Whistleblowing and Organizational Ethics

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The purpose of this article is to discuss an external whistleblowing event that occurred after all internal whistleblowing through the hierarchy of the organization had failed. It is argued that an organization that does not support those that whistle blow because of violation of professional standards is indicative of a failure of organizational ethics. Several ways to build an ethics infrastructure that could reduce the need to resort to external whistleblowing are discussed. A relational ethics approach is presented as a way to eliminate the negative consequences of whistleblowing by fostering an interdependent moral community to address ethical concerns.

Introduction

Whistleblowers are people who expose negligence, abuse or danger such as professional misconduct or incompetence that exists in the organization in which they work.[1] The disclosure of information outside of one's organization was the original meaning of the term 'whistleblowing', which compared the act to the shrill sounding of a whistle piercing the background noise and disrupting the false harmony or imposed silence of the status quo.[2,3] However, both external and internal whistleblowing present similar problems, challenges and risks.[1] The decision to blow the whistle on a colleague, an associate or an employer is never an easy one; unless there is a legal obligation to report, it should be considered a step one takes when all else has failed. A genuine case of external whistleblowing requires the whistleblower to have utilized, unsuccessfully, all appropriate channels within the organization to right a wrong.[4]

I will discuss an external whistleblowing event that occurred after all internal whistleblowing through the hierarchy had failed. I will argue that an organization that does not support those that whistle blow because of the violation of professional standards is indicative of a failure of organizational ethics. I will present ways to build an ethics infrastructure for the development of a moral community that could reduce the need to resort to external whistleblowing. Finally, I will discuss relational ethics as an approach that could eliminate negative consequences for whistleblowers.

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Summary of the ethical situation

I worked as an advanced practice nurse in an acute care psychiatric facility. Several clients diagnosed with schizophrenia approached me about a particular registered nurse. The nurse told them that she could 'cure' their mental illness by the laying on of hands, which she proceeded to do both individually and in groups. She was not practicing therapeutic touch but physically touching the patients on various parts of their bodies without their consent.

After these sessions the patients were visibly upset and required medication to help them to settle down. The registered nurse refused to discuss the situation with me. It was my impression that she was mentally unfit to perform her duties. I proceeded to whistle blow internally through the hospital's chain of command, including the most immediate administrative levels, from the Head Nurse to the Clinical Coordinator to the Acting Nurse Manager, and finally to the Nurse Manager for the whole hospital. Nothing was done to talk to the nurse in order to investigate her practice and the concerns about potential harm to clients. I was working in a morally deviant organizational culture. I felt pain, suffering, fear, grief, anxiety, rage and powerlessness. These are similar to the feelings expressed by other nurses who have suffered from moral distress.[5]

Nurses and other health care practitioners can be morally distressed about the prevailing conditions for patients and staff within modern hospitals.[5–10] Moral distress occurs when there is inconsistency between one's beliefs and one's actions.[11] When this leads to compromised integrity, Webster and Baylis[12] propose a notion of moral residue: 'that which each of us carries with us from those times in our lives when in the face of moral distress, we have seriously compromised ourselves or allowed ourselves to be compromised' (p. 218). Moral distress indicates sensitivity to the moral aspects of practice, the vulnerability of patients and staff, the values expressed in the code of ethics, and the acceptance of accountability and responsibility.[6]

The ethical dilemma

Judd[3] considers the main ethical dilemma of whistleblowing to be the clash of values, for example, loyalty to clients or to one's own integrity versus loyalty to the organization, the general public, professional standards, family and friends. The tension between the need to prevent abuses and preserve trust is an important tension point in whistleblowing and a major source of ambiguity.[13] However, at times loyalty to peers and the organization can be blind or misplaced, and thus ceases to be a virtue because harm, rather than good, can come from it.[14]

A whistleblower must blow the whistle for the right moral reason and reasoning. The patients were clearly emotionally distressed and suffering as a result of the registered nurse's practice. The Canadian Nurses Association *Code of ethics for registered nurses*[15]and the College of Nurses of Ontario (CNO) *Standards of practice for nurses*[16] compelled me to report misconduct, incompetence or incapacity to the CNO. The maintenance of professional standards in hospitals is not easy and the violation of professional standards is the most common cause of whistleblowing.[2]

Ultimately, the values of the dominant culture compromised my integrity and primary loyalty to prevent harm to clients. I believed that the harm or potential harm

to the clients was serious enough to warrant external whistleblowing to the CNO in order for a nursing investigation to take place. This placed me in direct conflict with the dominant organizational culture of the hospital.

External whistleblowing as an ethical failure at the organizational level

The hospital, like many health care organizations, was bureaucratic; goals were achieved by a fixed division of tasks, hierarchical supervision, and detailed rules and regulations. The tasks were so fragmented that no one was responsible or held accountable for any of the consequences of these tasks. Instead, the nurses and other health care professionals became like 'one' with the organization and its ideologies. The dominant organizational culture at the hospital was one of cover-ups, status quo, inaction and paternalistic control. Union stewards repeatedly warned members never to report on another union comrade. There was peer pressure to 'go along and get along' and to remain silent. To speak out was widely regarded as a breach of loyalty and a betrayal of those who conformed. As a result of my external whistleblowing to the CNO, union and human rights grievances on the grounds of harassment were filed against me. In the end, the CNO ruled that the practice of the registered nurse was abusive (ie the misuse of power and betrayal of trust by inappropriately touching clients). It was determined that she was mentally unfit to perform her duties. She was required to take a leave of absence from work for mental health treatment. On her return, her practice was restricted to working with clients in groups with peer supervision at all times. The Union grievance and the Human Rights Commission exonerated me on the charges of harassment.

The lack of response to internal whistleblowing represented an organization that had lost its moral compass and was ethically tainted to its core. Unethical behavior in health care organizations is systematic and traceable more to bureaucratic structures than to the individual moral deficiencies in which they arise.[17]A bureaucracy has the potential to mechanize almost every aspect of human life, eroding the human spirit and capacity for spontaneous action. A hierarchical bureaucratic structure can replicate the social class system in which a form of domination occurs whereby people are coerced by the use of threat or force.[13] Indeed, institutional coercion and the outright punishment of nurses who have been advocates or whistleblowers have been well documented in the nursing literature.[18] In this type of environment, any nurse who is unable to conform to ward routines, the norms of the team or the culture of the organization can be forced to change jobs or even professions.[19]

The International Council of Nurses'[20] definition of nursing speaks of autonomous and collaborative care, advocacy, and the promotion of a safe environment, research and participation in shaping health policy in patient and health system management, and education as being key nursing roles. The definition suggests a shift in focus within nursing ethics from the ethical obligations of the individual nurse to an approach that moves attention to the social relationships within an organization and how institutions distribute power. Moral integrity is therefore imbedded in social practice and collective action rather than only in individuals living up to norms and standards.[21] If morality is indeed rooted in collective life, a nurse's ability to have

integrity ultimately rests on the kind of community of which the nurse is part. Approaches that emphasize the individual decision making of particular health care professionals (whether based on principles, cases or ideals of virtue) are therefore not considered to be an adequate basis for ethical practice, and a more satisfying perspective on health care ethics must move attention to the social relationships and institutions that distribute power.[21]

Whistleblowers start off as people who are sympathetic to the system and devoted to their work and organizations. They change their views only when asked to violate their own ethical professional standards and then experience reprisals.[22] In a book edited by Gunderson *et al*.[23] there is talk about the crucial role that loyal heretics play in healthy organizations. These are key knowledgeable and committed people who may often question strongly, but from a stance that is aligned with the good that the organization strives to serve.[7,8,23] An organization that consistently silences or eliminates its loyal heretics is a system that is on its way to failure.[7,8,23] One that does not provide an adequate internal support system for their loyal heretics who whistle blow because of violation of professional standards is not ethically responsive.[7,8]

According to Hunt,[24] whistleblowing represents 'a multi-layered breakdown in accountability' (p. xvii). At the core of the whistleblowing issue lies accountability in both public and private sectors, between the organization and the health care professional, and between the health care worker and the consumer/client.[4] Accountability as defined by Freedom to Care[25] is 'a preparedness to explain and justify one's intentions, actions and omissions to stakeholders, and the means by which the preparedness is manifested' (p. 629). Health care organizations must undertake a deliberate process to build an ethics infrastructure to prevent a breakdown in accountability.[14] The lack of internal support, communication and value systems are major factors in issues leading to external whistleblowing.[13] We need to build ethical health care organizations with proper procedures in place so that respectful, committed, loyal heretics can speak out internally with regard to ethical issues. Thus, changes are needed to build an ethics infrastructure for the development of a moral community.

The building of a moral community

The contents of an existing organizational culture must be dealt with in order for positive change to occur. Organizations declare what really counts by their treatment of staff, the institutional goals they set, and how they handle controversy and conflict. As Reiser[26] has noted, 'institutions have ethical lives and characters, just as their individual members do' (p. 28). To ignore the existing culture and attempt to refocus the values orientation of an organization is similar to ignoring causes and treating symptoms.[27] Good restoration of a damaged organization begins with moral matters, of what it is that we seek to restore, and in the service of what moral ends.[28] Opening up the 'moral space' for such discussion to take place is not an easy task, but it is one that is worth pursuing.[29–31]

In order to create the 'moral space' for ethical concerns to be brought forward in a clinical setting, the participants must build a 'moral community' in which there is no gap between what participants know is the right thing to do and what they actually do.[29–31] In a moral community there is 'coherence between what a health care

organization publicly professes to be, namely helping, healing, caring environments that embrace the virtues intrinsic to the practice of health care and [in which] employees, patients and others both witness and participate' (p. 228).[12]

According to Potter,[32] one way to develop a moral community is through the evolution of clinical ethics to organizational ethics. Potter[32] defines organizational ethics as 'the intentional use of values to guide the decisions of a system' (p. 4). Hospital accreditation standards[29] do require that health care organizations express publicly some of the basic beliefs underlying their organizational culture in the form of mission statements and an articulated patients' bill of rights. Although the accreditation standards for hospitals have expanded to include organizational ethics, Hardingham has noted that it deals narrowly with different managements' aspects of health care organizations.[29] However, the standards do nothing to influence what may be called the 'ethical climate' of health care organizations.[33]

The ethical climate of an organization is the prevailing perception of that organization as reflected in its practices and procedures. One of the most important ways of promoting an ethical climate is to create an environment in which everyone can participate in the articulation of values and in making decisions on the process of putting those values into practice. Ultimately, it is the health care organization's responsibility to express the organization's ethical climate by identifying common values and beliefs so that both employees and patients are able to recognize the organization's core values and to hold the organization accountable for them. A positive ethical climate signals an integrated and coherent organization that implies that organization members have accepted the values and assumptions that are appropriate for their social context. Reiser[26] describes eight specific values as necessary to ensure co-operative, supportive and responsible environments. They include 'humanness, reciprocal benefit, trust, fairness, dignity, gratitude, service and stewardship' (p. 31). Reiser[26] describes the collective presence of all of these values as necessary for influencing an ethical organization.

Specific strategies to put the values of the organization into practice include: placing mission and value statements in highly visible locations throughout the organization; offering training programs that encourage interaction about the organization's values; using role playing, case studies and grand rounds to facilitate communication about ethics; and engaging employees in values-clarification techniques.[34] These strategies cannot be carried out in isolation, but rather in consort with an employee's specific goals within an organization. The organization's mission statement, vision and values should be coherent and according to the actions that people in the community live and see every day. Once an organization has defined its values it can then proceed to identify its current and future goals.

Organizations must create infrastructures for the formulation of a code of ethics and practice in a way that will provide the support that is critical for raising the organization's awareness of problems that may bring potential or actual harm to patients and the public. Organizational infrastructures determine both what are perceived as problems and how these problems are managed. Ethical analysis should be part of the administrative, policy-making and interpersonal aspects of organizational life. The important point about creating an ethical climate within an organization is that the proposed infrastructures should be multiple, interconnected with one another, and diffused throughout the organization.[33] Examples of such multiple structures are ethics committees, utilization review committees, designated executives

who have specific responsibilities for maintaining the organization's ethics and infrastructure, ethics taskforces, surveys of a community to evaluate an organization's ethics, and the integration of ethics structures with quality control structures such as total quality and performance management systems.[14] It is not enough for organizations to create an organizational code of ethics and an ethics infrastructure.

In addition, an ethical climate should ensure that nurses and other health care professionals who file complaints internally, or express concern regarding unethical practices within the organization can expect that these will be taken seriously and that procedures will be in place to arbitrate an issue. In such an environment, anyone who is unsure whether the right thing is being done can raise a 'red flag' without negative repercussions.

Institutions must develop and implement mechanisms for understanding and evaluating institutional and institutionalized patterns of behavior that may contribute to moral distress and all that ensues.[12] This is absolutely necessary if the institution is to meet one of the basic working conditions, that is, the ability of people to do their job without compromising their conscience. Although an individual's conscience can appropriately be a source of deep inner moral knowledge about the right path to follow in the face of challenge, neither people nor their consciences exist in a vacuum.[8] An act done in good conscience is a 'social act that has a structural and institutional impact in the workplace and in the wider community' (p. 32).[9] Protections therefore need to be put in place via which members of a community can address their experience of moral distress, moral compromise and moral residue at both personal and communal levels. In this way the organization will assume some responsibility for addressing moral distress, moral compromise and moral residue.[33] The formation of such a moral community would go a long way toward reducing moral distress and moral residue on the part of all the people working in it. In addition, a health care organization with an articulated ethical climate and published procedures for resolving ethical disputes can reduce the need for external whistleblowing. External whistleblowing cannot be entirely eliminated in cases of misconduct, incompetence or incapacity. However, a relational ethics approach could eliminate the negative consequences for the whistleblower.

The use of a relational approach as a foundation for health ethics means that principles of ethics, practice standards, codes of conduct, procedural rules and policies are regarded as useful guides for ethical action. Relational ethics is based on the assumption that ethical practice is situated in relationships.[6] Nurses are in relationships with individual patients, their families, other health care team members, employers, the profession and society as a whole. These multiple commitments can present difficulties and complicate the identification of barriers to the resolution of problems. The 'web of commitments' points out that a web is pervious to outside factors, and is thus 'a better metaphor for the social self in its commitments than is a metaphor of an impervious core-self composed of unshakable commitments' (p. 24).[35]A relational approach requires a search for understanding in place of control, ideologies and rules.

The basis of ethical practice is an understanding that human beings are essentially inter-related and that the ability to act with moral integrity (both personally and professionally) is therefore relational in nature.[29] Thus, gaining and maintaining our integrity is a relational process in which we need to reflect within ourselves and have a dialogue with others to do the work that allows us to settle on our principles and values, and to be able to justify them to others. We need to look with humility for the middle ground that cautions us against taking any one person's stance against

another's.[30] The middle ground is the shifting and ambiguous relational space that is enclosed by mutual respect, engagement, embodiment and dialogue.[31]

Winslow and Winslow,[36] in a discussion about compromise with integrity and the elements that must be present to make it possible, note that 'personal integrity is always a quest to the self in conversation with others and as long as personal life continues, the conversations matter' (p. 320). This understanding of compromise and integrity assists in appreciating what it means to act ethically in health care, and assists health organizations in the facilitation of moral reflection and action among all their staff members.

Brown[37] noted that engaging in ethical reflection requires an interdependent work environment marked by honesty, open inquiry, empowerment, role flexibility and trust. Ethical interdependence is another form of relational or ecological thinking, both of which are central to an organization's ethical health.[23] An organizational climate of mutual interdependence, empathic understanding and trust can reinforce one's beliefs about the social reciprocity and responsibility norms underlying altruistic behavior.[37]

Conclusion

Health care organizations must embrace an articulated organizational code of ethics and ethical infrastructures for the development of a moral community that could minimize the need for external whistleblowing. A relational ethics approach could eliminate the negative consequences of internal whistleblowing by fostering an interdependent moral community to address ethical concerns. We need to serve our patients, each other and ourselves with respect and dignity, valuing all our humanity and our imperfections. This shift in focus would result in nurses working to build a strong moral community and working with their nursing colleagues, professional associations and other members of the health care team to achieve a health care organization that will support moral integrity and ethical decision making.

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References

1 Canadian Nurses Association. I see and am silent/I see and speak out: the ethical dilemma of whistleblowing. *Ethics in Practice*. CNA, 1999.

2 Bernstein M, Jasper JM. Interests and credibility. *Soc Sci Inf* 1996; **35:** 558–65.

3 Judd PB. Whistleblowing. *J Bus Ethics* 1999; **21**: 77–94.

4 Fletcher JJ, Sorrell JM, Silva MC. Whistleblowing as a failure of organizational ethics. *Online J Issues Nurs* 1998. Retrieved 22 March 2004, from: http://www.nursingworld.org/ojin/topic8/topic8-1.html

5 Austin W, Bergum V, Goldberg L. Unable to answer the call of our patients: mental health nurses' experience of moral distress. *Nurs Inquiry* 2003; **10**: 177–83.

6 Austin W, Bergum V, Dossetor J. Relational ethics. In: Tschudin V ed. *Approaches to ethics.* Butterworth-Heinemann, 2003: 45–52.

7 Marck TB. Nursing in a technological world: searching for healing communities. *ANS Adv Nurs Sci* 2000; **23**(2): 62–81.

8 Marck TB. Ethics in hard places: the ecology of safer systems in modern health care. *Health Ethics Today* 2004; **14**: 2–5.

[9] Zoloth L, Rubin SB. *Margin of error: the ethics of mistakes in the practice of medicine.* University Publishing Group, 2000.
[10] Storch JL, Rodney P, Starzomski R eds. *Toward a moral horizon: nursing ethics for leadership and practice.* Pearson/Prentice Hall, 2004.
[11] Sinclair JM. *The report of the Manitoba Pediatric Cardiac Surgery Inquest: an inquiry into twelve deaths at the Winnipeg Health Services Centre in 1994.* Provincial Court of Manitoba, 2000. Retrieved 24 March, 2004, from: http://www.pediatriccardiacinquest.mb.ca
[12] Webster GC, Baylis F. Moral residue. In: Rubin SB, Zoloth L eds. Margin of error: the ethics of mistakes in the practice of medicine. University Publishing Group, 2000: 217–300.
[13] Hersh MA. Whistleblowers – heroes or traitors? Individual and collective responsibility for ethical behavior. *Annu Rev Control* 2002; **26**: 243–62.
[14] Silva MC. Organizational and administrative ethics in health care: an ethics gap. *Online J Issues Nurs* 1998. Retrieved 22 March, 2004, from: http://www.nursingworld.org/oijn/topic8/topic8_1.html
[15] Canadian Nurses Association. *Code of ethics for registered nurses*. CNA, 2002.
[16] College of Nurses of Ontario. *The standards of practice for nurses*. CNO, 2000.
[17] Chambliss DF. *Beyond caring: hospitals, nurses, and the social organization of ethics*. University of Chicago Press, 1996.
[18] Mohr WK, Horton-Deutsch S. Malfeasance and regaining nursing's moral voice and integrity. *Nurs Ethics* 2001; **8**: 19–35.
[19] Kelly B. Preserving moral integrity: a follow up study with new graduate nurses. *J Adv Nurs* 1998; **28**: 1134–45.
[20] International Council of Nurses. *Code of ethics for nurses: ethical concepts applied to nursing*. ICN, 2000.
[21] MacDonald C. Nurse autonomy as relational. *Nurs Ethics* 2002; **9**: 194–201.
[22] De Maria W, Jan C. Eating its own. *Aust J Soc Issues* 1997; **32**(2): 37–59.
[23] Gunderson LH, Holling CS, Light SS eds. *Barriers and bridges to the renewal of ecosystems and institutions.* Columbia University Press, 1995.
[24] Hunt G. Introduction: Whistleblowing and the breakdown of accountability. In: Hunt G ed. *Whistleblowing in the health service: accountability, law and professional practice.* Edward Arnold, 1995, xvii.
[25] Freedom to Care. The charter of public accountability of Freedom to Care. *Nurs Ethics* 2004; **11**: 629–36.
[26] Reiser SJ. The ethical life of health care organizations. *Hastings Cent Rep* 1994; **24**(5): 28–35.
[27] Groesnick LE. Governmental ethics and organizational culture. In: Cooper TL ed. *Handbook of administrative ethics.* Columbia University Press, 1994: 183–97.
[28] Higgs ES. What is good ecological restoration? *Conservation Biology* 1999; **11**: 338–48.
[29] Hardingham LL. Integrity and moral residue: nurses as participants in a moral community. *Nurs Philos* 2004; **5**: 93–186.
[30] Bergum V. Dossetor J. *Relational ethics: the full meaning of respect*. University Publishing Group, 2004; 173–76.
[31] Bergum V. Relational ethics in nursing. In: Storch J, Rodney P, Starzomski R eds. *Toward a moral horizon: nursing ethics for leadership and practice.* Pearson /Prentice Hall, 2004; 485–503.
[32] Potter RL. From clinical ethics to organizational ethics: the second stage of the evolution of bioethics. *Bioethics Forum* 1996; **12**(2): 3–12.
[33] Renz DO, Eddy WB. Organizational ethics and health care: building an ethics infrastructure for the new era. *Bioethics Forum* 1996; **12**(2): 29–39.
[34] Victor B, Cullen J. The organizational bases of ethical work. In: Worthley JA ed. *The ethics of the ordinary in healthcare: concepts and cases.* Health Administration Press, 1997; 119–21.
[35] May L. *The socially responsive self: social theory and professional ethics*. University of Chicago Press, 1996.
[36] Winslow B, Winslow G. Integrity and compromise in nursing ethics. *J Med Philos* 1991; **16**: 307–23.
[37] Brown MT. *Working ethics*. Jossey-Bass, 1999.