



A Wicked Problem? Whistleblowing in Healthcare Organisations

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

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Abstract

Mannion and Davies' article recognises whistleblowing as an important means of identifying quality and safety issues in healthcare organisations. While 'voice' is a useful lens through which to examine whistleblowing, it also obscures a shifting pattern of uncertain 'truths.' By contextualising cultures which support or impede whistleblowing at an organisational level, two issues are overlooked; the power of wider institutional interests to silence those who might raise the alarm and changing ideas about what constitutes adequate care. A broader contextualisation of whistleblowing might illuminate further facets of this multi-dimensional problem.

Keywords: Whistleblowing, Healthcare Organisations, Safer Care, Truth to Power

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Whistleblowing, Truth and Power

Mannion and Davies¹ seek to examine whistleblowing practices in context and they use organisational culture as a lens to understand how potential whistleblowers in healthcare organisations are silenced or encouraged to raise their concerns. Their conceptualisations of cultures of 'silence' and of 'voice' are useful as they draw into focus contested and competing ideas about whose voice matters, how whistleblowers are portrayed (as heroes or villains) and the various ways organisations might respond. They argue that whistleblowing should be embedded in organizational practice as a normal activity when examining care quality. These ideas are further elaborated by considering how ideas about patient safety and care quality are shaped, how we might understand whistleblowing as one form of organisational membership activity and the limits of healthcare organisations to respond. Simple solutions are unlikely, and if care quality was construed as a wicked problem the positioning of organizational members as 'whistleblowers' might be challenged.

Shaping Ideas About Care Quality and Patient Safety

At the beginning of their article, the authors nod towards Aaron Wildavsky's book *'Speaking Truth to Power'*² as they consider the unenviable position of potential whistleblowers who they define as those who use channels outside the normal to draw attention to unsafe, unethical or illegal practices.¹ Wildavsky noted the shifting terrain in which policy is made and analysed as he emphasised how answers change rapidly and regularly to questions about what constitutes truth and who holds power? This shifting terrain applies equally to ideas about patient safety and care quality. Potential whistleblowers are making decisions in a changing

environment about whether there is a problem and what to do about it. Ideas about what constitutes unsafe practice and poor quality care change over time and the whistleblower faces a dilemma about where and when to raise the alarm. For example, as austerity measures are put in place, eligibility criteria for certain services are redefined to limit demand. It is unlikely that patients' interests are best served by these restrictions but when is it unacceptable? When should the alarm be raised? For the potential whistleblower, it is unclear whether financial pressures are driving this trend, whether treatments have improved, whether the evidence is unequivocal, whether discursive practices are being used to rationalise these changes and/or to minimise the risks – in light of these uncertain 'truths' the best course of action is not always apparent.

Criteria for 'safe' and 'good quality' are not only shaped locally. They are also shaped by institutional forces affecting healthcare organisations – set and redefined by national bodies, governments, and interest groups. Therefore, the broader context in which care is provided must be taken into account. The authors reference the Francis Report³ into the failings at Mid Staffordshire Hospital which showed how a preoccupation with nationally set targets and remaining financially viable compromised care quality. Mid Staffordshire failed to balance competing requirements to remain financially viable and provide good quality care; the scandal related not only to internal culture, but also occurred in a wider context of financial targets and financial penalties for failure to meet targets – Mid Staffordshire served national and organisational goals to contain costs and speed up care. In the face of increasing financial pressure, there is a need to examine the collective and cultural effects of discursive

practices which use cost-effectiveness as a metric for decisions about healthcare provision. As austerity measures constrain the funding available to healthcare organisations, even as demand is rising, something must give⁴ and whistleblowers are perhaps the last line of defence in raising the alarm that care quality is at risk.

Whistleblowing as One Form of Organisational Membership Activity

Mannion and Davies¹ note that many whistleblowers are victimised, ostracised or bullied for raising legitimate concerns. They note the tendency for idolizing or vilifying those who raise concerns by portraying them as heroes or villains and they realise a more complex and sophisticated understanding is required. They rightly argue that hero or villain labels are value judgements subject to interpretation and post-hoc rationalisation; one may be legitimated as a whistleblower after having been successful in having concerns upheld. This tendency for wholesale idealization and blame plays an important part in creating organisational blind spots⁵ that prevent awareness of difficulties that may be evident to those outside the organisation.

As a form of organisational membership activity, whistleblowing is not well-understood. Having called into question the view of care workers as uncaring bystanders or deliberate participants in causing harm, we see how whistleblowers serve an important social and organisational function. But there is another side to this coin. What about those committed organisational members who, in serving organisational goals, compromise safety or care quality?⁶ For a fuller understanding of whistleblowing, we also need to understand how well-meaning organisational members might come to commit harm on behalf of the organisation. Howard Schwartz demonstrates how committed organisational members, in order to protect the organisation, can come to commit harm to others.⁶ This dual understanding (of the perspectives of whistleblowers and of those who commit harm) is important as it brings into view the two sides of the same coin; competing institutional goals healthcare organisations face and the conflicting messages healthcare workers receive.

The Limits of Healthcare Organisations to Respond to Whistleblowers

Mannion and Davies¹ describe whistleblowing as a process, preceded by informal attempts to raise the alarm and investigation into whether what is happening is indeed wrong. If heard, these attempts provide useful information to the organisation. The authors refer to the 'deaf effect' to account for lack of organisational reaction and the problem is exacerbated as managers hear the same complaints again and again. Not only do senior organisational members (and those representing institutional interests) become less able to hear (as the whistleblower is blamed for their persistence) but they also become committed to a failing course of action.⁵

At an institutional level, there remain questions about what sorts of protections whistleblowers might be afforded (outside the organisation) regardless of whether their complaints are upheld. For example, a safety culture may encourage open questioning but a lack of organisational protection for employees may mitigate against this. Reciprocal obligation

may be a fruitful line of inquiry in seeking to promote effective whistleblowing – not only encouraging people to speak up but then protecting them even when concerns are not upheld.

In all likelihood, most organisational activities serve some sort of goal and when those goals are competing or when they represent different interests, gaining a balance between moral, ethical and business concerns require the sort of sophisticated examination recommended by Mannion and Davies.¹ For example, when health workers serve business goals and strive for efficiency they may have to sacrifice some aspects of care quality. At the extreme, aspects of care may be redefined as falling outside the remit of the organisation – the question is more about which goal is prioritised; what is more important – patient safety, care quality or remaining financially viable? What decisions are being made to serve these competing pressures? In being able to hold these questions open, a poly-vocal account will reveal competing interests.⁷

Understanding how to enable organisations to listen and act requires a broader institutional perspective that takes into account which messages are being sent, who from, about what counts, and when, and about what patients might expect. The need for a sophisticated understanding of response dynamics is a point well-made.

A Wicked Problem?

Wildavsky² was, perhaps, prescient in his account as he portrayed social policy problems akin to recent notions of social problems as wicked problems.⁸ He recognised the difficulty of tackling broader social problems; '*problems are not so much solved as alleviated, superseded, transformed, and otherwise dropped from view*' (p386). This does not mean that such problems cannot be tackled, it means that linear or top-down solutions only displace the problem; '*past solutions create future problems faster than present troubles can be left behind*' (p70). The broader social problem in this case is how to maintain care quality under conditions of rising demand and severe financial constraint. In paraphrasing Wildavsky, researchers might be encouraged to examine the evolution of whistleblowing in an attempt to deepen our understanding of the institutional problems that give rise to the need for whistleblowing.

If whistleblowing is seen as a constructive act then we can also examine how committed organisational members come to commit harm. The conflicting and competing pressures facing healthcare organisations might be discussed and questions raised about which goals are being served and why. This would allow for re-engagement with a moral debate about what sort of healthcare national populations might reasonably expect and wish to provide. Moreover, it would enable examination of how competing organisational pressures (to simultaneously achieve financial viability and maintain patient safety) combine to discourage disclosure. Studying whistleblowing opens up a multifaceted problem – a wicked problem. By considering the problem broadly, it is possible to understand how ideas about patient safety and care quality are shaped, how we might understand whistleblowing as one form of organisational membership activity and the limits of healthcare organisations to respond. In conceiving of care quality as a wicked problem the important function of whistleblowing might be better understood.

Ethical issues

Not applicable.

Competing interests

Author declares that she has no competing interests.

Author's contribution

PH is the single author of the manuscript.

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