to adequately and safely manage patients undergoing that type of surgery. Hoffman anticipated, indeed expected, that her correctly submitted report would be met with the censure of Patel and a change in practice. Instead, Hoffman received directives stating that she was required to 'cooperate' and 'work together' with the surgeon, and that Patel had the full support of the hospital's Executive in continuing to offer this surgical option to the people of Bundaberg (QPHCI 2005 Exhibit 4, p. 50).

It was only subsequent to the FitzGerald Clinical Audit in February 2005, following three further deaths, that Patel received a verbal directive to refrain from performing these complex surgical procedures. During an audit interview with FitzGerald, Hoffman expressed her expectation that Patel would be stood down and suspended from performing any surgery pending the completion of the investigation. These expectations were not met.

The belief that those who violate clinical practice standards require censure stems from a desire that justice be seen to be done. Since censure involves punitive action, it upholds retributive justice. As has been noted previously,[193] proponents of retributive justice view punishment as having a central role in influencing group cohesion, particularly in maintaining the legitimacy of group norms. Punishment is seen to be a normative strategy for strengthening the validity and legitimacy of the extant rules, as well as serving to restore and maintain group cohesion (Trevino & Weaver, 2010; Victor *et al.*, 1993; Vidmar, 2002).

[193] see Chapter 4.

Retributive justice is not a subject explored directly in the nursing literature. Yet the idea that there is a commonly held desire to punish violators of social norms is relevant here since it is a matter that has been addressed in theories of justice, and particularly in organisational contexts. According to Zhu, Martens and Aquino (2012) employees pay close attention to matters of justice within an organisation as it represents the degree to which they and others are valued by the organisation. When no action is taken, this can be taken as a justice failure. For Zhu, Martens and Aquino, 'justice failure' encompasses situations in which 'one or more persons in an organization intentionally cause harm to others but goes [*sic*] unpunished' (p. 130). They suggest that when third parties witness justice failure they suffer psychic distress, a level of discomfort that unsettles their beliefs about an 'expected relationship between doing wrong and being punished as a result' (p. 130). Further, their research indicates that for some individuals the level of discomfort is strong enough to motivate efforts towards its alleviation.

The work of Zhu, Martens and Aquino (2012) and Taylor's (2009) concept that justice is a basic human need is, at this point, speculative (having not been tested in organisations such as healthcare). Nevertheless, it does seem reasonable to assert that the impulse to whistle-blow substandard clinical practice and unprofessional conduct forms part of what is termed an innate deontic motivation, and that a deontic reaction is undertaken as a means of alleviating the psychic distress of an unmet justice need.

In an attempt to explain the social phenomena of punishment and justice, and particularly the justifications for the behaviour of individuals within wider

social contexts, researchers have adopted a cognitive/affective approach to the understanding of justice evaluations (Trevino & Weaver, 2010). A 'justice evaluation' in the cases under examination here would have been exemplified had some action been be taken in response to violations of standards that caused patients to be harmed.

The desire to censure violators of social norms who cause harm has also been recognised in organisational ethics, most recently in a theoretical approach known as deontic justice (De Cremer, 2010; Rupp & Bell, 2010; Skarlicki, Brown, & Bemmels, 2012). The negative emotions evoked as a response to observing people flaunting moral principles and social norms was first described as a 'deontic reaction' by Robert Folger (2001).[194] A deontic reaction compromises assessments of what ought to happen. It is a psychological process whereby individuals experience moral outrage upon witnessing transgressions of acceptable social conduct which bring about a corresponding desire – the deontic reaction – to see the transgressors punished (Folger, Cropanzano, & Goldman, 2005). Folger, Cropanzano and Goldman (2005) delineate five attributes of the deontic response: 'automaticity, short-term irrationality, retribution as its own reward, reconciliation mechanisms, and emotion as the driver of behaviours' (p. 222).

Advocates of deontic justice argue that a moral framework and a corresponding need for justice are 'hardwired within the structure of the human

[194] Folger (2001) explains the term deontic reaction as a morally based reaction, often expressed as indignation when injustice is perceived. The term derives from the Greek term *deon* which refers to obligation or duty. With its roots in Kantian ethics 'deonance' represents the idea that an individual's behavior is motivated by cognitive processes linked to 'universal ethical principles of an innate and/or selfless nature', which brings with it a sense of 'duty, obligation and moral virtue' (Rupp & Bell, 2010, p. 90)

mind' (Rupp & Aquino, 2009, p. 207) having evolved to assist individuals in dealing with complex social conditions associated with groups (Folger *et al.*, 2005; O'Reilly & Aquino, 2011). In a series of studies supporting this theory, researchers employing a resource allocation paradigm[195] found that 'third-parties' or those who witness injustice, demonstrate a seemingly selfless willingness to 'sacrifice their own resources' in order to punish individuals known to be unfair (Rupp & Bell, 2010, p. 90).

Building on their earlier studies on deontic justice, Zhu, Martens and Aquino (2012) have called for further examination of the impact of 'justice failure' on third-party observers within organisations. Their interest in this area emerged in the wake of the global financial crisis and their desire to understand the failure of accountability measures to address the behaviours of executives who had committed patently illegal acts, such as failing to disclose investment risks.

Human reaction to justice violations, particularly the emotional and physical stress associated with such violations is seen by Taylor (2009) as a powerful, psychologically motivating force. Taylor (2009), Fischer and Skitka (2006) and, more recently, Johnstone (2011), advance the claim that justice is, in fact, a basic human need. Taylor (2009) validates his line of reasoning for this claim by first examining the concept of 'need', which he regards a feelings of want 'that provide[s] a basis for behaviour or action [...] a motivational state

[195] A resource allocation paradigm is one in in which the participants in a study are provided with a resource pool (usually money) and asked to decide how best to distribute it. They are then informed of unjust behaviour by some participants in a previous session and are asked to choose from various allocation patterns – such as *selfish* (taking the allocations for themselves), *balanced* (dividing the pool equally) or *sacrificial* (allocating less to themselves in an attempt to punish previous participants who were known to be unfair) (Folger *et al.*, 2005; Rupp & Bell, 2010).

resulting from such a feeling, a drive' (p. 6). Reflecting on his own experiences and witnessing the psychological reactions shown by those parliamentarians taken hostage during the attempted military coup in Fiji in 2000, Taylor (2003) attributed their 'symptoms of shock, horror, disillusionment, and disbelief' as resulting from 'the shattering of their legitimate expectations from being members of a community' (p. 210). It was the event that prompted Taylor (2006) to reappraise the idea of the need for justice as a motivating force, which he accomplishes by linking the concept to Maslow's (1943) hierarchy of basic human needs. Thus, justice is not just an ideal, but a need as basic to human survival as the need for air, food and water (Taylor, 2006; Taylor, 2009).

8.2.4 Reporting error requires change in processes

After human error was seen to have resulted in patient harm, the nurses expected that an investigation would take place and that strategies would be implemented to change the processes that contributed to the adverse event. Yet, no change in practice occurred. The nurses who witnessed the human errors causing harm to patients expected their reporting would provide an opportunity to bring into effect action (through change in practice or process) that would ensure the circumstances that contributed to the error were ameliorated and patients safeguarded in the future.

Nurse Bragg voiced her disappointment regarding the case of patient Sara Flegg[196] after the internal investigation had recommended only superficial strategies, such as 'better communication between the registrar and the VMO'

[196] Incident 44 at MHS: The substandard clinical practice that combined poor management, poor communication, under-diagnosis and the bungled transfer/transport of a near-term pregnant patient in acute respiratory distress that was reported by ICU nurse Vanessa Bragg – see Section 5.7 above.

(NSW Parliament, 2004a, p. 20). She believed this non-specific response obscured the actual cause of the error: inadequate planning for transport to Liverpool Hospital. Similarly, when Fraser reported the death of a patient who had been prematurely discharged from the emergency room, she requested that the investigation consider the level of medical staff coverage. The immediate response from the MHS Executive did not recommend change to practice, but instead criticised Fraser's recommendation. It was a further 12 months before any alternative course of action was suggested, that is, that better documentation be kept in patients' notes, an outcome that Fraser regarded as inadequate.

In BBH, serious errors that resulted in patient harm[197] were raised internally as sentinel events by nurses yet these failed to result in any immediate change in processes. Director of Medical Services Keating later admitted that four months after the sentinel event was raised he still had not documented a change in the emergency vascular policy prior to taking annual leave in April 2005 (QPHCI 2005 Exhibit 448). Despite the Queensland Health Policy requiring a full root cause analysis in the face of such incidents (QPHCI 2005 Exhibit 448- DWK51, Exhibit 162 -LTR6), Keating did not believe that such an emphasis was warranted.

It would, of course, be wrong to imply that the application of an investigatory process would have necessarily produced change. Alterations to practice and processes in the wake of an investigation into human error or processes by methods such as root cause analysis and even Commissions of

[197] Such as the amputation of 15-year-old P26's leg due to Patel's poor surgical technique, and subsequent delays in the transfer of that patient to Brisbane as outlined by Rashford, the Director of Clinical Co-ordination and Patient Retrieval Services for Queensland Health

Inquiry can still fail to deliver expected changes. For example Gluyas, Alliex and Morrison's (2011) case study into changes in clinical governance following the King Edward Memorial Hospital (KEMH) Inquiry[198] in Western Australia found that, despite clear recommendations, 'changes were not demonstrated in processes that would increase the skills of clinicians at the interface between clinicians and patients in the delivery of care' (p. 154).

In each of the BBH and MHS cases, an absence of will to investigate is what influenced the lack of action. According to Card *et al*. (2012) one of the reasons that changes are not made when sentinel events are reported is that the investigation is often left to healthcare workers unskilled in the principles of safety engineering. This factor is implied in Keating's inaction. He was later to admit that none of the staff at BBH had received any training in root cause analyses and that this 'affected the hospital's ability to investigate any events rated high, very high or sentinel in risk' (QPHCI 2005 Exhibit 448 p. 80).

Even when staff are engaged in performing root cause analyses, the recommendations that result from the investigation can still be limited. In Mengis and Nicolini's (2011) ethnographic study of ten incident investigations at two National Health Service Trusts in the UK, recommendations for changes in practice were confined to small, local departmental adjustments rather than encompassing anything that could be deemed system-wide. More complex system-wide interventions were seen as beyond the capacity and resources of the investigation team (Mengis & Nicolini, 2011).

[198] The KEMH inquiry was initiated when Mr Michael Moodie, the Chief Executive of King Edward Memorial Hospital Western Australia raised wide –ranging and serious concerns about the quality of clinical care and resultant patient safety on 7 December, 1999. The KEMH inquiry examined the provision of obstetric and gynaecological services at King Edward Memorial Hospital during 1990 to 2000. (Douglas, Robinson, & Fahy, 2002)

These findings are commensurate with the situations at MHS and BBH. Quality committees from both organisations reported a lack of resources, time and staff necessary to assess complaints, to make recommendations and to implement change. When no change eventuated from incident and error reporting, the nurses attempted other measures to prevent adverse outcomes. Examples at BBH include: Aylmer following Patel with a box of gloves 'to improve his practice [and] to minimise the risk of cross infection' (QPHCI 2005 Exhibit 59, p.2). Druce's actions in establishing an 'alternative clinical area [in which] to perform Peritoneal Dialysis', the 'Baxter solution',[199] came in response to the 'high number of adverse catheter related events' at the hospital (QPHCI 2005 Exhibit 70 RP4).

Mengis and Nicolini (2011) noted that the investigating teams and management in their study had not been focussed on managing change and, as such, 'were totally unprepared to address the challenges of turning recommendations into sustainable service transformation' (p. 179). This supports earlier Australian work by Iedema *et al.* (2006) which found that clinicians engaged in root cause analyses were not given the power to effect changes in areas such as resource allocation and the organisation of hospital services. Instead the investigating teams formulated more 'controllable solutions' which were 'de-coupled from practice' and thus failed to deliver improvements in healthcare service (Mengis & Nicolini, 2011, p. 180).

The study by Gluyas *et al* (2011) into the application of recommendations from the King Edward Memorial Hospital Inquiry in Western Australia

[199] The Baxter solution was outlined in Chapter 6.4.4 and involved having patients requiring catheters for peritoneal dialysis to have these inserted by private surgeons at the Friendlies Private Hospital in Bundaberg, rather than by Patel at BBH.

similarly found that post-inquiry changes were made in administrative functions in the areas of credentialing and performance management (a controllable solution), while deficits remained in the 'provision of training and up skilling for clinicians to improve their communication skills and interactions with patients' (p.147).

It is unthinkable to many within healthcare organisations that recommendations that result from investigations into serious adverse events would not lead to changes in practice. Yet this occurs and raises provocative questions as to the possible reasons why those in leadership roles who have both the authority and responsibility to effect positive change, fail to do so. It is to exploring this idea further that the remainder of this chapter now turns.

8.3 Fay's Theory of crisis

Fay (1987) proposes a Theory of crisis that requires a historical account of the 'structural bases' of the society under examination, and of how, when combined with the false consciousness of that society's members, a crisis results (p. 32). Structural bases for Fay are comprised of 'certain social practices and institutions – some of which are coercive' (p. 37) and which provide the underlying stratification and organisational rules for a society. Interactions between members of a society are governed by their relative adherence to, or rejection of, these rules and it is through such interactions that the structures themselves are created and maintained (Fay, 1996).

Examples of social practices within institutions would include 'traditional' notions of paternalism. For example, the entrenched idea that position and function at a particular level automatically imbues an individual

with an authority that is unimpeachable, especially by those from lower strata or from different backgrounds.[200] The sometimes-coercive nature of such practices (a natural consequence of a hegemonic system) contributes to the formation of crises.

For Fay (1987), the use of a critical theory is most fruitful when there is 'a situation in which some sort of choice is *forced* on people because they are no longer able to function as they have done in the past' (p. 30, emphasis in original). In MHS and BBH, the nurses' whistleblowing acts represented such a crisis. The public exposure of the hospital Executives' inaction in response to repeated internal reports of substandard practice, unprofessional and/or unethical conduct, patient injury and death, posed a threat to social cohesion within the hospitals. The public reaction to the whistleblowing acts then threatened broader social cohesion, ultimately resulting in the commissions of inquiry.

8.3.1 Structural bases

The four perceived structural bases that contributed to the development of the crisis in the MHS and BBH cases and that lie at the heart of the events in this study are:

- the propensity to apportion blame;
- wilful blindness;
- the network of hierarchical observation and discipline and, finally;

[200] Legitimate power and influence as the result of an official title such as the Director of Surgery, or years of experience as a surgeon, for example Patel was not accepting of nurses having any authority to tell him to wash his hands or don gloves. When renal nurse Tuner 'asked him to put on sterile gloves and his response was *"Sister, I don't have germs"* (QPHCI 2005 Exhibit 197, p. 2, emphasis in original).

- the use of confidentiality as a mechanism with which to silence dissent by nurses and prevent their disclosures external to the organisations.

It is to examining these structural bases that the discussion now turns. In so doing, some of the contextual effects of power, of information dissemination and of the ethics of the reporting behaviours of the nurses will also become clearer.

8.3.2 Apportioning blame

Blame, in its most simple formulation, is concerned with the finding of fault so as 'to reproach; to fix the responsibility upon; to make answerable' some individual, individuals or circumstance (OED, 2014). In its application to human elements, blame is a evaluative response to behaviour that is considered 'morally wrong or socially opprobrious' (Alicke, 2000, p. 556). The notion of blame carries within it a need to affix responsibility upon someone and to hold them accountable for a morally wrong or socially unacceptable action. Gibson and McCann (2012) explain that blaming involves a 'judgment of moral responsibility' attributed to one who has violated a norm and deserves sanction (p. 309). Blame is also 'constructed from *perceptions* of events, not necessarily "objective" reality' (Gibson & McCann, 2012, p. 309, emphasis in original). As an overt response, blame is the expression of disapproval of, or contempt for, an egregious act or a flaw in character (Sher, 2006).

Apportioning blame to an individual or individuals after a disastrous event, particularly to those who are perceived to have caused irreversible injury or death, is usual. Blame offers victims and witnesses an emotionally satisfying

answer to assist the resolution of 'complex inter-personal or situational problems' caused by the event (O'Connor, Kotze, & Wright, 2011, p. 115).

Errors and adverse events in healthcare, whether they occur because of unprofessional or substandard behaviour, or are iatrogenic, can result in patients' irreversible injury or death. Healthcare is thus an area where a strong name, blame and shame dialectic has operated (Gibson & McCann, 2012; Runciman *et al.*, 2007). Outside of healthcare, too, the assignment of blame has been recognised as an 'ancient and well-perfected device for trying to feel better' (Chodron, 1997, p. 100). Apportioning blame has also been linked to the maintenance of social order (Nadler, 2012; Sher, 2006). This association enables the characterisation of blame as a structural base in the sense indicated above.

In the aftermath of an adverse patient event, which is the most common triggers of incident reports in healthcare, the desire, indeed the need, to apportion blame manifests as a strong human reaction (Alicke, 2000; O'Connor *et al.*, 2011; Reason, 2000b).[201] Sher (2006) describes the need to act morally and the need to condemn those who do not as 'indissolubly linked' (p. 135). According to Sher, being the object of blame results in a negative emotional reaction in the blamed individual that stems from a 'desire not to be viewed as a bad person' or to have others believe that their 'moral balance has been reduced' (p. 77). This 'negative affective element' can be used to coerce the blamed individual to conform to more accepted social practice (p. 79).

[201] Alicke (2000) refers to the work of Kelsen (1943) who suggests controversially that the need to identify a culpable agent is in part derived from primitive human retributive motives.

Blame has also been viewed as a psychological matter, particularly as it involves a process of attribution (Nadler, 2012). The attribution of blame is not simple, but, results from a cognitive process, the first step of which is the detection of a negative outcome or event that clearly deviates from shared norms (Malle, Guglielmo, & Monroe, 2012). Next, comes an assessment that an individual (agent) has caused that outcome or event. The third step comes with determining the level of intent as a measure of differentiation between an error (an unintentional action) and a violation (an intentional action).[202] The process concludes with consideration of the reason or reasons for the action having been taken. Once culpability has been established, blame is assigned, but graded with due consideration of justifications offered by the offender: 'minimal blame if the agent was justified in acting this way; maximal blame if the agent was not justified' (Malle *et al.*, 2012, p. 314).

It is during the third phase of blaming, determining the level of intent that individuals engage in what Alicke (2000) calls blame-validation processing.[203] During this process there is a stronger tendency to apportion blame to the human agent than there is to examining the 'prepotent [i.e. overriding] controlling forces' (p. 568), or any mitigating circumstances that may underlie the harmful event (Lagnado & Channon, 2008). Alicke (2000) and, later, Lagnado and Channon (2008), hold that human actions are perceived to be

[202] Intent is evident here in the cognitive process of blame and is also critical in the differentiation between an error (an unintentional action) and a violation (an intentional action) as described by Runciman earlier.

[203] Blame-validation forms part of Alicke's (2000) 'culpable control model', which attempts to explain the psychological processes that occur when individuals apportion responsibility and blame; it is also termed 'causal reasoning' by other theoretical researchers in Social Psychology (Lagnado & Channon, 2008).

more controllable and human error easier to rectify than the often amorphous influential environmental factors in which they are framed.

Alicke's (2000) and Lagnado and Channon's (2008) blame validation processes may help to explain the lack of investigation into concomitant causes at the centre of many of the reports of error and unsafe practices at MHS and BBH. The favoured approach at BBH was to claim that the 'blame free' approach was the reason for the lack of clinician details gathered regarding the adverse events or the complaints register (QPHCI 2005 BHCI Transcript Day 21 p. 2302). At MHS, blame was assigned to individuals (with the treatment of Nurse Fraser being the most palpable) who reported their concerns, and regularly missed addressing the root cause(s) of the problems (NSW Parliament 2004a, p. 10).

The ease with which individuals were blamed, and / or the fact that a 'no blame' approach was used, appeared to prevent rigorous investigation. Inaction in the identification of root causes or the finding of evidence substantial enough to hold people accountable, contributed to the nurses' sense of dissatisfaction. In the case of the MHS nurses, when an individual manager or safety committee member was called ostensibly to examine incident reports, they instead focussed on the individual who had reported the error and attributed blame here, rather than pursue active strategies to alter the underlying circumstances. In BBH, after 22 months of submitting complaints,[204] the nurses were in despair at the news that the FitzGerald investigation was 'only a fact finding mission to decide whether or not an investigation should be carried out'

[204] Complaints which resulted in 16 separate pieces of evidence in the form of 40 pages of attachments pointing to Patel's incompetence being sent to the FitzGerald Clinical Audit.

(QPHCI 2005 Exhibit 4, p. 50); its purpose was 'not to collect "evidence" for any particular disciplinary or other process' (QPHCI 2005 Exhibit 225, par 63). The rationale behind not addressing the root cause of the problem and the ease with which blame was fixed elsewhere is now explored with reference to other research.

The fear of blame and the inappropriate attribution of blame identified as barriers to internal incident reporting at both MHS and BBH are present as factors in other studies (Attree, 2007; Bjørkelo, 2013 ; Blake, 2009; Davies, 2005; Evans *et al.*, 2006; Forster, 2005; Jackson, Peters, Andrew, Edenborough, Halcomb, Luck, Salamonson, Weaver*, et al.*, 2010; Kingston *et al.*, 2004; Moore & McAuliffe, 2010; Schectman & Plews-Ogan, 2006; Walker, 2004a). In Attree's (2007) study, when things went wrong, the response from management was either an attempt to find one person accountable or focus the investigation on the staff member who made the report. The perception of reporting or raising concerns became 'a high-risk: low-benefit act' (Attree, 2007, p. 395). Addressing this perception and the lack of internal reports and incident forms has been at the centre of calls for a 'blame-free' culture in healthcare in order to ensure an increase in reporting to inform learning from adverse incidences (Ralston & Larson, 2005; Wakefield, 2002; Wolf & Serembus, 2004). However, because the desire to attribute blame 'is so persistent, there are psychological as well as normative impediments to its abolition' (Sher, 2006, p. 135), thus the ideal of a blame-free organisation remain an elusive goal.

Mengis and Nicolini's (2011) research into root cause analyses in practice in two English NHS Trusts found that blame remained, even when the notion of 'no blame' was an edict espoused by the organisation so as to ensure that a learning approach resulted from an adverse event (Mengis & Nicolini, 2011). Rather than blame being recognised and accepted as an essential psychological process that is a consequence of adverse events, it was concealed or displaced[205] within the official investigations, and instead took place 'in a less open form and [was] swept under the proverbial carpet' (Mengis & Nicolini, 2011, p. 181). At the same time, within the official investigation, the 'no blame' discourse resulted in 'un-discussables', so that blame itself remained in circulation. This created a process whereby 'questions of responsibility and blame often featured in the informal meetings and conversations that occurred outside the formal RCA [root cause analyses] processes' (p.181), but to no constructive end. Mengis and Nicolini's study indicates that some form of apportionment of blame will always be present as a response to such incidents.

An attempt to abandon apportioning blame is perhaps not the best strategy to improve reporting of concerns and management of incidents that harm patients. The MHS and BBH cases, as well as other research demonstrate the pervasiveness of blame, particularly when patients are harmed. In his work '*In praise of blame'* Sher (2006) suggests that there is a 'price we pay for abandoning blame' (p. 134). Without blame, people become less responsive to

[205] Root Cause Analysis (RCA) investigators were regarded by clinicians as intruders and the RCA investigation an 'almost legal investigation' where culpability and discipline remained a concern (Mengis & Nicolini, 2011, p. 181). Thus instead of verbalising blame in official interviews it was raised in 'the informal meetings and conversations that occurred outside the formal RCA process' (Mengis & Nicolini, 2011, p. 181).

and considerate of accepted principles of social behaviour and their grounding and, as such, individuals could act wrongly with impunity or accountability.

Therefore it behoves the healthcare (and other) professions and organisations to strive for what HCCC Commissioner Adrian, at the beginning of the report into MHS, called a *'collective understanding of where the line would be drawn between blameless and blameworthy actions'* (HCCC, 2003, p. ii, empahsis in original). The lack of individual accountability present in a 'blame-free' organisational culture, is now the centre of calls questioning the validity of the concept (Wachter, 2012b; Walton, 2004).

8.3.3 Wilful blindness

In law, the term 'wilful blindness' refers to the actions of a person, or persons, who intentionally fail to inform themselves of matters that may result in criminal liability (From, 2011). This legal concept originates in Christian religious discourse where it was used to describe the judgement of those who would deny the truth and light of the Christian Gospel (Minister of the Church of England, 1724; Richmond, 1811). In 1685, the term 'wilful blindness' was co-opted to a secular, legalistic purpose. It was first used in a legal case in which the accused were found not guilty on an indictment of theft because the jury did not believe that the act of plundering was a felony despite the evidence 'of three or four witnesses, who were Spectators, and saw them carry away the Goods' (Ryves, 1685, p. 354).

Heffernen (2011) and From (2011) trace the term's entry into the modern English legal lexicon to its use in *Regina v. Sleep* in 1861. In that case, a jury had convicted a defendant found to be in unlawful possession of stolen naval

stores (From, 2011). The basis for the jury's decision was that the stores were clearly marked and the defendant should therefore have known that they were stolen. The presiding judge overruled the conviction on the grounds that the defendant was neither aware that the mark indicated that the stores belonged to the government, nor had he 'willfully shut his eyes to the fact' (Heffernan, 2011, p. 3).

The doctrine of wilful blindness has been used in a number of recent high-profile legal cases. Examples include the Enron executives in 2009 in *United States v. Skilling* (From, 2011) and, on 19 July, 2011, in the questioning of James Murdoch by the Culture, Media and Sport Committee investigation into News Limited International and the accusations of phone-hacking against it (Harding, 2012; Whittingdale, 2012). According to author Margaret Heffernan, speaking on ABC Radio National's *Late Night Program* of 25 July, 2011, the legal doctrine of wilful blindness is applicable if it can be demonstrated that

> the information you [*sic*] needed was available and so you could have known it and that it was part of your job to understand what was going on, so you should have known it then the law should treat you as though you did know it.

Although applied in legal cases for many years, the term's application to human phenomena occurring in everyday lived situations and within organisations has only recently been re-examined.[206] In her book on the topic *Willful Blindness: Why We Ignore the Obvious at our Peril*, Heffernan (2011) defines wilful blindness as having the 'opportunity for knowledge, and a

[206] Wilful blindness was commonly used in English Christian discourse to describe the unwillingness of people to see the true light of Christ's actions. It was also used in the House of Commons Chimney Sweepers' Regulation Bill which records a charge of wilful blindness against those 'who shut their eyes, their ears, and all their senses, against the circumstances which rendered it indispensably necessarily' (Hansard, 1817, p. 1156).

responsibility to be informed, but it is shirked' (p. 3). She further contends that wilful blindness 'is a human phenomena [*sic*] to which we all succumb in matters little and large' (p. 3) and that it is 'the human desire at times to prefer ignorance to knowledge, and to deal with conflict and change by imagining it out of existence' (p. 87). In this sense, wilful blindness becomes a process by which the brain filters and edits what it takes in: by admitting 'information that makes us feel great about ourselves, while conveniently filtering whatever unsettles our fragile egos and most vital beliefs' (p. 4). The presence of wilful blindness in the cases of MHS and BBH is examined next in light of these considerations.

8.3.3.1 Dangerous convictions

Referring to recent developments in cognitive neuroscience and psychology, Heffernan (2011) argues that individuals treat incoming information differently depending on how it fits their existing, firmly held belief systems. This effect, known in psychology as 'motivated reasoning' or 'confirmation bias', explains emotionally biased decision-making phenomena as individuals selectively processing information in order to support preconceived conclusions (Helzer & Dunning, 2012; Nairne, 2014). This situation is especially pronounced when a person is wedded to certain unshakeable core beliefs, even to dangerous convictions, that they are unwilling to let go despite the emergence of contradictory evidence (Heffernan, 2011).

In the BBH case, several clear examples of such motivated reasoning are evident, with perhaps the most obvious being the documented unwillingness of Director of Medical Services Keating to acknowledge that Patel could not

perform complex surgical procedures and that his (lack of) surgical technique had led to an increase in surgical complications. Keating was apparently convinced that the proliferation of complaints resulted merely from interpersonal conflict and this view supported the conclusion he had already reached: that the complaints were unjustified. Keating remained resolute in this conviction as late as December 2004 when he prepared documentation to extend Patel's contract as Director of Surgery until March 2009.

Despite the extent of the evidence to the contrary, Keating still appears to have firmly believed that there were 'a large number of staff actively undermining the continuing efforts of Dr Patel to provide a general surgical service to the people of Bundaberg' (QPHCI 2005 Exhibit 448 – DWK66, p. 5). He was 'wilfully blind' to the emerging evidence of surgical complications, of wound dehiscence, of sentinel event outcomes following complex surgery and of Patel's unwillingness to transfer seriously ill patients to tertiary hospitals in Brisbane.

Keating's predetermined conclusion about the nature of Patel's work is further evidenced in the briefing paper he wrote to support the extension of Patel's contract. In that document, Keating sees only Patel's 'contribution to increasing the surgical activity levels, outpatients scheduling, and endoscopy procedures, and [his] excellence in achieving the extra elective surgical targets' (QPHCI 2005 Exhibit 448- DWK 67). Thus, by the end of 2004, rather than acknowledge the emerging crisis, Keating used selective aspects of Patel's performance (e.g. in managing the tilt train accident) as evidence of his abilities (QPHCI 2005 Exhibit 448- DWK 67). This suggests that Keating was allowing

himself to accept only that information that made him feel better about himself, about his own judgements and about his inaction in dealing with the previous complaints and incident reports. Keating, in the language of Heffernan (2011), seemed to have unconsciously filtered out information that was unsettling and that contradicted his most firmly-held conviction: that Patel was a capable Director of Surgery.

Even prior to the cessation of Patel's work at BBH, the nurses seemed aware of the Director of Medical Services' motivated reasoning, having already reported that 'Keating preferred the version given by Dr Patel over that given by the nursing staff' (QPHCI 2005 Exhibit 59, p. 8). They had been required to provide further data to support their contentions in the form of, for example, 'Dr Patel's adverse events for renal procedures compared to his non- adverse events' (QPHCI 2005 Exhibit 139, p. 4). Nurse Pollock, who had provided Keating with the 'Peritoneal Dialysis Catheter Placements – 2003' report wondered '"What more proof did he [Keating] need?"'(QPHCI 2005 Exhibit 70, p. 8).

Keating also preferred Patel's explanation of the sentinel event regarding Mr Bramich, after which Patel had accused the nurses of 'mis-information, mis-representation, and personal bias' and had maintained that the patient died from his injuries as confirmed by the post-mortem findings (QPHCI Exhibit 448 DK 46, p. 29). Keating's behaviour is consistent with motivated reasoning as described by Helzer and Dunning (2012), where

> People show a tendency not to need much evidence in favor of conclusions they like. However, when it comes to conclusions they would rather avoid, they show a marked tendency to demand more evidence and to place whatever uncongenial evidence they have under intense scrutiny.

(p.7)

When faced with the serious sentinel event complaint by Rashford,[207] Keating reasoned that the cause of the substandard management was confined to patients requiring specialist vascular surgery, rather than having been an 'issue as to his [Patel's] technical skills as a general surgeon' (QPHCI 2005 Exhibit 448, p. 34).

Helzer and Dunning (2012) explain what seems to be an apparent contradiction by suggesting that 'the conclusions that people reach often [lie] some distance from objective truth or an impartial reading of the evidence...[and] motivated reasoning allows them to cling to favoured beliefs and attitudes' (p. 5).

District Manager Leck, and Director of Nursing Mulligan, also demonstrated apparent motivated reasoning by fallaciously considering the nurses' complaints to be 'related to Dr Patel's behaviour and not to any issue related to the standard of patient care' (QPHCI 2005 Exhibit 180, pp. 44-45). Like Keating, Leck and Mulligan at various times demanded additional evidence from the nurses. Still, as with Keating, even after they had received such evidence they took no action to address the concerns raised by the nurses.

When Patel's actions became public, Leck continued to maintain that no advice had been received to substantiate the allegations against him, falling back on the supposed authority of the FitzGerald Clinical Audit investigation. This was so, despite the fact that the investigation had neither collected evidence towards a disciplinary outcome, nor investigated Patel's scope of

[207] The Director of Clinical Co-ordination and Patient Retrieval Services for Queensland Health who had accepted the transfer of 15year old patient P26, following two attempts at vascular surgery by Patel at Bundaberg,

surgical practice. Instead, District Manager Leck held with his conviction that Patel was an 'industrious surgeon who [had] spent many years working to improve the lives of ordinary people' (QPHCI 2005 Exhibit 473).

The MHS case presents three instructive examples of wilful blindness. The first involves the failure of General Manager Collins to heed the recommendations by the Director of Internal Audit Services that the Stow report was inadequate and should not be used to support the suspension of Nurses Quinn and Owen. The second comes with the Nurse Unit Manager of the Camden Hospital medical ward failing to consider the precipitating events at the centre of Enrolled Nurse Martin's actions. No attention was given to Martin's rationale that it was an unreasonable skill mix and lack of available staff that resulted in her taking over 'duties, roles and responsibilities not normally' within her scope of practice (HCCC, 2003, p. 158). The third example comes with the failure of the hospital executive to correctly investigate AHNM Fraser's report of a lack of senior medical coverage in the Camden Hospital Emergency Department. Coupled with the decision to implement a revised nursing assessment form for use, rather than address the issue raised is further indication of a failure to acknowledge and address the problem.

In each of these instances, management took a punitive stand against the nurses, largely ignoring newly emergent evidence of circumstances that would explain their behaviour and their attempts to advocate for patients and patient safety. In each case, managers sought evidence that would confirm and reinforce their own already-held views that the hospital was safe. When confronted by evidence to the contrary, they had a difficult choice to make: to

either face the very uncomfortable fact that hospital processes or staffing levels were not adequately protecting patients, or to reach the more palatable conclusion that the problem lay with the 'vexatious' nurses who were making 'unsubstantiated allegations' of substandard care. In line with the observations regarding blame made previously, the choice was made to place the onus on the people reporting rather than to fully examine the underlying non-human factors and processes.

8.3.4 The network of hierarchical observation and discipline

At both MHS and BBH there came periods following the submission of incident reports and formal written complaints during which the nurses faced increased scrutiny of their behaviour. In some instances, the level of this scrutiny led to more formal investigations that then uncovered information which was used by management to discipline the nurses. This was particularly the case when a reporting nurse had identified the substandard practice and/or unprofessional conduct of a medical practitioner or when their report highlighted a verifiable lack of resources devoted to the maintenance of patient safety.

Foucault's work examining disciplinary power provides a means of explaining some of the reactions demonstrated by the Executive when they were faced with the nurses' reports of substandard practice and/or unprofessional conduct.[208] Foucault (1977) sees discipline as a 'specific

[208] Examples include: Hoffman's reported concerns related to the death of Mr Bramich which she believed was 'due to a doctor's [Patel's] negligence'(QPHCI 2005 Exhibit 4, p. 35). Fraser reported on the response of MHS to the death Mrs T a 52-year-old woman who presented to Campbelltown Emergency Department and was discharged without a senior medical review.

technique of power' that coerces behaviour through a mechanism of 'hierarchical observation' (p. 170). The reporting of substandard practice and unprofessional conduct that threatened patient safety at MHS and BBH presented a challenge to the hierarchy within these organisations.

The initial altercation between the two MHS nurses and Anaesthetist D1 that led to a grievance being lodged against both nurses, resulted from their attempt to cancel a patient case on the elective operative procedure list because precautions to prevent and or manage malignant hyperthermia had not been taken. Nurses Quinn, Owen and Solarz at MHS became the focus of a two-month investigation by the Quality Manager and the Director of Medical Services, that resulted in the suspension of Quinn and Owen and a drawn-out investigation performed by Stowe. Nurse Hoffman was scrutinised and reproached by her immediate manager Mulligan for her poor communications with Patel (QPHCI 2005 Exhibit 4 – TH 22). On each occasion, the focus of inquiry into the nurses' disclosure failed to address this key issue. Instead, the individual who had reported the problem became the focus of what Foucault (1977) would term as 'hierarchical observation' (p. 170).

The nurses' reporting actions had, in effect, lifted a veil to reveal the substandard practice of medical practitioners who held greater power than they in maintaining the status quo. Alford (2001) suggests that when whistleblowers reveal organisational inaction as a response to reports of wrongdoing, rather than 'looking at what lies beyond the veil', observation instead becomes focused on 'the one who lifts it' (p. 133). When this occurs, Alford suggests

that disciplinary power, as articulated by Foucault, is applied so that a hierarchical observation is cast upon

> the whistleblower almost as though the organization were a physician, treating the whistleblower not as someone who has challenged the power of the organization but as one who is sick, ill, morally suspect, criminal, or disturbed, and so must be isolated from those who are normal.
>
> (p. 104)

Mulligan's response to Hoffman's concerns about Patel also reflect this stance, as is indicated in Hoffman's testimony:

> Ms Mulligan said to me that it was - she said to me, "Why aren't I getting any complaints from anyone else? Why is it only you who's complaining?", and she suggested that it was a personality conflict between myself and Dr Patel and she gave me a book to read on how to deal with difficult people and told me to go away and read it, and told me to go and seek EAS [Employee Assistance Scheme] support, professional support, from a psychologist to learn how to deal with difficult people.
>
> (QPHCI 2005 BHCI Transcript Day 2, p.131)

Foucault's disciplinary power operates by increasing the calculability[209] of individuals, and this increase occurs under increased hierarchical observation (Clegg, 1994; Kelemen, 2002). The disciplinary action that followed the increased level of scrutiny (hierarchical observation) at both the BBH and MHS varied from reprimand, isolation and performance review, to more the extreme measures which occurred at MHS to Quinn and Owen, and resulted in suspension and escorted removal from the hospital premises.

The treatment and discipline imposed upon the BBH and MHS nurses who became the focus of hierarchical observation is not unique to the events related here. Various levels of disciplinary action have been recounted by

[209] Foucault (1977) used the term 'calculable man', (Kelemen (2002) and Clegg (1994) use 'calculability'), when referring to the measurement and accumulation, collecting data about the individual so that it is easier 'classify, to form categories, to determine averages, to fix norms' (1977, p. 190).

employees and managers in whistleblowing research more broadly. The tendency to focus on the person reporting the wrongdoing rather than upon the important message disclosed has been borne out in the Australian *Whistling While They Work* research (Annakin, 2011), where managers admitted to making 'assumptions that staff who have something to say are trouble makers instead of interested and concerned employees' (p. 243) or that

> the person who's reported the wrong doing is seen as the person who's caused the problem. Like if they've just been quiet about it and left it be, everything would have been alright... it's almost like we're putting them up for trial.
>
> (p. 243)

And that

> There is a tendency to be defensive, protective and secretive. The organisation is not open and is concerned that its image may be tarnished. The organisation is concerned about adverse media or political reaction. There is a tendency to protect those who [have had] allegations are made against [them] and ostracise (through "shunning") the individuals who report wrongdoing. Those reporting wrongdoing are portrayed as difficult and malcontents.
>
> (p. 242)

The network of hierarchical observation and discipline that follows the internal reporting of wrongdoing or misconduct has been recognised in other research as well, but is most often classified in terms of retribution or bullying (Adams, 2002; Andersen, 1990; Black, 2011; Griffin, 2005; Hutchinson, Vickers, Wilkes, & Jackson, 2009; Jackson, Peters, Andrew, Edenborough, Halcomb, Luck, Salamonson, Weaver*, et al.*, 2010). Past personal experiences of, or the witnessing of others being subjected to, workplace retaliation following disclosures of wrongdoing, have been found to be a statistically significant factor contributing to a lack of reporting (Black, 2011). For example

Hutchinson *et al.*'s (2009) study, examining the experiences of emergency department nurses in a major public hospital, found bullying behaviour could be viewed as a form of 'discipline' for expressing dissent regarding patient safety. They report the experiences of some of their nurse respondents and note that:

> Working in an environment where there was continued censorship apprehension was expressed by respondents that, raising concerns, rather than being seen as a legitimate attempt to right a wrong that was within the organization's power to rectify, they themselves would, instead, be framed as the problem. Speaking of this concern, it was recounted 'you knew your job was gone if you spoke out' […] Confirming how silence was enforced in her work unit, [participant] Linda spoke of continued censorship and cover-up of misconduct. She recalled how a colleague in a position of authority targeted for dismissal an employee who had raised concerns about clinical errors and patient safety: 'the nurse who did nothing but identified the mistake was crucified. She lost her job because of that'.
>
> (p. 218)

Similarly Jackson *et al.* (2010), who interviewed 11 nurse whistleblowers, found that the participants reported co-worker hostility, bullying and a loss of trust as a result of reporting their concerns.

Retribution in the form of increased scrutiny and discipline has also been found in other organisational settings. Andrade (2011) and Alford (2001), for example, found increased psychological stress levels in employees subjected to unworkable performance targets and also denied the resources to achieve them. Armed with the resultant inevitable poor performance data, these organisations were able to claim vindication by the subsequent resignation or dismissal of these harassed employees (Andrade, 2011, p. 29).

Increased hierarchical observation and associated disciplinary actions are also evident in the nurse whistleblowing background outlined in Chapter Two.

Whistleblower Kevin Moylan reflected that once he had reported 'poor quality work practices', instead of being commended for his advocacy role he was 'isolated and intimidated into silence' (Armstrong, 2002, p. 19). The historical whistleblowing cases, such as that of Nurse Laura Goodley from the London Hospital in 1909 and Mrs Edwards Superintendent at the Victorian Infant Asylum and Foundling Institute 1906 also share these themes. Upon presentation of her anonymous letter, Nurse Goodley faced the real threat of an investigation by the very surgeon/anaesthetist she was reporting, while Mrs Edwards lamented that 'that instead of investigating the cases properly they were putting me on my defence' (*The Age,* 1906, p.110 in Lemin, 1999, p. 205).

Being the focus of an investigation, being subjected to increased hierarchical observation and then being disciplined, was not the systematic response that the nurses at either BBH or MHS had expected. As discussed previously, the action that they expected was investigation into the performance of the specific practitioner at the centre of their formal complaint and, perhaps, ultimately, his or her censure. What they failed to see was that an increase in hierarchical observation would be levelled at them.

That the nurses were discredited is consistent with Gobert and Punch's (2000) observation that when whistleblowers upset the status quo 'they often find themselves facing an all-out effort by their employers to discredit them' (p. 34). Vinten (1994) underscores this observation , noting that 'the path of the whistleblower will never be an easy one' (p. 258). Once on the path, nurses can

find that they themselves are under increased scrutiny, possibly becoming the focus of the investigation (Andersen, 1990; Vinten, 1994).

The BBH and MHS managers were able to be very resourceful in their attempts to discredit the nurse whistleblowers. One response was to repeatedly accuse the nurses of being guilty of violating the organisations' and their own professional codes of conduct, specifically that they had breached confidentiality. The strict mandate to maintain confidentiality was a demand embedded in the hegemonic formalisations of power relations that existed within the healthcare services establishment. The demand to maintain confidentiality, however, was not to defend the patients these organisations were charged to serve and protect, but rather, to silence those who would advocate for the patients' rights and wellbeing.

8.3.5 Confidentiality

The notion that nurses should be silent in the face of unscrupulous medical practice can be traced throughout the history of nursing and the imposed 'virtues' of silence, obedience, loyalty and duty to the physician. When looking back at the discourse surrounding the development of hospitals and the nurses working within them it is apparent that the nurses 'duty to obey',[210] to be silent (confidentiality) and to stoically endure institutional subordination constructed by the medical men was deeply entrenched. Historical social orders and divisions of labour in the hospital were reinforced by the requirement of professional etiquette within the hospital that had obedience and silence as its

[210] The construction of the nurses 'duty to obey' is well articulated in chapter 5 of Johnstone's (1994) work, *Nursing and the injustices of the law*.

cornerstones (Berghs & Gastmans, 2006; Johnstone, 1994). Most nurses became accustomed to their position within this social order, which resulted in the chastisement and even the self-regulation of nurses who dared challenge the positions of dominance assumed by male hospital superintendents and by physicians themselves (Johnstone, 1994).

Evidence of the medical and nursing discourse extolling religious and Victorian virtues of silence, obedience, loyalty, and duty can be readily located in early nursing and medical literature. That a Dr Jacobson could successfully publish the following personal manifesto about the obligations and duties of the trained nurse in *Una* the journal of the Victorian Trained Nurses Association c.1905, is testament to the demeaning and patronising nature of such edicts.

> The nurse is the helpmeet of the doctor. Your [*sic*] art has become the right arm of medicine. Much is entrusted to you, and much depends on its skilful and conscientious performance. The nurse is further enjoyed to take upon her the obligation of *confidentiality*, that duty in the fullest sense is to meet fully the obligations resting upon you, and it is unnecessary for me to remind you of your obligations to the medical attendant. You are to be loyal to him, You are not to question his instructions… Your responsibility ends with the carrying out to the letter what the medical attendant has required of you. The nurse who antagonises the physician soon learns that her period of usefulness will be brief.
>
> (Jacobson, 1905 p. 171 in Lemin, 1999, p. 95, emphasis added)

As Johnstone (1994) observed, the nature and outcome of medical interventions were to be kept 'strictly private' (p. 135) by the nurse. The silence in front of patients, patient relatives and the public, was designed to ensure unimpeachable confidence in the doctor's omniscient position in the doctor-patient relationship, as well as to establish and maintain protection from scrutiny. Discussing the competence of the doctor with others (including and

especially the patient) was seen as one of the most serious breaches of loyalty and resulted in severe censure.[211]

These Victorian virtues, once imposed by a patriarchal society and perpetuated and compounded by the patriarchal hospital system, have largely disappeared from contemporary nursing language. However, nurses who speak out, reporting misconduct in efforts to advocate for their patients, continue to face considerable challenges.

The historical origins of nurse powerlessness to speak out and breach confidentiality when they witness and report wrongdoing, have been shown to be linked to the development of the patriarchal medical hierarchies within hospitals and to the Victorian virtues of expected silence, obedience and loyalty on the part of women (Johnstone, 1994).

As a reflection of changing times, more recent considerations of confidentiality have been understood as a desire by health professionals generally to protect patient rights to privacy with respect to their personal and health/medical records and treatments (Hunt, 1995). Central to this desire has been a perceived need to increase the level of trust resident in the therapeutic relationship between health professionals and their patients (Johnstone, 2009, in press; Neitzke, 2007). It is this ethical principle of confidentiality that nurses recognise and accept in the context of their own professional ethics and which is communicated via their professional codes of practice (McMahon, 2006). For example, the Nursing and Midwifery Board of Australia[212] (2008b) *Code of*

[211] See for example the treatment and dismissal of Frances Gillam Holden, the Lady Superintendent of The Children's Hospital in Glebe in 1887 in Chapter 2.

[212] Formally Australian Nursing and Midwifery Council *Code of Professional Conduct for Nurses in Australia* (ANMC 2008). Rebranded by NMBA in 2013

Professional Conduct for Nurses in Australia, requires that 'Nurses treat personal information obtained in a professional capacity as private and confidential' (p. 1).

The more recent development of the legal concept of confidentiality as it is applied to healthcare providers can be found in the health-related legislation. So, in the *Queensland Health Services Act 1991 Part 7 Division 2 Confidentiality 62A*, a clear statement outlines staff obligations regarding confidentiality, such that:

> (1) A designated person or former designated person must not disclose to another person, whether directly or indirectly, any information (confidential information) acquired because of being a designated person if a person who is receiving or has received a public sector health service could be identified from the confidential information.
>
> Maximum penalty—50 penalty units.

The justification provided by Queensland Health (2012) in their guidelines to support the *Health Services Act 1991* and the concomitant need for confidentiality, are very similar to those underlying ethical principles just mentioned:

> If the trust of members of the community in the confidentiality of records held by these services is eroded they will be unlikely to participate openly and willingly in their healthcare. If they are not open and honest with the various health professionals who care for them this may adversely affect the ability of these professionals to correctly diagnose and care for the individuals themselves. This will negatively impact on the continued integrity of the health system.

However, at BBH and, more broadly, within Queensland Health, the perception of some staff was that their obligation to maintain confidentiality was primarily concerned not with the ethical principle of protecting the patient in the context of a professional code, but rather was principally intended to

protect the organisation from unwanted disclosures. Central to the concept of confidentiality in this instance were the ability to control the release of any sensitive information (Ellenchild, 2000). The *Code of Conduct* and the requirement for patient confidentiality was misused to intimidate Queensland Health staff and to control the flow of information that would otherwise be considered in the public interest (Forster, 2005).

Dr David Molloy, from the Queensland branch of the Australian Medical Association (AMA), testified to the QPHCI that on the 'large number of occasions' doctors had 'been threatened under the code for drawing interest [to] matters of public health to the public's attention':

> Queensland Health has put most forcefully to me on a number of occasions when I have advanced that view that – that they are a corporation, that in the private sector MIM [Mount Isa Mines] would immediately, or [other corporations such as] AXA or BHP would immediately sack an employee who went public and complained about management fiddling the books, or, you know, safety conditions at one of their plants, and they expect the same standard of behaviour of their employees in terms of protecting the reputation of the organisation as would perhaps be evinced by private sector companies.
>
> (QPHCI 2005 BHCI Transcript Day 8 pp.853-4)

District Manager Leck used the *Queensland Health Code of Conduct* to intimidate nursing staff in a meeting called after the Hoffman letter was tabled in Parliament. As Nurse Pollock testified:

> Basically he sited [sic] the Code of Conduct and confidentiality, you know, in speaking to the media, that the person responsible would be severely reprimanded. I took that to mean that that person would lose their job.
>
> (QPHCI 2005 BHCI Transcript Day 11, p. 1174)

Many Queensland Health staff expressed the opinion at the BHCI and in The Forster Review[213] that the *Code of Conduct* and the issue of confidentiality were abused by these actions (Davies, 2005; Forster, 2005). Commissioner Morris, when questioning Chief Health Officer Fitzgerald commented:

> Doctor, on this subject, we've heard a lot of concern from clinicians, both nurses and doctors, about what is referred to as the Code of Conduct - or as some of them affectionately know it, the Code of Silence - and there is a perception, rightly or wrongly, amongst people at the coalface of the medical system that that is used as a bludgeon to prevent them raising concerns with, for example, members of parliament, or indeed the media…
>
> (QPHCI 2005 BHCI Transcript Day 30, p. 3232)

The use of confidentiality as a mechanism to silence staff and deter them from speaking out about their concerns is not unique to the BBH case. During the Cartwright Cervical Cancer Inquiry (1988) in New Zealand, Superintendent in chief Dr Leslie Honeyman similarly directed Dr Gabrielle Collison the Superintendent of the National Women's Hospital,[214] to send a memo

> to all staff saying that because of 'the forthcoming Cartwright Inquiry' she was drawing their attention to the section of the Hospitals Act concerning patient confidentiality 'to remind you that it is an offence to disclose to any person any information concerning the condition or medical history of any patient.
>
> (Coney, 1988, p. 224)

The New Zealand Nurses Association indicated at the time that the Collison Memo was interpreted by its members 'as an instruction NOT to cooperate with the inquiry' (Coney, 1988, p. 224, emphasis in original).

Hunt and Shailer's (1995) pilot survey of 30 whistleblowing healthcare professionals (19 of whom were nurses) from the UK's National Health Service

[213] Examined in Chapter 7.15.1 The Forster Queensland Health Systems Reiew

[214] Known as the 'unfortunate experiment' the Cartwright inquiry examined the allegations concerning the treatment of cervical cancer at National Women's Hospital New Zealand (Coney, 1988, p. 9).

(NHS) found similar themes. The participants reported counter-complaints and disciplinary action for unprofessional conduct due to their 'not complying with management instructions', their 'breaching confidentiality' and their having 'damaged the reputation' of the health service (p. 10). Sixteen of the participants were sacked or resigned. Hunt (1995) concludes that in those incidents in which a breach of confidentiality was used to expel the whistleblower from the NHS, the underlying cause was

> a confusion of confidentiality taken from professional ethics, with the purpose of protecting patients and respecting autonomy, with commercial confidentiality and trade secrecy taken from the context of business, with the purpose of protecting competitiveness and profits.
>
> (p. xxii)

Jackson *et al.* (2011) also identify the abuse of the ethical principle of confidentiality and its employment as a punitive measure in the context of nurse whistleblowing. These researchers interviewed 18 Australian nurses, 11 of whom shared experiences as whistleblowers. Four nurses had been witnesses to a whistleblowing event and four had been the subjects of a whistleblowing complaint. The researcher's work demonstrated that confusion existed surrounding the principle of confidentiality, with participants indicating it was more often used to shield the organisations for which they worked against a loss of reputation than to protect their rights as staff or to defend the rights of the patients who had suffered injury as a result of substandard practice (Jackson *et al.*, 2011).

The examples above highlight cases where 'confidentiality no longer serves the purpose for which it was intended' and instead becomes 'a means for deflecting legitimate public attention' (Bok, 1983, p. 30). Executives such as

Leck at BBH and Collison in the Cartwright Cancer case outlined above, show, in their actions, that they were concerned less with the confidentiality of a patient's personal medical records and more with secrecy and the protection of an organisation's reputation. One explanation for this apparent contradiction in applying the principles of confidentiality can be found in Bok's (1983) work. She suggests that on occasion executives can 'transpose the confidentiality owed to individuals to the collective level' (p. 30) as a means to shield the existence of illegitimate activities that have the potential to endanger others (Bok, 1983, 1984).[215]

Evidence of misuse of the principle of confidentiality are to be found in Patel's threat to take legal action against Queensland Health,[216] as well as Leck's email to Zonal Manager Bergin about sending 'a strong message to the person(s) concerned that they are on very dangerous ground' and inviting 'the Audit team [to] come up and deliver some training sessions around the *Code of Conduct* and deliver some firm and scary messages' (QPHCI 2005 Exhibit 447). This represents a transgression of the moral purpose of confidentiality in healthcare – a principle intended to protect patients – and its transposition to an aggressive course of action designed to threaten and subdue dissenters. The very language in which the 'message' is couched, with its emphasis on

[215] The example used here by Bok (1983) is the invocation of collective confidentiality by medical staff at asbestos companies in the US, when they were actively blocking the release of employee patient data in an attempt to conceal the medical complications that resulted from asbestos dust. 'When a reporter approached a physician associated with the concealment as consultant for a large manufacturer, the physician turned down his request for an interview on grounds of confidentiality owed as a matter of "the patient's rights," and explained, when the astonished reporter inquired who the "patient" was, that it was the company' (p. 30).

[216] 'To take legal action against a variety of staff as well as Q[ueensland] Health for failing to stop the leak of confidential material and for not providing [him with] definitive support in relation to all allegations' (QPHCI 2005 Exhibit 475).

'scaring' the nurses regarding the 'dangers' they faced suggests the inherent hostility in these actions.

The disclosure of confidential patient information by the nurses at MHS was also a subject of concern to the Executive of MHS, who were clearly unhappy with the fact that while on leave from the hospital the nurses were supplying patient data to the HCCC investigators. This was summarised by HCCC Commissioner Adrian who, when questioned in the SCICCH, indicated that in conversations she had had with 'the area health service, there were some very significant threats being thrown around by the area health service about them [the whistleblowing nurses] having information that they were not entitled to have'(Walker, 2004f, p. 432).

This response, like that from the Executive at BBH and from Queensland Health, can be associated with a desire to control any information that may be placed in the public domain. Misapplication of the duty of confidentiality in this way is a process that transforms the ethical intent of the principle into a powerful offensive force for dissuading health professionals from making any disclosures or releasing any sensitive information outside the organisation.

Queensland Health (2012) outlines the requirements to which staff must adhere in relation to the *Health Services Act 1991.* If a member of staff from Queensland Health wanted to disclose confidential information (for example the Hoffman letter or documents of a similar nature identifying misconduct or illegal action that exposed patients to increased risk), it is incumbent on them to first apply in writing to the Director-General of Queensland Health. To do so they must address the following criteria:

- what confidential information is proposed to be disclosed (including verification that the information is subject to the duty of confidentiality in Part 7)
- to whom it is proposed to disclose the confidential information, and how it is envisaged that the confidential information will be used
- the public interest arguments in favour of disclosure
- the public interest arguments in favour of maintaining confidentiality
- how the public interest arguments balance or outweigh each other
- who it is proposed should disclose the confidential information (i.e. the Director-General or a person authorised by the Director-General) and how it is proposed to disclose the confidential information
- how it is proposed to communicate to the recipient the scope and elements of any obligation of confidence that may be imposed or required in relation to the information being disclosed; for example, obtaining undertaking/s from the recipient
- any other relevant information; for example, whether there is any urgency attached to the disclosure.

Additionally:

> Attached to the brief should be an "Authority for Public Interest Disclosure" form. This form must be completed and submitted for the Director-General's signature. The form should identify the relevant Queensland Health staff member(s) by name or by position; describe the confidential information to be disclosed (information that is capable of identifying an individual should not be included in the description of information to be disclosed); note the intended recipient(s) of the information, and set out the duration of the authority.
>
> (Queensland Health, 2012, p. 10)

The Director-General will then consider if the written brief advances a strong enough case to ensure that disclosure in the public interest is stronger than any argument that would favour confidentiality. These inbuilt organisational requirements can be viewed as an attempt to powerfully filter and control the release of any embarrassing information.

One model that attempts to explain the power of filters that are used to control the release of information in the public interest can be found in Herman

and Chomsky's (2006; 1988) Propaganda Model (PM). Used to explain media behaviour and performance the five filters from the PM include:

> (1) the size, concentrated ownership, owner wealth, and profit orientation of the dominant mass-media firms;
> (2) advertising as the primary income source of the mass media;
> (3) the reliance of the media on information provided by government, business, and "experts" funded and approved the size by these primary sources and agents of power;
> (4) "flak" as a means of disciplining the media; and
> (5) "anticommunism" as a national religion and control mechanism.
>
> (Herman & Chomsky, 2006, pp. 257-258)

The filtering constraints applied to the system described in the PM above are not directly congruent with the phenomena of information power used in hospitals; however, there are similarities that make the description of filtering a noteworthy analogy.[217] The PM advances the notion that filters are part of the structure of any hegemonic system in order to protect the elite and powerful: those in authority (Klaehn, 2002). Information that is released, in this case to the public domain, must first pass through a number of filters leaving what Herman and Chomsky (2006) describe as a 'residue fit to print' (p. 257).

The guidelines related to confidentiality outlined by Queensland Health can be seen as an attempt to 'fix the premises of discourse and interpretation' (Herman & Chomsky, 2006, p. 258). In this case, by outlining what information can be shared, with whom it can be shared, and when those in power should vet it. In this context such operations towards secrecy and control can be seen as, in

[217] The use of the phrase 'public interest' provides a point of entry here. Much historical debate has taken place regarding the meaning of this term (Ho, 2012). Conflict ensues from the sometimes incommensurability of matters that may be seen to impact upon the well-being of the general public (in the public interest) with those that merely appeal to or assuage the curiosity of the general populace (interesting to the public) (Bentley, 1999; Harding, 2012). It is towards the latter formulation that the filtering of information seems to be addressed in the organisational controls noted here, while the former is ignored in order to maintain and protect both the reputation and hegemonic structure of the organisation.

effect, propaganda campaigns. For Bok (1984), confidentiality used in this way becomes more akin to secrecy.

From the examples provided in this chapter, the BBH and MHS cases display intentional and manipulative movement of the ethical principle of confidentiality from its original objective of protecting and promoting interpersonal relationships and trust between health professionals and their patients, to one that protects the organisation. For health professionals who feel the need to disclose confidential patient information that has been collected to advance cases of wrongdoing by either a health service or individuals within it, there does however exist a juridical option that offers some protection in the form of public interest disclosure or whistleblowing legislation. It is imperative, though, that nurses are aware of the limits of this protection and understand the reporting processes that must first be exhausted within their organisation in order to ensure that their claim for protection is a valid one. A lack of awareness of this protection may explain why so few of the nurse whistleblowers applied for protection at MHS and BBH. This issue is examined later in this chapter.

8.4 Fay's Theories of education and of transformative action

The application of Fay's Theories of education and of transformative action provide a robust theoretical frame from which to examine and explain the events which this thesis has investigated. Fay's Theories in this study have revealed the false consciousness of the key nurse informants in the face of institutional power, and the manner in which external conditions contributed to instances of injustice in the workplace. Fay's Theories of education and

transformative action now require further consideration in relation to key aspects of an organisational culture[218] that must be altered in order to avert a future crisis in clinical governance (social crisis), and to lessen the dissatisfaction of members hospital staff and particularly nurses (Fay, 1987). Transformative action also requires consideration of a detailed plan of action that includes identifying those responsible to be the 'carriers' of any anticipated social transformation (Fay, 1987, p. 31).

The processes that contributed to these failures and triggered the whistleblowing crises included both systemic and human factors.[219] Reason's Swiss cheese model of system failure, as discussed previously in Chapter Five, provides a frame to explore the flaws in MHS and BBH systems.

The BBH and MHS cases both exemplify failures in clinical governance. These failures serve to highlight the genuine complexity of healthcare organisations and forcibly remind us that a healthcare organisations is

> run by humans for humans and that like other human organisations, it includes people, even in senior positions (perhaps especially in senior positions), who are irrational, ill informed, self-deceiving and easily seduced by power, high salaries and prestige.
>
> (Larizgoitia, Bouesseau, & Kelley, 2013, p. 842)

Any transformation of healthcare organisations must focus on those human factors influencing, not just clinicians, but also managers and leaders who receive reports of failure in their organisation.

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[218] Fay refers to aspects of society, however given that the healthcare organisation is the social sphere where the whistleblowing crisis occurred it is appropriate to look at aspects of the healthcare organisational culture that warrant change.

[219] The UK's industrial safety regulatory body, the Health and Safety Executive (HSE), provides the definition of human factors accepted by the World Health Organisation: those 'environmental, organizational and job factors, and human and individual characteristics which influence behavior at work in a way which can affect health and safety' (Ramanujam & Rousseau, 2006, p. 5).

8.4.1 Application of Reason's Swiss cheese model of system failure

While defence systems should be impermeable, what was evident in the MHS and BBH cases was that they were weakened by active failures and latent conditions (Reason, 2000b, p. 769). A key latent condition observable in the BBH case comes with Queensland Health's allocation of elective surgery budgets that were strategically focused on meeting unrealistic target numbers (Davies, 2005). Additionally, a policy requiring specialist registration for Area of Need[220] positions was undermined by the absence of credentialing and privileging processes. Had these conditions been in place, Patel's capacity to meet the requirements for the Director of Surgery position may have been reviewed, Patel's application for the position rejected and the position readvertised (Davies, 2005). These latent conditions, when aligned with the active failure of the Director of Medical Services at BBH to countenance criticism of Patel, and with the Medical Board of Queensland's failure to check for missing attachments in Patel's 'Verification of Licensure', constituted a cumulative weakness in the system's defence barriers.

Key latent conditions may also manifest in the form of an organisation's policies and procedures that are strategically designed and relied upon to strengthen the defence system against errors, accidents and adverse events that harm patients. Because of their inevitable alignment with human factors, the formulation of such procedures can be subject to limitations. For example, should no policies for specific conditions exist, practitioners may make them up as they proceed – and may do so badly. Alternatively, sometimes such policies

[220] See footnote 108 in Chapter 7

do exist, but are not followed correctly, or are followed to the letter despite the fact that they no longer fit their original purpose.

8.4.2 Policies and procedures – key latent conditions

The MHS case exemplifies circumstances in which no policies or procedures existed to guide staff, thus creating 'gaps' that enabled poor decision-making. For example, Campbelltown ICU Nurse Bragg was pro-active in highlighting the deteriorating condition of Mrs Flegg, a near-term pregnant women suffering from acute respiratory distress. Yet, a lack of policy regarding when, or even whether to activate the care flight ambulance transport, allowed an obstetrician to override a decision made by the ICU staff to evacuate the patient by air. Instead, Mrs Flegg was transferred by road ambulance from Campbelltown Hospital to Liverpool Hospital, thirty kilometres away.

Similarly, a lack of policy directing the provision of adequate medical coverage in the Emergency Department after-hours resulted in patients being prematurely discharged (HCCC, 2003; NSW Parliament, 2004f; Walker, 2004a). Nurses attempted to effect remedial action and to have a policy and/or procedure created to address the situation by reporting their concerns to the relevant authorities within the organisation. By so doing, the nurses expected that the Critical Care Review Committee would investigate their concerns about the system's lack of safeguards.

In other instances, policies and procedures had been instituted to safeguard patient safety, yet, in both the MHS and BBH cases, patients were, or had the potential to be, harmed, when practitioners within those organisations ignored them.

In the BBH case, the College of Intensive Care Physicians' classification system informed the admission policy regarding the types of surgery that should and should not be undertaken in a hospital with a Level One ICU. The ICU at BBH was under-staffed and ill equipped to facilitate the recovery of patients who had undergone complex surgery and required ventilation for more than 48 hours (QPHCI 2005 Exhibit 4). Nevertheless, the admission policy was ignored by Patel and the BBH Executive, with the result that complex surgical procedures continued to be undertaken for a further two years after the first death, despite concerns being raised. It took intervention by the Chief Health Officer of Queensland Health Fitzgerald to ensure that no further complex surgical procedures would be conducted (QPHCI 2005 Exhibit 225, par 65). Inadequate procedural requirements meant that Patel was even able to ignore the policy requiring that all post-operative deaths be reported to the Coroner for investigation. For example Mr Kemp's death, post-oesophagectomy, should have been reported, but was not.

Procedural violations formed the basis of the majority of concerns raised by nurses about Patel: by Hoffman (ICU nurse), by Aylmer and Jenkins (infection control and surgical nurses), by Pollock and Druce (renal nurses) and, later, by Zwolak, Gaddes and Law (perioperative nurses). Patel and each of the hospital's Executives ignored these concerns. At BBH, Director of Medical Services Keating ignored Queensland Health's policy requiring the reporting and investigation of serious patient adverse incidents as Sentinel Events (QPHCI Exhibit 448, Davies, 2005). At MHS, the requirement to assess the possibility for malignant hypothermia prior to proceeding with paediatric

surgery was clear, but was nonetheless disputed. A subsequent investigation failed to resolve this dispute and censure the anaesthetist who failed to comply with the requirement.

The generation of internal reports that reflect policy or procedural violations, or that hold additional material identifying the need to initiate new policies, is a warning sign that a defence system designed to avert errors and mitigate their effects has been weakened. Even when a good clinical governance system requiring sound and evidence-based policies are in place, human factors can still undermine it. For example, if the defence mechanisms incorporated within a policy or procedure are overridden or ignored, reports made by health professionals within the organisation will be to no avail. The two cases examined in this thesis detail what can can occur when those responsible for dealing with reports of policy violation, or with the need to review or create new policy, are unresponsive.

The lack of response by the authorities at MHS and at BBH was an outcome of an underdeveloped/under-resourced clinical governance system, particularly in those very areas charged with investigating and providing feedback to submitted complaints and risk/error reports. This lack of response was amplified by priority being placed on corporate governance: privileging the economic viability and financial efficiency of healthcare provision over and above the assumed priority of ensuring effective and safe clinical outcomes. When viewed alongside the numerous instances of managers failing to acknowledge the issues, these warning signs should have been apparent to those in charge.

8.4.3 Human factors in clinical governance

The impact of human factors on the causes of preventable risk and error at the clinical coalface are well recognised. However, little has been done to examine their specific bearing on the behaviour of managers and executives who receive complaints and incident reports. Such an examination is likely to uncover what Walshe and Shortell (2004) have described as 'self-deception and post hoc rationalisation in the face of unwelcome information' (p. 107) as well as what has been described by this study as 'wilful blindness' (Heffernan, 2011, p. 2).

The pervasiveness and influence of human factors throughout any governance system requires the development of mechanisms that recognise situations in which the unresponsiveness of managers or healthcare leaders may place patient safety at risk. Clinical incident reporting is usually the first such strategy used by health professionals to report adverse events and error (Wolff & Taylor, 2009).

Despite the clear advantages in terms of ease of reporting facilitated by new computer-based programs (previously identified in Chapter Five), voluntary reporting on its own continues to be seen as inadequate, particularly when staff remain reluctant to report, or when the data available lacks the specificities to generate accurate analysis for informing measures to improve processes (Anderson *et al.*, 2013; Schneewind, 2001; Shojania, 2008, 2010; Thomas *et al.*, 2011). Moreover, comparisons made between the reporting rates of health professionals continue to find that it is nurses who report more frequently or are more willing to report using incident reporting systems (Bagenal, Sahnan, & Shantikumar, 2014; Evans *et al.*, 2006; Pfeiffer, Manser,

& Wehner, 2010; Pfeiffer, Briner, Wehner, & Manser, 2013). Reasons for this are speculative. Some suggest that nurses are more aware of the system than doctors, and are more motivated to report issues; others suggest that doctors place less value on reporting or have greater concerns about being blamed (Bagenal *et al.*, 2014; Evans *et al.*, 2006; Pfeiffer *et al.*, 2013).

Other recent research into staff perceptions of incident reporting reveals a more positive response to actual reporting, but concerns remain about its efficacy in changing practice (Anderson *et al.*, 2013; Bagenal *et al.*, 2014). Anderson *et al.*'s (2013) study into staff perceptions of voluntary incident reporting at two large teaching hospitals in the UK found that staff expressed positive feedback and acceptance that incident reporting was useful for increasing an awareness of risk. Even so, reporting often failed to produce effective changes in systems. Staff indicated that recommendations were often of poor quality or were too numerous and complex to implement. This occurred because the clinicians charged with implementing change were not often consulted in the process to ensure the 'feasibility and potential benefits of recommended solutions' (p. 4).

Extracting realistic recommendations from incident reports remains an onerous challenge, especially when the reports are completed by healthcare staff who may have only a partial understanding of the event, or who complete the report using a narrative style not suited to a comprehensive analysis of the event (Larizgoitia *et al.*, 2013).

A further concern regarding current incident reporting systems is the suggestion that they do not capture what Banja (2010) refers to as acts of

'normalised deviance' (p.139). Normalised deviance occurs when health professionals consistently and brazenly disregard established rules and standards of care, which then become condoned or 'normalised practice patterns' (Banja, 2010, p. 140). One seemingly innocuous example provided by Banja is the poor penmanship of medical staff. In circumstances under which nurses confront the author of an illegible order or report and experience a negative response, they become reluctant to speak up again. Instead, they resort to assembling other nurses and collectively attempt to decipher the illegible handwriting rather than report the incident as a breach of patient safety protocols. Banja refers to the work of Maxfield, Grenny, McMillan, Patterson, and Switzler's (2006) which found that less than 10 percent of healthcare staff [221] who witnessed 'broken rules, mistakes, lack of support, incompetence, poor teamwork, disrespect, and micromanagement' (p. 3) raised the matters with the offending co-worker. Fear of retaliation, a lack of confidence to speak up and a belief that speaking up will not result in any change, all contribute to the normalisation of deviant behaviour (Driver, Katz, Trupin, & Wachter, 2013).

Banja (2010)suggests that normalised deviance will continue to occur in healthcare organisations when reports of systemic flaws or problematic behaviours are revised and diluted by those in the chain of command. In an examination of the culture and behaviour of the UK's National Health

[221] 1,700 healthcare staff surveyed (1,143 nurses, 106 doctors, 266 clinical care staff, 175 administrators) surveyed (Maxfield *et al.*, 2006, p. 3). Ten percent of healthcare workers who were able to raise their concerns report better patient outcomes, greater satisfaction at work and less desire to leave.

Service,[222] Dixon-Woods, *et al.* (2014) found that across the NHS considerable time and resources had been invested in data collection and monitoring systems. Nonetheless, the degree to which the data collected were 'translated into actionable knowledge, and then into effective organisational responses' (p. 110) relied on the particular human responses of management and executive. Dixon-Woods *et al* (2014) differentiated senior management's responses into 'problem-sensing' or 'comfort-seeking' behaviours (p. 111). The former occurred when senior managers actively sought out weaknesses in their organisations, using not only the formal incident reporting systems, but also 'softer intelligence' (p.111).

Dixon-Woods *et al* (2014) identify the notion of 'softer intelligence' to include actively listening to staff and patients, making 'unannounced visits to clinical areas', role swapping and having consumers engage in the services in a manner similar to the 'mystery shopper' technique used in the retail industry (p. 111). Dixon-Woods *et al* (2014) noted that those who used problem-sensing tended not to focus on blaming and sanctioning the clinicians involved in patient care as their main mechanism to promote change. On the other hand, when management demonstrated 'comfort-seeking behaviour', they sought data from a limited range of sources, were pre-occupied with compliance, external expectations and positive news, in order to actively receive 'reassurance that all was well' (p. 111). They also tended to distance themselves from frontline staff

[222] Dixon-Woods *et al.*'s (2014) large mixed method research program involved seven sub studies which included data from 107 interviews with senior level stakeholders involved in quality and safety, 197 interviews with executive, board members and frontline clinicians, 715 surveys, two focus groups and 10 interviews with patients and the public, patient and staff satisfaction survey data from 2005-2011 and 621 clinical teams assessed using Aston Team Performance Inventory.

and perceived concerns raised or critical comments merely as 'whining or disruptive behaviour' (Dixon-Woods *et al.*, 2014, p. 111)

The behaviour of senior managers exemplified in Dixon-Woods *et al.*'s (2014) study reinforces a key conclusion of this study: that in order to improve patient safety the focus must move beyond reporting systems and turn instead to examination of the human factors underlying the responses of managers and leaders who receive the reports of failure in their organisation. Although voluntary reporting systems have documented shortcomings and researchers have called for other forms of data to strengthen intelligence, little research has been undertaken on the human factors associated with senior managers who face the 'uncomfortable reality' of 'structural and cultural threats to patient safety' (Dixon-Woods *et al.*, 2014, p. 113; Larizgoitia *et al.*, 2013).

Dixon-Woods *et al.*'s (2014) recommendation that senior managers demonstrate problem-seeking behaviours, resonates with Heffernan's (2011) suggestion that mitigation of the conditions that contribute to wilful blindness can be achieved by those who 'actively seek disconfirmation' (p. 224).[223] Further research and investigation is required to explore why some healthcare managers distance themselves from frontline staff who raise concerns about patient safety or who are critical about the organisation's status quo. Healthcare staff speaking up can represent the very disconfirmation sought by healthcare managers to assist their determination of what is really occurring in an organisation and the search for opportunities to learn.

[223] Seeking disconfirmation is to ensure that motivated reasoning or confirmation bias is overcome (see earlier section 8.3.3.1 in this chapter).

In the interests of patient safety healthcare organisations need to formulate pro-active interdisciplinary investigative teams that include members who see 'provocation as one of their essential roles' (Heffernan, 2011, p. 225). This would allay the unwelcome evolution of 'group think'[224] and stifle the development of dangerous convictions among management regarding patient safety prioritisation.

8.4.4 Rethinking no blame and accountability

Contemporary literature dealing with patient safety reflects a shift in focus from a 'no blame' paradigm towards recognition of the fact that individual, malfeasant practitioners do unfortunately exist within organisations, and that such individuals must be held personally accountable for the damage they may cause (Dekker, Nyce, & Myers, 2013; Driver *et al.*, 2013; Wachter, 2012b).

The no blame or 'blame free' approach was originally promulgated as part of the patient safety movement to promote a 'nonjudgmental recognition of the ubiquity of human and systems error' (Pettker & Funai, 2010, p. 927). It was seen as the key strategy for improving levels of reporting and for refocussing the attention of those investigating error towards system failures (Driver *et al.*, 2013; O'Connor *et al.*, 2011). According to Watcher and Pronovost (2010), the early adoption of the no blame approach has enabled the successful application of myriad system-wide initiatives to reduce adverse incidents in healthcare. However, the ineffectiveness of getting recalcitrant individual practitioners to abide by clear evidence-based safety guidelines (such

[224] A term coined by social psychologist Irving Janis (2012b) that describes the pattern of thinking that occurs when individuals in a group desire harmony thus minimising conflict in order to reach a consensus decision. This occurs without critical evaluation of alternative ideas or viewpoints thus leading to an inability to explore alternatives and inferior decisions.

as correct hand hygiene to reduce healthcare related infections) has resulted in a call for an even more aggressive approach to individual accountability (Wachter, 2012a, 2012b).

The tension around balancing notions of accountability and of 'no blame' when applied to healthcare error has resulted in a new conceptual paradigm, 'just culture' which distinguishes adverse clinician behaviours as constituting either:

- *human error* – inadvertent action, a slip, lapse or mistake;
- *at-risk behaviour* – e.g., taking a shortcut, but where this is a choice away from safety rules or;
- *reckless behaviour* – conscious choice, knowing that it poses a serious risk

(Marx, 2001).

The purpose of a just culture is to provide a clear distinction between acceptable and unacceptable behaviour (Reason, 2000a), while at the same time attempting to preserve 'the collegial exchange and openness that are so essential to organizational learning' (Wachter & Pronovost, 2010, p. 276). The focus of activity in this area, however, has been mostly concerned with 'caregiver's action' or in dealing with clinicians at the sharp end of patient care (Wachter, 2012b). So, when caregivers are involved in incidents entailing human error, they are consoled, and when at-risk behaviour is found to have occurred, coaching is recommended. However, when reckless behaviour is uncovered, discipline is deemed to be warranted (Wachter, 2012b).

Calls for individual accountability are currently primarily focussed on the interactions between individual clinicians, healthcare teams and patients, and have not yet extended to the behaviours of managers and executives. In light of the findings of this study, there is scope to extend the notion of individual accountability to healthcare managers, particularly those who receive voluntarily-submitted, unsolicited incident report data or evidence of the reckless behaviour of clinicians, but fail to act or investigate.

8.4.5 Retaliation and the lack of awareness of legal protections

The legal implications of whistleblowing, and the limitations of the protection provided to those who choose to whistleblow, are clear. Significantly, this is not the case for the ethical considerations. When nurses observe repeated inaction in response to their concerns and come into conflict with managers who are unresponsive to reports of substandard practice and unprofessional conduct, the decision to go outside the organisation to effect action is not an easy one to make – despite nurses' codified obligation to report. In each of the cases profiled in this study, whistleblowing was an act that was fraught with personal and professional risk. Australian and international research into nurse whistleblowers confirms this finding (Attree, 2007; Firth-Cozens *et al.*, 2003; Jackson, Peters, Andrew, Edenborough, Halcomb, Luck, Salamonson, Weaver*, et al.*, 2010; Jackson, Peters, Andrew, Edenborough, Halcomb, Luck, Salamonson, & Wilkes, 2010; McDonald & Ahern, 2000; Orbe & King, 2000; PCaW, 2008). Politics and power dynamics were constantly at play within these hospitals. Managers were reluctant to have the issues under dispute

brought to light, fearing, as they did, a loss of reputation for their hospital within the community.

Retaliation against whistleblowers has been well-recognised and well-documented in the literature (Sawyer, Johnson, & Holub, 2010). [225] By the time a whistleblower considers taking action, they are often at direct odds with their organisation and its management, who then direct their attention to the protection of the organisation's reputation. For Sawyer, Johnson and Holub (2010) the relationship is negatively correlated: the whistleblower wants to reveal the truth, while the organisation seeks to conceal it. One (albeit flawed) mechanism that can be used by whistleblowers to protect them from retaliation are public interest disclosure or whistleblowing laws.

In Chapter Five, the various state and Commonwealth laws guiding how disclosures should be made in Australia, who they should be made to and the extent to which whistleblowers can be protected, were outlined. Varying levels of protection are seen to come in the form of, for example, immunity from other legal liabilities that may present as a result of making a disclosure. This can include 'disciplinary or criminal prosecution for unauthorised disclosure of information, or civil action such as defamation', as well as ensuring that 'those who deliberately undertake detrimental action against those who make disclosures can be prosecuted' (Brown, 2006, p. 34). However, the level of protection is often tied to questionable criteria governing the body to whom a whistleblower is permitted to disclose. For example, at the time of BBH nurse Hoffman's meeting with MP Messenger, the Queensland *Whistleblowers*

[225] See also Chapter section 3.3.5 Retribution/Retaliation

Protection Act 1994 afforded no protection for disclosures to Members of Parliament (Dadic, 2009; Davies, 2005).[226] Of particular interest to this study is the fact that in neither the BBH nor the MHS cases did a nurse express awareness of the limits of public interest disclosure law. Only one nurse, Janelle Law, from the BBH Operating Theatre requested whistleblower protection prior to submitting her statement.

Any nurse who may contemplate taking the step of disclosing to entities or individuals outside their organisation, must consider the limits of the legal protections offered to them. This may require their being educated as to the appropriate persons or authorities covered by the legislation, and cognisance of the legal requirement that they exhaust every avenue internal to their organisation before attempting to raise the matter elsewhere.

Ultimately, the decision to whistleblow is a personal ethical choice that cannot be simplified, nor taken lightly. Each nurse, as an individual moral agent, must and will independently weigh up their choices as to whether or not to uphold or deviate from their codes of ethical conduct (if, in fact, they are even aware of them). This brings to the fore one of the most significant findings of this study: there is no evidence in either the BBH or MHS case to suggest that nursing's professional ethics played a role in the nurses' individual decision-making. That is, even though the NMBA (2008, p.2), *Code of Ethics* includes the 'responsibility to question and report what they consider, on reasonable grounds, to be unethical behaviour and treatment' (p. 2) including

[226] The law was amended in 2007 to include Members of Parliament. Both the Davies (2005) and Forster (2005) Inquiries recommended changes to the Queensland Whistleblowing legislation to include Members of Parliament. In 2005, the only state that afforded protection to those who disclosed to Members of Parliament was New South Wales (Dadic, 2009).

'cases of unsafe, incompetent, unethical or illegal practice' (p. 3), the nurses in this study did not, at any point, articulate that their actions were motivated in any way by a need to meet this codified professional obligation. Nor was this raised as a possible consideration in the inquiries that followed.

In King and Scudder's (2013) study, a different finding emerged. Sixty–five precent of the participant nurses (n-68) rationalised that 'a 'violation of nurses' professional ethics' motivated their intention to report wrongdoing (p. 632). While these findings are of interest, these participants were asked to reflect on observed wrongdoing in the previous 12 months and reporting was *internal* reporting not whistleblowing (King & Scudder, 2013). [227]

8.4.6 Impact of professional ethics on ethical reasoning

In lieu of any reference to an obligation to uphold professional ethics, there emerges a discourse centred on the nurses' personal deontic reactions and general expectations that those who transgressed acceptable social conduct and caused harm should and would be censured (Folger, Cropanzano, & Goldman, 2005). The findings of this study indicate that individual human reactions to perceived justice violations and the nurses' own personal values exerted more influence on their decision-making than an awareness of or obligation to professional ethics. For example, Enrolled Nurse Martin began her submission of a series of incident forms at MHS in direct response to being reprimanded for operating outside her scope of practice, particularly when her own attempts

[227] In this study nurses were asked to reflect on past episodes in the last 12 months. Additionally they were provided with a scenario derived from Norris and Ketefian's (2007) *Judgements about Nursing Decision* instrument which described human error involving a large dose of a toxic medication that resulted in a one-year old patient requiring intensive care treatment for heart failure (King & Scudder, 2013).

to address the necessity for such practice (an unreasonable skill mix and lack of available staff) were dismissed. She appears to have formed the view that in order to justify her own transgressions she had to highlight other instances of substandard clinical practice and inadequate staff or skill mix to deal with patients. The overriding influence of Martin's own personal values on her decision-making is explicit in her statement: 'If I remained silent, I'd be the kind of nurse I don't want to be' (Zimmer & Jones, 2004, p. 4).

Nurse Hoffman's final whistleblowing act of reporting her concerns regarding BBH outside of Queensland Health, suggests that an important stimulus or catalyst for such action may be a need for the internal psychological peace that comes from standing up for a personal non-negotiable principle (Lachman, 2007). Alford (2007) epitomises the personal nature of what he calls this 'choiceless choice'[228] faced by whistleblowers, with a selection of self-justificatory quotes from individuals who had undertaken the difficult path of reporting:

> I did it because I had to… because I had no other choice… because I couldn't live with myself if I hadn't done anything…because it was speak up or stroke out… what else could I do? I have to look at myself in the mirror every morning. (p. 226)

Such choiceless choice is reflected in Hoffman's recollection of her own rationale underlying her decision to inform her local Parliamentary Member. Hoffman discussed her path in an *Australian Journal of Advanced Nursing* editorial in 2005:

[228] Alford's (2007) work is based on narrative analysis of many whistleblowers.

> ‘My main concern was with the patients and potential patients. My main concern was to stop the surgeon and stop him quickly. The patients would then be safe, and the nursing staff would be relieved.’ [I] ‘agonised for months over what to do, [and] tried all of the other channels’… ‘I was very aware that by going to a member of parliament I was breaking my health department’s code of conduct. I was aware I could lose my job, I would lose favour within the system amongst the current executive and any future potential employers would view me as a liability. Some people would be hurt and alliances and friendships within my small town would be fractured.’
> She emphatically states
> **‘I had to act’.**
>
> (Jones & Hoffman, 2005, p. 5)

Noteworthy here is the fact that Hoffman does not directly refer to the nursing professions’ *Code of ethics* as justification for, or explanation of, the motivating forces behind her apparent compulsion to act. Why this is so, is a matter for speculation. She does however demonstrate an awareness that her actions would breach the Health Department’s code of conduct and of the potential negative outcome of such as breach. Nonetheless, she decided to act.

The ethical reasoning processes undertaken by nurses, and their associated actions, reactions or resultant behaviour, are complex. While attempts have been made to examine the factors that influence it, the exact elements that underlie nurses’ ethical reasoning remain elusive (Fumagalli & Priori, 2012; Goethals, Gastmans, & de Casterlé, 2010). What is known is that such reasoning is embedded in the specific context in which it occurs. Goethals *et al.*’s (2010) analysis of the literature pertaining to the ethical reasoning and behaviour of nurses, identifies various elements influencing ethical reasoning, including: personal relationships, personal values, convictions, religion, education and upbringing, as well as past personal and professional experiences. Guided by Kohlberg’s (1981) moral development theory, other

researchers (de Casterle, Izumi, Godfrey, & Denhaerynck, 2008), suggest that nurses engage in moral reasoning in a conformist manner, being 'guided by conventional workplace rules and norms, rather than using creativity' (p. 548) to reach decisions.

Much research in the area of ethical reasoning employs what Sonenshein (2007) refers to as rationalist models, where the prevailing view, often based on a theory of moral development such as Kohlberg's, is that individuals approach ethical issues with 'deliberate and extensive moral reasoning' (p. 1022). This view of the use of deliberate, directed and overt reasoning to deal with ethical issues, is now being called into question, with suggestions being made that previous assumptions had overestimated the influence of formal reasoning on ethical judgement (Johnstone & Hutchinson, 2013; Musschenga, 2009; Sonenshein, 2007).

A growing body of cognitive science research is showing that individuals rarely use deliberate reasoning when faced with ethical dilemmas and that, instead, decisions are made intuitively, as an automatic response to a challenge, and are often 'elicited without awareness of underlying mental processes' (Bargh, 1999; Bargh & Chartrand, 1999 in Musschenga, 2009, p. 598). [229] Haidt's (2001) examinations of moral reasoning from a psychological

[229] See also Haidt *et al* (2013), Gazzaniga (2012) and Lehrer (2010).

perspective propose that two clear, underlying cognitive processes are in action: the unconscious intuitive process and the conscious rational process.[230]

According to what business ethics researchers have labelled 'bounded personal ethics' (Sonenshein, 2007), individuals often take action with little or no appreciation or awareness of the ethical implications. Instead, they are motivated by emotion, self-interest and personal expectations. Sonenshein (2007) argues that it is only after action has been taken that individual's turn to ethical reasoning as an explanation or justification of their own behaviour. This argument suggests that it is often only during this evaluative or justificatory phase that ethical reasoning is initiated.

Sonenshien's notion is in keeping with Haidt (2001), whose central claim is that 'moral judgement is caused by quick moral intuition followed (when needed) by slow, ex post facto moral reasoning' (p. 817). A more recent example of this is to be found in the recollections of a UK emergency nurse, Helene Donnelly, from a Mid-Staffordshire hospital who witnessed 'repeated poor and even fraudulent practice' and was asked to 'fabricate waiting times to meet the 4-hour A&E [Accident and Emergency] targets'. She reportedly stated:

> I have been asked how I reconciled poor practice in the A&E department with my nursing code. I was of course aware of the nursing code but it was not even this that convinced me to raise concerns. My own moral code told me that the standards of care were not right. I would go home in tears because people were

[230] Haidt (2001) suggests that moral intuition 'occurs quickly, effortlessly, and automatically, such that the outcome but not the process is accessible to consciousness, whereas moral reasoning occurs slowly, requires effort, and involves consciousness' (p. 818). Neuro-scientific investigations are increasingly becoming interested in moral reasoning and behaviour and suggest that many brain structures share neural networks during moral reasoning. The temporo-parietal junction, for example, has been shown to contribute to moral intuition and belief attribution during moral judgement and is related closely to the processing of emotion (Fumagalli & Priori, 2012).

> being treated so badly in that Hospital and were suffering so unnecessarily.
>
> (Patient Safety Surveillance Unit, 2013, p. 1503)

Donnelly's self-assessment is a graphic example of how nurses face ethical issues in the workplace, and that their responses are driven by bounded personal ethics. As such, it is their personal deontic reactions and general expectations rather than their professional responsibilities that find expression and drive nurses to action.

8.4.7 Absence of professional ethics discourse

The absence of a discourse related to the impact of professional ethics on the nurses' ethical reasoning could be attributed to a lack of interrogation and or cross-examination on the matter during the commission proceedings. Certainly in neither the MHS nor the BBH case were the nurses questioned about their professional obligation to report. The lack of narrative and questioning of the nurses in either commission of inquiry leaves room for speculation as to the underlying reasons for such a lacuna.

One possibility which has been raised previously in the literature (and peripherally in this study) is the historical reticence to accord legitimated authority to professional nursing ethics (Johnstone, 1994). Three previous legal cases add weight to this conjecture. First, an Australian industrial relations case (*In re the alleged unfair dismissal of Ms K Howden v. the City of Whittlesea* (1990) involving a Victorian maternal and child health nurse, Howden, who had received a report from a mother that her child had been observed at play with another child who displayed disturbing sexually explicit behaviour. Upon receiving this report, Howden became suspicious that the behaviour may have

been the result of child sexual abuse. Howden reported her concerns to Community Services Victoria as well as to the parent of the other child, who had been identified by the nurse. The mother of the suspected child formally complained to the City of Whittlesea Council, which employed Howden, arguing that the nurse had breached patient confidentiality. Howden was dismissed for 'professional misconduct' related to the alleged breach of patient confidentiality.

Howden was ultimately exonerated for her action, but only on the basis that she had been denied procedural fairness, rather than on her defence's standpoint that claimed her actions were motivated by the *International Council of Nurses (1973) Code for Nurses* (Johnstone, 1994).[231] The code by which Howden mounted her defence was deemed by the deputy president of the Industrial Relations Commission to be 'imprecise' and 'of limited value in the circumstance' and as such, he advised the Council to

> become involved in the development of [precise and clear-cut] guidelines. Otherwise, the City leaves the field to an imprecise code of nursing ethics, to standards of a professional peer group with whom the City may disagree
>
> (In re the alleged unfair dismissal of Ms K Howden by the City of Whittlesea (1990), p.29 in Johnstone, 1994, p. 261)

Adding further weight to the undermining of the authority of nursing codes of ethics is a case from the US: *Warthen v. Toms River Community Memorial Hospital*. Corrine Warthen, a nurse at Toms River Community Memorial Hospital New Jersey, refused to administer kidney dialysis to a

[231] Specifically the code's statement that 'the Nurse holds in confidence personal information and *uses judgement* [emphasis added] in sharing this information' (In re the alleged unfair dismissal of Ms K Howden by the City of Whittlesea (1990), p. 13 in Johnstone, 1994, p. 261)

terminally ill patient[232] on the grounds of 'moral, medical, and philosophical objections'. This resulted in the termination of her employment. Her appeal for wrongful termination was denied by the Superior Court of New Jersey, which concluded that

> even under the circumstances of this case the ethical considerations cited by plaintiff do not rise to the level of a public policy mandate permitting a registered nursing professional to refuse to provide medical treatment to a terminally ill patient, even where that nursing professional gives his or her superiors advance warning. Beyond this, even if we were to make the dubious assumption that the Code for Nurses represents a clear expression of public policy, we have no hesitancy in concluding on this record that plaintiff was motivated by her own personal morals, precluding application of the "public policy" exception to the "at-will employment" doctrine.
>
> (Warthen v. Toms River Community Memorial Hospital, 488 A. 2d 229 - NJ: Appellate Div. 1985 emphasis added)

Diminution of the authority of a nursing professional code of ethics is also to be seen in the more recent case *Irwin v. Ciena Health Care Management*, *Inc.*, Michigan, USA. There the plaintiff nurse, Janine Irwin, likewise appealed the wrongful termination on grounds that her refusal to administer insulin without an updated medical order accorded with the *American Nurses Association Code of Ethics* 'for refusing to provide care that potentially places a patient's health in substantial jeopardy' and that this be considered as the 'basis of public policy'. Her appeal was overturned in a number of areas, but reference to the code elicited the following decision:

> Even if standards are outlined in the American Medical Association Code of Medical Ethics or the American Nurses Association Code of Ethics, our Supreme Court has specifically rejected the premise that a private organization's code of ethics be the source for a public policy based wrongful termination claim.

[232] On two previous occasions when Warthen dialysed the patient 'she had to cease treatment because [he] suffered cardiac arrest and severe internal haemorrhaging' (*Warthen v. Toms River Community Memorial Hospital,* 488 A. 2d 229 - NJ: Appellate Div. 1985.)

> (Irwin v. Ciena Health Care Management, Inc., Michigan: Court of Appeals 2013. p. 3)

In each of these cases nurses argued that their actions accorded with their codified ethical obligations. These cases imply that the supposedly legitimised authority of ethical decisions based on a professional ethical code remains weak, at least in legal proceedings, and particularly when used as a central argument against unfair dismissal. Thus while professional nursing organisations implicitly acknowledge that nurses undertake ethical decision-making to ensure advocacy for and protection of patients and families within their care, it is poorly-regarded and treated as subordinated to organisational needs in dispute cases. With the notable exception of Johnstone's work in this area, little attention has been given to the subordination of nursing ethics in jurisprudence.

The absence of consideration of the nurses' professional codes is also to be found in the media coverage surrounding the BBH and MHS cases. Much was made of the nurses' great courage and ethical conviction, but nowhere was it recognised that reporting in the manner adopted by the nurses was an obligation proscribed by their professional ethics. In 2006, Hoffman was awarded an Australia Day honour as Local Hero of the Year. The National Australia Day Council (2006) webpage celebrating this honour lauds the fact that Hoffman had completed a Masters degree in Bioethics and had 'experienced considerable personal stress but held true to her conviction'. No reference is made to the fact that she remained true to the expectations clearly articulated in the nurses' professional code of ethics. Oakley's (2005) editorial in the *Monash Bioethics Review* describes Hoffman's actions as a 'particularly

impressive example of bioethics in action', labelling her as not only an 'ICU nurse' but also a 'Master of Bioethics graduate' (p. 1). These references leave the reader wondering whether Hoffman's whistleblowing actions were perhaps motivated, or at least informed by her prior study of such issues, rather than her perceptions of her ethical obligations as a nurse.

The findings of this study suggest that the nurses' professional codes of ethics were not a key factor that influences nurse's decision-making in the face of ethical dilemmas in the workplace. The legitimised authority of ethical decisions based on a professional ethical code were not only unrecognised by the nurses at BBH and MHS, but were also absent from media discourse of the cases and weakened in law.

8.5 Conclusion

This chapter has applied the work of social theorist Fay in order to promote an understanding of not only the way that these events unfolded, but also the reasoning (or lack thereof) behind certain actions and responses by the nurses and those with the power to take action. The lack of appropriate action on the part of the hospital authorities at MHS and BBH became the primary motivating force behind the nurses' decisions to blow the whistle. The nurses mistakenly believed that reporting through internal channels would result in censure of individual practitioners and/or a change in processes that would mitigate the risks of patient injury or death. Instead, four organisational structural bases contributed to the whistleblowing crisis: the propensity to apportion blame, the wilful blindness to the problems before them on the part of the hospital Executive, the use of a network of hierarchical observation and

discipline directed at the nurses and the use of confidentiality as a mechanism to silence dissent and prevent disclosures to authorities outside the organisation.

Examination of the cases uncovered the prevalence of human factors in the creation of conditions under which nurses who reported failure felt morally compelled to report outside their organisations. This is particularly so when the observational gaze and consequent sanctions are turned back upon the whistleblower, rather than upon the inadequacies and transgressions that they have uncovered.

Clinical governance is the new paradigm under which healthcare organisations operate. Even this new framework displays inadequacies however, particularly in its inability to ensure that those individuals capable of making effective policy change employ 'problem-seeking' rather than 'comfort-seeking' behaviour and listen to those who report substandard or dangerous practice. In the final chapter to follow, a number of strategies for change informed by critical theories of education and of transformative action will be proposed and conclusions drawn.

CHAPTER 9

CONCLUSIONS AND RECOMMENDATIONS

9.1 Introduction

The inquiry advanced in the previous chapters has provided a comprehensive account of the social phenomena of nurse whistleblowing. In doing so, and by using the MHS and BBH cases as its focus, the contextual effects of power, information dissemination and organisational politics on reporting nurses' behaviour were explained. This, the final chapter of the thesis, draws together the threads of analysis and discussion advanced in those previous chapters to inform the conclusions and recommendations for further research. Highlighted are the core conclusions of this study which include the failure of clinical governance, false consciousness by nurses, the presence of bounded personal ethics and the phenomenon of wilful blindness.

9.2 Failure of clinical governance

The study has resulted in a critical case study of what amounted to a substantial breakdown in clinical governance. A key contributor to this breakdown at MHS and BBH were the latent conditions within the organisations which included human factors (ie. of the managers and leaders), all of which contributed to the whistleblowing crisis. Drawing on the findings of this study, the following inferences have been drawn.

Underdeveloped and poorly resourced reporting systems resulted in undue attention and surveillance being directed at the nurses who reported

patient safety concerns. This was at the expense of due attention being given unsafe practices reported by the nurses, the processes and practitioners who contributed to them and the lessons learned. Healthcare staff involved in patient care need to feel safe raising concern without risking a breakdown in relationships between themselves and management. Voluntary reporting and the ability to raise concern by nurses and other clinicians involved in direct patient care captures the 'complex causal links between events and harm' and provides opportunities to learn from error (Russell & Dawda, 2014, p. 107). However, what this critical case study and many other healthcare inquiries have shown is that when attention is focussed more on the messenger rather than the message, the ability to capture and learn from the concerns raised is hampered by fear of retribution and or apathy that nothing will be done.

The way forward may be advanced by looking at those organisations that have developed transparency, accountability and trust. Those features of healthcare organisations that have demonstrated success when dealing with reports of organisational failure and are thus confirmed to maintain high levels of safety would benefit from further research. Such a recommendation is aimed not just to import systems or interventions from other organisations that appear to improve reporting, but to also examine the full context of such successful organisations. A broadening of the investigation into successful healthcare organisations is recognition that an intervention or system that results in success in one organisation does not necessarily deliver positive change in others. In order to successfully achieve sustainable quality improvement and organisational change in healthcare, there is the need for a closer examination

of the multiple levels of structural and cultural factors that provide the social context under which healthcare organisations function. To achieve this end Robert and Fulop (2014) recommend research that is contextually focussed, based on realist evaluation and with a focus on the qualitative case study.

9.3 False consciousness of nurses

Nurses at the forefront of reporting patient safety concerns were hampered by the misguided belief (false consciousness) that organisational processes would be 'on their side' and that action would be taken to address their concerns. When no action was taken, and worse, when retributive action was taken against the nurses, the difficult decision to raise concerns outside the organisation in order effect action and protect patient safety was made.

The nurses expected that those who had transgressed and caused harm would be censured. When no internal action was taken, the nurses took their concerns to their parliamentary representatives, and later, to the media. The nurses took this initiative without giving due consideration to the legal protections (or lack thereof) afforded to whistleblowers under protected disclosure legislation.

Nurses' false conscious belief that organisational processes will be 'on their side' requires attention. This research has highlighted that the processes used to report incidents are flawed, vulnerable to the impact of the human factors at play and to the faults and failings of those charged with the responsibility to take action. Nurses cannot in these circumstances remain strategically naïve, were they to do so they would risk remaining powerless to effect action in the presence of substandard practice, and/or unprofessional and

unethical conduct. This conclusion presents an opportunity for renewed interest in the influence (or lack of) that nurses have on the politics of healthcare organisations.

A key strategy underutilised by nurses, faced with the extant powerlessness to effect action, is to use the strategic resources at their disposal beyond the immediate organisation for which they work. For instance each Australian state has a Chief Nurse and senior leaders who function at high-level, strategically influential points within healthcare departments. Nurses must see (and must be encouraged to see) these leaders as approachable, and as a valid, even preferred, avenue through which to raise concerns related to matters of patient safety. This did not occur in the BBH case, even though Jillian Jeffery had outlined her new role as Chief Nurse Advisor to the nurses. Although Jeffery's advice was given after the BBH nurses were challenged by executive inaction to previous reports about Patel, they did not consider involving her. This raises questions of how nurses perceive the role of Chief Nurses in Australia and what are the enablers and disablers of approaching a Chief Nurse or other senior leaders when they face organisational failure to address patient safety concerns.

In light of these events and others where nurses have not accessed legitimate resources to assist them to bring to light serious concerns, there is a rising recognition of the need for change. In the UK for instance, the Francis report on *The Mid Staffordshire NHS Foundation Trust Inquiry* resulted in resources being developed to guide nurses and midwives on 'raising concerns' which include detail about external avenues that can be used if concerns are

ignored and the limits and protections of current UK whistleblowing legislation (Gillen & Sprinks, 2014; Nursing and Midwifery Council, 2013). No national resources of this kind are available in Australia. This is so even though a resource of this calibre would be of benefit to Australian nurses. Such a resource would provide a clear structure of the various legitimate avenues to report concern and strategies of where to turn if their concerns are ignored. A resource of this nature, one that clearly articulates the limits of whistleblowing legislation is particularly pertinent as the findings of this thesis found that only one of the whistleblowing nurses [233] reportedly requested protection under the Whistleblowing Act and those who went to the media, did so with no safeguards. This suggests that the nurses had little knowledge of the legal protections and limitations of protected disclosure or whistleblowing legislation available to them. The nurses were fortunate not to have faced prosecution for the unauthorised disclosure of information or a defamation civil action.

9.4 Bounded personal ethics

Influenced by personal deontic reactions and by the search for an internal psychological peace which comes from standing up for a non-negotiable principle, the nurses made the 'choiceless choice' to blow the whistle. The analysis of the discourse employed by nurses to rationalise their whistleblowing actions has revealed surprising results. The expectation and assumption that nurses would use their professional code of ethics as a decision-making frame

[233] There may have been others but no evidence was present in the Commission of Inquiry documents.

when confronted with circumstances such as those related in the two cases here, proved to be unfounded.

Instead, nurses' responses appeared to be driven by bounded personal ethics. This revelation begs an examination of whistleblowing in relation to cognitive science research and theories of ethical decision making. Such research would inform the inference that the nurses facing ethical challenges in the workplace may be inclined to respond according to their bounded personal ethics rather than the expectations and behaviours prescribed by their professional codes of ethics.

Further study is required to more completely understand the 'psychological underpinnings and ethical components of nurses' responses to ethical issues in the workplace'(Johnstone & Hutchinson, 2013, p. 3). Nurses and their professional leaders would benefit from a re-examination of the moral objectives of professional ethical codes and consider how these could be revisited and re-evaluated (Meulenbergs *et al.*, 2004).

9.5 Wilful blindness

Finally, this study demonstrates the phenomenon of wilful blindness as an adverse human factor with the capacity to have a negative impact on the propensity of leaders and management who receive reports on patient safety concerns to act towards their mitigation. It is acknowledged that the MHS and BBH cases occurred in the last decade. Nonetheless, despite the obvious improvements in healthcare, when nurses report instances of substandard or unethical practice they do so within a social structure where politics and power are constantly in play. Such contextual considerations contributed to the MHS

and BBH cases and their aftermath. However, contextual considerations can also be key to the systems transformation, playing a part in the design and implementation of future preventive measures.

The development of healthcare systems that satisfactorily deal with patient safety is an ongoing endeavour. This study recommends that the way forward requires a refocussing of attention and research, not just on clinicians at the sharp end of patient care but also upon the managers who receive reports of failure in patient safety provision. Whistleblowing need never occur if those responsible for receiving and acting (including senior managers) within an organisation actively hear the messages of failure and adequately address them in a culture of transparency, trust and accountability. The call to action to improve quality and patient safety involves all stakeholders in healthcare, patients, clinicians, managers, executives, health boards as well as government bureaucrats (Russell & Dawda, 2014).

9.6 Conclusion

In this final chapter conclusions have been drawn from the work advanced in previous chapters and strategies for change and recommendations with reference to future research directions are offered. The examination of whistleblowing as a social phenomenon is far from complete. Even so, it is hoped that this study has contributed substantially to what should be an ongoing inquiry into patient safety and the critical nature and experiences of healthcare staff who report their concerns regarding patient safety.

Appendix 1

Studies investigating internal reporting and whistleblowing by nurses
(in date and country of origin order)

Reference	Key Terms	Definition of whistleblowing	Method and sample	Key findings	Limitations
McDonald and Ahern (1999) Australia	None stated	No definition provided	Derived from McDonald's (1999) Masters research. Descriptive survey design. Questionnaire guided by Lazarus and Folkman's (1984) model of stress and coping (67-item checklist of commonly used coping methods (p. 7). 95 Nurses: 70 identified themselves whistleblowers, 25 identified themselves as non-whistleblowers.	Four coping strategies considered to be effective by whistleblowers were: I talked to someone who I thought could do something about the problem (n=36, 51%) I stood my ground and fought for what I believed was the right thing to do (n=42, 60% I asked a friend or relative I respected for advice and support (n=40, 57%) I drew on my past experiences to come up with a way to handle the problem (n=48, 69%) No coping strategies considered effective by non-whistleblowers. 45% (n=43) of the nurses reported that they would avoid the patient or people involved in the whistleblowing event, but 34% (n=32) acknowledged that avoidance did not make them feel better.	No limitations recorded in this article however, the limitations acknowledged in subsequent articles indicate: small sample due to poor response rate (20%); unequal number of whistleblowers and non-whistleblowers.
McDonald and Ahern (2000) Australia	None stated	A nurse who indentifies an incompetent, unethical, or illegal situation in the workplace and reports it to someone who may have the power to stop the wrong.	Derived from the McDonald's (1999) Masters research. Descriptive survey design base on published literature related to patient advocacy and whistleblowing	Events that nurses recorded reporting included: 14 cases of patient assault, 11 cases of physical or sexual misconduct, 10 cases of racial or sexual discrimination, 13 cases of drug or alcohol impairing a peer's ability to work, 13 cases of patients' rights violated, 3 cases of patient death from negligence, 33 nurses	Small sample due to poor response rate (20%). Unequal number of whistleblowers and non-whistleblowers

		Non-whistleblowers defined as 'nurses who identify incompetent, unethical, or illegal situation in the workplace but do not report it openly' (p. 314)	95 Nurses: 70 whistleblowers, 25 non-whistleblowers. Twenty events of misconduct listed and nurse participants asked to select the event that best described their experience.	reporting that abusive or incompetent staff were allowed to continue to work with patients (p. 316) Actions taken: 23 nurses reported completing incidence forms; 7 nurses took their concern outside the organisation. Reprisals: 28% of whistleblowers reported official reprisals (verbal or written reprimand, demotion, suspension and referral to psychiatrist); 10% were referred to a psychiatrist; 100% of whistleblowers reported unofficial reprisals (threats, isolation, ostracism and pressure to resign) (p. 318).	
McDonald and Ahern (2002) Australia	None stated	The same definition used in McDonald and Ahern (2000)	Derived from the McDonald's (1999) Masters research. Questionnaire guided by Lazarus and Folkman's (1984) model of stress and coping. The participants included 95 Nurses: 70 whistleblowers and 25 non-whistleblowers. Health problems were listed and participants identified symptoms they believed they had suffered in a whistleblowing situation.	Events of reporting and actions taken as above. Physical effects of identifying misconduct: 70% of whistleblowers (W) and 64% of non-whistleblowers (non W) 'suffered stress induced physical symptoms as a result of identifying misconduct in their workplace' (p. 18) Lack of energy and sleep disturbance: 66% (38% W; 28% non W) Physical problems that affected immune, nervous systems or caused body disturbances: 10% (7% W;4% non W) Digestive problems: 12% (8%W;4%non W), Appetite loss 21% (13% W; 8% non W) Cardiac problems: Palpitations 17% (9%W;8%nonW), Chest pain 6% W Stress related emotional problems: 94% W; 92% non-W. Thus 'remaining silent in the face of misconduct does not seem to protect one from emotional pain' (p.	All the limitations listed in the 2000 publication but omission of some of the factors that contribute to ill health such as genetic disposition, personality and the environment.

				22) Feeling unworthy (e.g. guilt and shame) reported higher by the non-whistleblower participants: 40% non-W compared to 19% W.	
Jackson, Peters, Andrew, Edenborough, Halcomb, Luck, Salamonson, Weaver and Wilkes (2010) Australia	whistleblowing; workplace relationships; nurses; conflict; qualitative study.	'[A] nurse who identifies an incompetent, unethical or illegal situation in the workplace and reports it to someone who may have the power to stop the wrong' (Ahern & McDonald, 2002, p. 305) in (Jackson, Peters, Andrew, Edenborough, Halcomb, Luck, Salamonson, Weaver, *et al.*, 2010, p. 34). '[I]s a measure of last resort, and used when other means of drawing attention to issues fails' (Jackson, Peters, Andrew, Edenborough, Halcomb, Luck, Salamonson, Weaver, *et al.*, 2010, p. 35)	Qualitative narrative inquiry. Purposive sampling. 18 nurses (17 female) from several states across Australia. 11 whistleblowers (W), 4 bystanders to a whistleblowing incident (B) 3 subjects of whistleblowing complaints (S) (2-40 years of nursing experience). Data collected by semi-structured interview, conducted by phone or in person, none occurred in the participant's workplace. Data thematically analysed into meaningful codes.	'Whistleblowing had a profound and overwhelmingly negative effect on working relationships' (p. 37) Clustered into four themes: 1. Leaving and returning to work: *The staff don't like you*; 2. Spoiled collegial relationships: *Barriers between me and my colleagues*; 3. Bullying and excluding: *They've just closed ranks*; and 4. Damaged interprofessional relationships: *I did lose trust in doctors after that* (p. 37).	Recruitment occurred through via a large industrial nursing organisation, advertised in a professional magazine. Non-members of this organisation may not have been exposed to the invitation to participate. Nurses who did volunteer to participate may have previously experienced negative experiences motivating them to participate. Thus, the sample may not represent experiences of all nurses involved in whistleblowing.

Jackson, Peters, Andrew, Edenborough, Halcomb, Luck, Salamonson and Wilkes (2010) Australia	Narrative enquiry; nurses; patient advocacy; whistleblower; whistleblowing.	Not defined	Qualitative narrative inquiry. Inclusion criteria required participants are Registered or Enrolled Nurses with direct experience of being a whistleblower. Derived from the same project as Jackson *et al.* (2010a). Purposive sampling. From the 18 nurses in the larger study, 11 nurses (all female) met the criteria of whistleblowers.	The reasons nurses decided to become whistleblowers, and insights into nurses' experiences of being whistleblowers. Three main themes: Reasons for whistleblowing: *I just couldn't advocate* Feeling silenced: *Nobody speaks ou*t, and Climate of fear: *You are just not safe*. (p. 2197)	As per Jackson *et al.* (2010a)
Peter, Luck Hutchinson, Wilks, Andrew and Jackson (2011) Australia	narrative inquiry; nurses; nursing; whistleblowing; whistleblower; workplace emotion.	'[A] party or parties take matters that would normally be held as confidential to an organisation, outside that organisation despite the personal risk and potentially negative sequelae associated with the act' (Firtko & Jackson, 2005, p. 51) in (Peters *et al.*, 2011, p. 2908)	Qualitative narrative inquiry. Derived from the same project as Jackson *et al.* (2010a;2010b) Purposive sampling. From the 18 nurses in the larger study, 14 nurses (all female) whistleblowers (W), or the subject of a whistleblowing episode (S).	Three themes capturing the emotional experiences: Overwhelming and persistent distress: *I felt sad and depressed* Acute anxiety, nightmares: I was having panic attacks and hyperventilating, Flashbacks and intrusive thoughts: *I had all this playing on my mind* (p. 2909).	None stated in the article but as per Jackson *et al.* (2010a)

Jackson, Peters, Hutchinson, Edenborough, Luck, and Wilkes (2011) Australia	Confidentiality; nursing; qualitative study; whistleblowing.	'[A] a conscious act of disclosure about organizational or individual practices and behaviours to those who could achieve positive change'(Jackson *et al.*, 2011, p. 656)	Derived from a much larger project See below Jackson *et al.* (2010a; 2010b).	Four emergent themes relating to confidentiality: 1. confidentiality as enforced silence; 2. confidentiality as isolating and marginalizing; 3. confidentiality as creating a rumour mill; and 4. confidentiality in the context of public's right to know (p. 658).	None stated in the article but as per Jackson *et al.* (2010a).
Moore and McAuliffe (2010) Ireland	Whistleblowing, Hospitals, Patient care, Ireland, Health services	When a member of staff within an organisation discloses that an employee has acted in a way that is a cause for concern, and the person it is reported to has the ability to do something about it (p. 166)	Exploratory quantitative research design based on that used by Firth-Cozens, Firth and Booth (2003) 152 nurses from eight acute hospitals in the Health Services Executive (HSE) regions in Ireland. Participants asked to recall incidents of Bad clinical practice/ error/ incompetence. Poor treatment/ abuse of patients/ staff. Management problems/ irregularities Colleague's mental health.	88% of respondents, i.e. nurses working in acute hospitals, have observed an incident of poor care in the past six months. 70% of those who observed an incident of poor care reported it. Bad clinical practice/error/incompetence 57% Management problems/irregularities 37% Poor treatment/abuse of patients/staff 35% Colleagues' mental health 10% Nurse managers are more likely to report than staff nurses (reporting rates of 88% and 65% respectively). Method of reporting: verbally 79%, incident report form 36%, anonymously 3% Satisfaction with outcome of report 40% extremely dissatisfied or dissatisfied meaning 'that only one in four nurses who reported poor care were satisfied with the way the organisation handled their concerns' (p. 166). Outcomes of reporting included: 41% did not experience 'any repercussions' 27 % 'were supported' 23% believed their complaint was taken seriously	None identified.

				22% 'not taken seriously' 15% unsupported The strongest factors preventing reporting are 47% 'fear of retribution' 44% 'would not want to cause trouble' 41% 'would not be listened to' 41% 'hurting a colleague'.	
Mansbach and Bachner (2010) Israel	Advocacy; ethical dilemma; reporting misconduct; whistleblowing.	'[T]he disclosure by a staff member of an organization of practices and/or polices engaged in by that organization or its employees that wrong or harm a third party. The objective of the disclosure is to stop the harmful behavior and to prevent such conduct in the future' (James, 1980; Ray, 2006) in (Mansbach & Bachner, 2010, p. 483). Internal disclosure – reporting wrongdoing to an authority within the organisation. External disclosure: reporting to an outside agency e.g. professional organisation or the Press.	Quantitative method 83 professional nurses (90.4% female) from wards at four medical centres responded voluntarily to a multiple choice questionnaire survey related to two vignettes describing ethical dilemmas. Responsibility to a patient vs. loyalty to a colleague or management to replicating characteristics in previous acts of whistleblowing.	In both vignettes participants rated misconduct very high and reported that they were likely to approach internal authority rather than external. No correlation between professional experience and the severity with which respondents' rated the misconduct.	Small sample. Response to vignetters examined intention to report not actual reporting. Unable to corroborate whether nurses would disclose the malpractice of colleagues or other personnel if presented with a real case. No opportunity to collect the rationales for reporting to different hierarchical levels.
Davis and Konishi, (2007) Japan	advocacy; Japan; loyalty; professional responsibility;	'[A] professional and ethical responsibility' (Davis & Konishi, 2007, p. 194); as 'an act of advocacy	Quantitative questionnaire of 24 female nurses, consisting of Master's students and clinical	42% (10) had reported another nurse for a wrongful act in the past. 50% (12) had reported a physician for wrongdoing. 92% (22) identified that their reporting a	Very small sample. Participants had higher level of education

	whistleblowing	specifically means that, if nurses have the ethical responsibility to protect patients from harm, then at times they must report the incompetent or unethical actions engaged in by colleagues' (Davis & Konishi, 2007, p. 196).	teachers from nursing college in Japan. Questionnaire on advocacy with a section on whistleblowing.	colleague for wrongdoing depended on the results of first going directly to the wrongdoer. If this interaction did not produce results, then they would probably report to a supervisor. Rationale for reporting: concerns about the effects of wrongdoing on the patient. belief that the head nurse should receive information due to her overall responsibility for the hospital unit. Rationale for not reporting: Earlier reports had poor outcomes.	compared with average nursing population – decreasing generalisability. Questionnaire format did not allow researchers to probe for additional meanings.
Ohnishi, Hayama, Asai, and Kosugi (2008) Japan	Interview; nurses; professional responsibility; psychiatric hospital; whistleblowing; wrongdoing.	'[T]he disclosure by organization members (former or current) of illegal, immoral, or illegitimate practices under the control of their employers, to persons or organizations that may be able to effect their action' (Near & Miceli, 1985, p. 4). However Ohnishi *et al.* (2008) differentiate between internal and external. Internal considered internal reporting; external considered whistleblowing	Modified grounded theory. Interview of two nurses who had worked in a psychiatric hospital and decided to blow the whistle to the media about negligent practice and poor standards of care.	Three chronological phases representing the whistleblowing process: suspicion of wrongdoing awareness of wrongdoing and conviction of wrongdoing. Factors that impeded the nurses from reporting earlier included: appreciation, affection, and a sense of duty.	Only two participants who were interviewed years after the events transpired. Participants' memories, feelings and details of events may have faded over time.

Malmedal, Hammervold and Saveman (2009) Norway	Care for the elderly; elder abuse; inadequate care; nursing homes; nursing staff; report;, whistleblow.	As any reporting of misconduct in the workplace or the disclosure of wrongdoing that threatens others (Calland & Dehn, 2004; McDonald & Ahern, 2000) in (Malmedal *et al.*, 2009, p. 744).	Quantitative questionnaire survey – seven statements to elicit reaction to witnessing a colleague provide inadequate care to a resident in a Norwegian nursing home. 16 nursing homes targeted. 616 staff (97% female, 80% part time) 25% university/college educated, mostly registered nurses, more than 50% licensed practical nurses and 12% nursing aids.	Age determinant – older nursing staff preferred not to report on their colleagues, did not feel brave enough to speak out, were afraid of what would happen to them if they did, and dealt with such matters internally. By contrast, higher educated nursing staff would report colleagues, and felt less afraid of what would happen to them if they did.	Hypothetical statements on reporting inadequate care, not about actual reported situations. Thus intention to report not actual reporting.
Burrows (2001) United Kingdom	None stated	'[A]ny situation where any health professional raises concerns about the performance of a doctor, either within an organisation or externally' (p.111)	Quantitative research: 70 Community nurses invited to complete a short structured questionnaire of mostly closed end questions with options to comment. 49 nurses completed the questionnaire. The focus of the seven questions was about reporting performance of a general practitioner.	61% of nurses indicated that they would report a 'risky' GP performance, 6% would not report, 33% unsure. Only 37% knew who to report to, with up to 14 routes or combinations identified. Showing little clarity as to the correct internal reporting routes. Factors identified reducing likelihood of reports being made: Unlikely to make a difference anyway 56% Lack of trust in person/authority to take action 56% Don't know how to report it 50% Fear of retribution 44% Concern about being identified 31% 82% indicated an awareness of a duty to report. When probed if their response would be different if the poor performance related	Results not widely generalisable.

				to a nursing colleague 57% indicated no, 39% yes. Nurses were more likely to report a nurse's poor performance. Only 5 nurses or around 10% considered the current system of reporting was adequate to protect patients.	
Firth-Cozens, Firth and Booth (2003) United Kingdom	Health services; whistleblowing; doctors; .nurses	Use reporting of incidents and whistleblowing synonymously. It 'occurs when a staff member tells a more senior member within that organisation or another, that an employee has behaved in ways that are a cause for concern, whether clinically legally or ethically' (p. 331).	Exploratory quantitative research design 624 participants: 342 nurses, 201 hospital doctors, 81 general practitioners. Questionnaire asking participants to identify if they had reported a member of staff for actions thought to be unethical or wrong in terms of patient care. Then participants were asked to describe the incident. Situations coded into poor clinical practice/error; management problems/irregularities ; poor behaviour to/abuse of patients/staff; and colleagues mental health. Participants were then asked to identify repercussions and outcomes of action.	Hospital doctors record reporting more, when the situation reflected poor clinical practice (n=58; 44.6%). They are less likely to perceive or report poor behaviour or abuse to patients or staff (only 4 examples of this were witnessed and only 1 doctor identified that it was reported). 68.1% of nurses record reporting poor clinical practice and 56.4% poor behaviour. Outcomes of reporting included: Nothing negative happened from reporting: doctors 61.9%; nurses 51.4%. Nothing happened to change situation: doctors - 25.4%; nurses 12.9% Victimisation from colleagues - doctors 0%; nurses 27.1% 98.7% of doctors and 94.3% of nurses said they would whistle-blow again if required. For those not reporting: fear of retribution, wouldn't be listened to and impossible to prove, were strong considerations influencing their decision, particularly for the nurses.	Response rate for organisational survey is too low to make firm conclusions. Not all participants completed all of the survey
Attree (2007) United Kingdom	Disincentives; organizational system; quality; reporting.	Not focussed on 'factors that influence nurses' decisions to raise concerns about standards of practice'	Grounded theory used to collect and analyse data from semi-structured interviews with 142	Nurses acknowledged that raising concerns about standards was a nursing responsibility (p. 395) The process of raising concerns was	Sample not statistically representative of the whole NHS population.

		(p. 392), which the researcher did not consider as whistleblowing	practising nurses, theoretically sampled from three Acute NHS Trusts in England.	characterised as a difficult journey (p. 397). Disincentives to raising concerns included: fear of repercussions, retribution, labelling and blame for raising concerns, about which they predicted nothing would be done. Reporting was perceived as a high-risk: low-benefit action. Nurses lacked confidence in reporting systems. Nurses characterised their organisational culture as closed, concealing and blaming. Nurses identified unwritten rules and norms that construed raising concerns as: 'not the done thing', 'telling tales', 'grassing', 'shopping' and 'whistleblowing'; and was accompanied by fear of blame and repercussions (p. 398)	
Public Concern at Work (2008) United Kingdom	None stated.	None stated.	Quantitative survey 752 nurses responded voluntarily to a survey on their experience of whistleblowing.	Number one reason cited by nurses for not raising a patient safety concern was that nothing will be done. The most significant deterrent was fear of hostility from, and/or loyalty to colleague rather than fear of management discipline. 96% of nurses identified that they raised serious concerns internally; only 4% raised concern outside their workplace. 38% of nurses reported suffering serious or lasting damage to their career for raising their concern.	None noted.
King (1999) United States	None stated	Refers to Near and Miceli's definition. However, does not agree with the inference that internal disclosures particularly to peers constitute whistleblowing.	Literature review to explore two propositions: Whistleblowers use of internal disclosure channels may be affected by the structure of an organisation.	Five organisational structures examined and propositions made: Centralised – less open to individual opposition, management may feel threatened or challenged by employees who dissent from established policy. Whistleblowers are more likely to disclose externally. Climate more retaliatory.	Lack of comparable empirical evidence to make strong conclusions. Further research required.

			Attributes of various organisational structures may influence internal disclosure of perceived wrongdoings (p. 20).	Matrix: Dual authority provides more than one avenue to report. However, this may enhance employee frustration. Clear and proper channels to report not always evident. Horizontal: Immediate supervisor or boss may be far removed from employee. Unclear channels of communication, wrongdoing may go unreported. Hybrid: Because of communication channels between a business unit and management, wrongdoing can be resolved internally without damaging the organisations reputation. Divisional: Encouraged internal reporting due to departmental autonomy. Decentralised decision-making and clearer reporting channels. Conclusion: Organisational structure and hierarchy may affect whistleblowing but the lack of empirical evidence decreases the validity of generalising propositions.	
Orbe and King (2000) United States	None stated	Not defined, as study focused on the ways in which registered nurses communicate about organisational wrongdoing, which the researchers considered internal disclosure or reporting.	Phenomenological study of 202 critical incidents from 372 returned surveys from registered nurses (93%female).	Five themes inherent in the process by which decisions of reporting are made: perceptions of wrongdoing upholding the ideals of the profession clarity and evidence of wrongdoing consequences of reporting, and workplace dynamics	Does not propose to represent all registered nurses responses to violations in the workplace.
King (2001) United States	Behaviour, intentional; organisational; peer reporting; perception; wrongdoing.	Not independently defined. Distinguished from peer reporting. Whistleblowing in this definition is an attempt to gain an	Exploratory quantitative research design, 372 nurses completed a survey asking them to respond to ten	Severity of wrongdoing influenced reporting behaviours. Nurses indicated they would not report unintentional wrongdoings to immediate supervisor instead confronting the wrongdoer. Nurses indicated that for	Response to hypothetical scenario statements examined intention to report

		'upward control' of circumstances, while peer reporting 'lateral control' (p. 3)	scenario statements that illustrated both intentional (5) and unintentional (5) wrongdoing. Two scenario statements, one intentional and one unintentional, were later removed due to ambiguity.	medication error the type of medication would influence their reporting behaviours.	not actual reporting. Responses from nurses in various working environments meant that controlling extraneous variables such as job characteristics, not possible. Suggestion for single site research.
Beckstead (2005) United States	workplace wrongdoing; substance abuse; incompetence; healthcare	Not defined, as study focussed on the probability of reporting peer wrongdoing and not the avenue used for reporting.	Quantitative research using Formal Inference-based Recursive Modelling to examine the likelihood of 120 nurses (94% female) reporting a hypothetical co-worker for wrongdoing. The research 42 scenarios describing the characteristics of a hypothetical nurse-co-worker, substance abuse and/or incompetence related to practice.	Nurses view working under the influence of any type of substance to be a very serious offense. 41.6% likelihood of reporting a co-worker for off-duty substance use. Increased probability when there was a perception of high level of incompetence 43.6% alcohol, 53.2% Marijuana and 62.8% Narcotics. 92.5% likelihood of reporting a co-worker for using substances while at work. Little difference to the level of incompetence perceived e.g. No and low 91.4%, high 94.6% For co-workers who did not use any drugs the likelihood of reporting varied considerably and related to the level of incompetence perceived. Low 18.7% and high 35.5% likely to report.	Self-reports of likelihood of reporting may be subject to bias. Level of knowledge of substance abuse was not examined. Although not indicated in the article response to hypothetical scenario statements examined intention to report not actual reporting.
Grube, Piliavin and Turner (2010) United States	None stated	Not defined as study focused on examining nurses' decisions to report observed wrongdoing within the organisation, which	National survey of 330 (97% female) nurses. Mixed method of analysis. Survey questions	Probability of nurses reporting is influenced by the frequency of unsafe practices increases nurses strong role identity, and when nurses have a strong	Respondents were not given the opportunity to define unsafe practices. Given that

		the researchers do not consider as whistleblowing.	quantitatively analysed: What factors are associated with nurses stating that they have observed tolerance for unsafe practices? What fosters reporting of unsafe practices? and What is the impact on nurses' commitment to the organization and the profession as a result of observing unsafe practices? (p. 155). Survey question qualitatively analysed When you chose *not* to report an incident, what factors led you to that decision (76 respondents)? Analysis used two theoretical frameworks: identity theory and group identity theory.	organisational identity Risk-averse nurses will report if the organisation values safety and quality, but will not report if support is absent. Frequency of unsafe practices increased nurses' reported intent to leave the organisation. Nurses who perceived organisational value for safety and quality as low decreased incidence of reporting due to a belief that nothing would be done.	willingness to report is influenced by the perception of errors and or unsafe practice, the researchers recommends future research include this.
Black (2011) United States	Las Vegas hepatitis C outbreak; patient advocacy; whistleblower.	'[T]he attempt, in good faith and in the public interest, to disclose and resolve in a reasonable and non-vexatious manner, but in the face of significant institutional or professional opposition, a significant deficiency	Patient Advocacy Activities of Registered Nurses in Nevada study. Questionnaire about respondent's experiences with patient advocacy activities and perceived ability to report unsafe patient care situations,	73% (412) of respondents had previously reported unsafe patient care. 34% (194) did not report it. 93% (368) reported to a nurse manager/supervisor 44% (79) indicated concern about retaliation. 38% (68) didn't expect an outcome of reporting. Peer reporting – nurses indicated reporting the actions of a: staff nurse (62% ;352)	Potential response bias i.e. negative workplace experiences may have increased the likelihood of questionnaire completion. The questionnaire did not differentiate

		in the quality or safety of health care.' (Bolsin, Faunce, & Oakley, 2005, p. 613) in (Black, 2011, p. 27)	answerable using a 4-choice Likert agreement scale. 564 Registered Nurses in Nevada participants – 91% female	or physician (64%; 362) to a nursing supervisor. 61% (342) felt that they could report without experiencing workplace retaliation. Retaliation was witnessed after reporting the actions of another staff nurse (41%; 230), nursing supervisor (30%; 170) or a physician (30%; 167). 36% (200) felt their workplace was not supportive of nurses reporting. 23% (127) felt their workplace failed to encourage nurses to report. Resulting in a culture of fear that influences nurses not to report known patient safety violations.	types of unsafe situations or levels of retaliation.
King and Scudder (2013) United States	None stated	No definition provided	238 participants asked to identify if they reported wrongdoing in the previous 12 months. 68 nurses identified that they had reported wrongdoing participated in a quantitative survey. The 10 item instrument included various rationales of why a nurse would choose to report wrongdoing. A short scenario derived from Norris and Ketefian's (2007) *Judgements about Nursing Decision* instrument used as a manipulation check.	72 nurse participants (30%) observed a wrongdoing. 68 of these reported the wrongdoing (94%). No statistically significant difference between those who had reported a wrongdoing and those who didn't when using *Judgements about Nursing Decision* scenario. Both nurses who reported and those who did not showed a strong 'tendency to overlook' mistakes made by 'a friend who had a reputation of being a competent nurse' (p. 631). Moral responsibility (82%) and violating nurses' professional ethics (65%) were the found to be the most common rationale for internal reporting.	Factor analysis could not be adopted due to small sample size. No ability for nurse participants to note data related to a rationale not listed in the ten items provided. Future research recommendations includes using a larger sample size

Appendix 2

Bases of power

Form or base	Theorist	Definition	Link to other theorists
Force	Wrong (1995, p. 24)	Physical or biological. Physical obstacle that restricts freedom of another. Differentiated into violent and nonviolent.	
	Fay (1987, p. 120)	A removes from B the 'choice to act otherwise'. Thus ensuring B does what is desired by A.	Similar to Wrong (1995) in relation to restricting freedom.
Leadership	Fay (1987, p. 121)	B accepts A's authority as reasonable in the circumstances. However power in leadership depends on the willingness of B.	
Authority	Wrong (1995, p.23)	Consisting of various intended features (see related themes: coercion, inducement, legitimate, competent and individual).	See French & Raven (1959) topology. Parsons (1963b) sees authority as an institutional code that defines the rights of participation, which is organised and legitimised. Authority unlike power is not a circulating medium.
Manipulation	Wrong (1995, p. 28)	Power holder withholding intention, concealed control over. B is not aware of A's intention, yet A manages to get B to achieve the intended outcome.	Fay (1987, p. 121) same definition as Wrong 1995.
Persuasion	Wrong (1995, p. 32)	Requires communication of ideas. Occurs if A changes the behaviour of B as a result of arguments, appeals and exhortations. The communication is not constrained by penalties, reward or obligations. Examples such as mass media illustrate this form.	Because freedom of choice is integral to persuasion other theorists may not regard this as a form of power Wrong (1995, p. 32).
Reward	French & Raven (1959); Raven (1988); (2001); Raven *et al*. (1998)	Promise of favours/reward by monetary and/or non-monetary compensation.	Wrong (1995, p. 44) Seen as authority by inducement. Offering rewards for compliance.
Coercive	French & Raven (1959); Raven (1988); (2001); Raven *et al*. (1998).	Opposite of reward power and based on fear and threats of punishment.	Wrong (1995, p. 41) Seen as coercive authority. A threatens B with force in order to gain compliance. However B must be assured of both A's capability

			and willingness to use force. Fay (1987, p. 121). Coercion linked to threat of deprivation.
Legitimate	French & Raven (1959); Raven (1988); (2001); Raven *et al*. (1998).	Drawing on the right to influence as the result of an official title.	Wrong (1995, p. 49) seen as legitimate authority – A has the right to command and B acknowledges the obligation to obey. Parsons (1963) work sees communal trust as defining or legitimising positions of authority and leadership.
Expert	French & Raven (1959); Raven (1988); (2001); Raven *et al*. (1998).	Relying on knowledge, expertise or experience.	Wrong (1995, pp. 52-53) seen as competent authority. Based on specialised knowledge and skill, however this cannot be equated with persuasion. Both Wartenburg (1992) and Foucault (1980) recognise the rise of expertise in modern society, and the development of specific social structures that allows it holders to wield power.
Referent	French & Raven (1959); Raven (1988); (2001); Raven *et al*. (1998).	Based on the individual's identification with influencing agent.	Wrong (1995, pp. 60-61) Personal Authority - based on the personal qualities of A that make others, including B want to follow their leadership.
Information power	Raven (1988); (2001); Raven *et al*. (1998).	The information base of power occurs when individuals have information required for others to function or achieve their goals.	Propaganda Model (PM) Herman and Chomsky 1988 in Klaehn (2002, p. 1502002, p. 150). The discussion here is related to journalists and the media, however there is a particular emphasis on information dissemination 'in support of the special interest groups, that dominate the state and private economy' (p.150). Herman and Chomsky in the PM argue that meanings which are formed and produced at an unconscious level are '*filtered*' by the constraints built into the system in which they are developed. Although the filtering constraints applied to the system described in the PM is not directly congruent with the phenomena of information power used in hospitals, there are similarities that make the description of filtering amenable to application in this study.

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Appendix 3

The Hoffman Letter

TH37

27th October 2004
Peter Leak,
District Manager,
Bundaberg Base Hospital,
P.O Box 34,
Bundaberg, 4670.

Dear Peter,

I am writing to you to officially inform you, of the concerns I have for the patients in ICU in relation to the behaviour and clinical competence of one of the surgeons, Dr Patel.

Dr Patel first voiced his displeasure with the ICU around the 15th May 2003. A patient UR number 04-2345 came to the ICU post oesophagectomy. This patient had multiple comorbidities and for the last 45 minutes of surgery, had an unstable blood pressure. The anaesthetist who accompanied him into the ICU, stated " It was a very expensive way to die." He required 25ug of Adrenaline and 100% O2. Dr Patel stated the patient was stable. The Nursing staff who were communicating with the patients family told the patients mother that he was extremely ill. Indeed he progressed to brain death. Dr Patel continued to say the patient was stable. The course of treatment for this patient was very difficult, he required dialysis and there was constant conflict between the anaesthetist, Dr Patel and the Physicians about his care. The Director of Anaesthetics and ICU was away and Dr Yoonis was left in charge, he was reluctant to question whether or not we should be doing such large operations here at BBH. Dr Jon Jolaoso and I went to see Dr Keating to voice our concerns. We both believed we could not offer adequate post op care for oesophagectomies. The literature stated a hospital should be doing at least 30 per year to maximise outcomes. At this time I first raised my concern that Dr Patel could describe a patient on maximum inotropes and ventilation as stable. I voiced these concerns to Dr Keating. After this incident Dr Patel and I had a conversation where I told him that the ICU wished to have a good professional working relationship with him. I tried to tell him that we were a level one ICU and that our staffing levels and scope of practice meant that we could only keep ventilated patients for 24-48 hrs , before transferring them to Brisbane. Dr Patel stated that he would not practice medicine like this and he would go to "Peter Leak and Doreen Keating and care for his own patients." This incident was reported relatively soon after the fact. Dr Patel would threaten the staff with his resignation when it was suggested it was time to transfer out a ventilated patient. He continually stated he was working in the " third world" here. He would use "Peter Leaks" and "Doreen Keatings" names as a type of intimidation and threat to the staff. He stated on several occasions he would go straight to Peter Leak as he had made him " half a million dollars this year". Every time we had a ventilated patient in the ICU that required inotropes he would argue with the anaesthetists about which inotrope to use. His choice of inotropes did not reflect best practice guidelines in Australia. He refused to speak to the writer, (myself). All requests for a bed would go through either another nurse or doctor. He would yell and speak in a very loud voice, denigrating the ICU and myself and at times the anaesthetists. The nursing staff felt they were often the " meat in the sandwich" He would harass them and ask them " Whose side they were on". At times he would actively try to denigrate my ability as a NUM to the nursing staff and other doctors. (See attached documentation).

Soon after Dr Patel started operating here the nursing staff observed a high complication rate amongst the patients. Several patients had wound dehiscences and several experienced perforations. This is a list of patients I believe require formal investigation. This is taken from our ICU stats and are not a full and comprehensive review as there are no stats from OT or Surgical Ward.

UR 130284 6/6/03 post op oesophagectomy
126603 wound dehiscence.
13/5/03 2nd wound dehiscence
suffered a third wound dehiscence was transferred to Brisbane on the 2006, had a J tube leak and peritonitis. A bed had been obtained earlier for this man, but Dr Patel went up to Dr Keating who advised our anaesthetist to keep him for a few more days, in which time the bed was taken, and he stayed several more days whilst another bed was sourced. The Registrar at RBH questioned why we were doing such surgery here when we were unable to care for these patients.

UR 083923 post op oesophagectomy ventilated for 302 hrs.

UR 091420 Ventilated for many days transferred to Brisbane after many arguments in the ICU with DR Patel who refused initially to transfer this patient.

UR 330266 leave with transferring patient to Brisbane.

UR 083665 Bowel Obstruction Resection and Anastomosis on 7/2/04 T/F to Brisbane on the 11/2/04 on the 12/2/04 laparotomy showed perforation and peritoneal soiling.

UR 134442 Wound Dehiscence and complete evisceration 2/4/04. Booked for sigmoid colectomy and found to have cancer ca.

UR 020309 2/4 Wound dehiscence.

UR 2005 Insertion of Vascath performed @ 11. 05/7/04

UR 056684. Delay in Transfer to Brisbane , Son obtained report, Pt died.

UR 017784 10/7 laparotomy for Ventral Hernia, developed haemorrhage in ward and attempted evacuation done without any analgesia. Drs notes consistently say patient well when Pt was experiencing large amounts of pain and wound open.

UR 057809 pt had Whipples , death cert stated he died of Klebsiella pneumonia and inactivity

UR 063164 death cert stated pt died of exhaustion. Had been operated on 31/7/04. died 17-8-04

several conversations were had with other doctors , Acting Directors of Nursing and NUMs. Dr Marsh refused to allow Dr Patel to care for his patients as he stated he had 100% complication rate with Peritoneal Dialysis insertion. This was stated in a Medical Services forum as well as in a private conversation with myself. This data was shown to the Acting Director of Nursing Mr. Patrick Martin.

On the 27th July 2004, Pt UR number 056644 returned to ICU in Emergency with a chest injury. The events of these 13 hrs is well documented. Dr Patel interfered in the arranged transfer of this patient to Brisbane and the patient died after it was thought the retrieval team were on there way to retrieve this patient. The subsequent events of this intervention and the traumatic pericardial tap (described by the nurse caring for the patient as repeated stabbing motions)resulted in the ICU staff requesting advice from the nurses union . The staff involved in this situation described it as the worst they had ever seen. They were acutely distressed. An attempt was made to seek EAS support, but they were unable to assist due to their workload. One staff member accessed Psychological support privately. I was requested to fill in a critical event form , by the then QI Manager Dr Jane Truscott. The events of this incident were discussed at length with the union, who offered support to the staff. They also offered me several ways I could report the long standing concerns I had with the current situation in ICU. The day after the patients death , when I thought he had safely been transferred to Brisbane , Dr Strahan came to talk to me in the office and found me very distressed. He offered to talk to some of the other doctors and get back to me as the representative of the AMA in Bundaberg. He did this stating " there is widespread concern, but at the moment no-

one is willing to stick their neck out" He urged me to keep mute on my concerns. I spoke with Dr Dieter Basson and informed him the nursing staff were going to report their concerns with Dr Patel to an official source. He stated he would support us , by telling the truth, but he was concerned he would lose his job and Dr Patel would be the one left behind. It is widely believed amongst the medical and nursing staff that Dr Patel was very powerful, that he was wholeheartedly supported by Peter Lock and Darren Keating and was untouchable. Anyone who tried to alert the authorities about their concerns would lose their jobs. This perception was indeed perpetrated by Dr Patel on a daily basis. Many of the residents and PDO"s have expressed their concerns, Dr Alex Davis, and Dr David Rixon., But were aware of what to do because of the widespread belief Dr Patel was protected by executive.

The Nurses union have offered advice in that there are several ways these concerns can be reported if not dealt with internally, after my conversation with Peter Lock and Linda Mulligan on Wed, I believe they were not in receipt of the full concerns, but now that they are they will deal with them.

Dr Marsh has expressed he has dealt with the issue by not letting Dr Patel near his patients. These concerns were openly discussed at the medical services forum.

A peripheral concern is the reports the junior doctors have voiced about fingers not being killed out correctly, of being told not to use certain words in discharge summaries, and various other short irregularities.

Toni Hoffman.

Documentation from Karen Bruner,Karen Fox, Kay Bolden x2, Karen Jenner , Vivienne Tejedor included.

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