"Whistleblowing": a health issue

K Jean Lennane

Abstract

***Objective*—To examine the response of organisations to "whistleblowing" and the effects on individual whistleblowers.**

***Design*—Questionnaire survey of whistleblowers who contacted Whistleblowers Australia after its publicity campaign.**

***Setting*—Australia.**

***Subjects*—25 men and 10 women from various occupations who had exposed corruption or danger to the public, or both, from a few months to over 20 years before.**

***Results*—All subjects in this non-random sample had suffered adverse consequences. For 29 victimisation had started immediately after their first, internal, complaint. Only 17 approached the media. Victimisation at work was extensive: dismissal (eight subjects), demotion (10), and resignation or early retirement because of ill health related to victimisation (10) were common. Only 10 had a full time job. Long term relationships broke up in seven cases, and 60 of the 77 children of 30 subjects were adversely affected. Twenty nine subjects had a mean of 5·3 stress related symptoms initially, with a mean of 3·6 still present. Fifteen were prescribed long term treatment with drugs which they had not been prescribed before. Seventeen had considered suicide. Income had been reduced by three quarters or more for 14 subjects. Total financial loss was estimated in hundreds of thousands of Australian dollars in 17. Whistleblowers received little or no help from statutory authorities and only a modest amount from workmates. In most cases the corruption and malpractice continued unchanged.**

***Conclusion*—Although whistleblowing is important in protecting society, the typical organisational response causes severe and longlasting health, financial, and personal problems for whistleblowers and their families.**

Introduction

"Whistleblowing" is defined in the American Whistleblower Protection Act 1989 as occurring when a present or former employee discloses information "which the employee reasonably believes evidences a violation of any law, rule, or regulation, or gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety." Recently it has become an important issue in Britain: health professionals who have spoken out about changes to the NHS that adversely affect patient care have been dismissed or otherwise disciplined.[1-4] There have been similar reports from New Zealand[5] and Australia,[6] and in the United States nursing journals have extensively covered the longstanding issues of incompetent or impaired surgeons, corrupt hospital administration, and maltreatment of patients.[7,8] As in the McBride case,[9] the exposure of fraudulent research depends largely on whistleblowers.

Other important public health issues are environmental contamination; the safety of roads, trains, and aeroplanes; and protection from disease. To prevent disasters we depend on the conscientiousness, efficiency, and incorruptibility of the responsible institutions and, if things have slipped, on individual whistleblowers to raise the alarm. But however desirable whistleblowing may be for the public good, people who expose corruption and malpractice, even in a democracy, do so at considerable personal risk.

A support group, Whistleblowers Australia, was founded in July 1991 because of concern about cases of victimisation of whistleblowers. After a publicity campaign many previously unknown whistleblowers made contact, and it rapidly became obvious that they were seriously traumatised with appreciable health problems. Although the protective legislation recognises that whistleblowers are likely to suffer, there are no published medical reports on their suffering, and, although most whistleblowers seek medical help, there is no guidance on how best to care for them. I conducted a questionnaire survey late in 1992 of whistleblowers who had contacted Whistleblowers Australia during the previous 12 months.

Subjects and methods

A questionnaire was developed in consultation with Whistleblowers Australia. This covered problems which seemed common, including items from a less detailed survey in the United States.[10] One hundred and fifty seven people who had contacted the support group were asked if they would agree to receive the questionnaire. Ninety two questionnaires were sent out to those who agreed, with a reminder two months later. Thirty five were returned in time for this analysis. Although the questionnaires were anonymous, suspicion of Whistleblowers Australia, then an unknown quantity, seemed a major factor for failing to respond; reluctance to reopen old wounds was another.

The sample was not random in any way. Subjects made contact because they were dissatisfied.

There were 25 men and 10 women from several states. Only two were under 35 years of age; 22 were between 35 and 50; and the rest were over 50. Ten had exposed the corruption or malpractice less than two years before; 11, 2-4 years before; five 5-10 years before; five 11-20 years before; and four more than 20 years before.

Eight were public servants; four each were in health, transport, or teaching; three each were in banking or finance, law enforcement, or local government; and the remaining six worked in other disciplines, including four who had not worked for the organisation they had confronted.

Subjects classified the type of problem they sought to expose predominantly as corruption (often coupled with waste and mismanagement) and danger to the public (table I). Some cases entailed both.

Results

All subjects had started by making a complaint internally, through what they considered were the proper channels. Three had not made a complaint but submitted a report during the normal course of their duties. Three subjects had not progressed beyond making an internal complaint. The remaining 32 had subsequently complained to some official external body—for example, ombudsmen, members of parlia-

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TABLE I—*Corruption and malpractice exposed by 35 whistleblowers*

	No of subjects
Corruption	
Estimated cost to taxpayer ($A):	
100 million	3
1 million-30 million	9
100 000-900 000	6
Thousands	5
Danger or damage to public	
Disease/contamination	2
Unsafe:	
Hospital equipment	1
Aircraft	1
Railway signals	1
Work conditions	1
Licensing of incompetent drivers	1
Child sexual abuse	2
Arson-sabotage	1
Wrongful eviction	1
Insider trading	1
Immigration rackets	1

ment, their union, the Independent Commission Against Corruption, the auditor general. The number of external bodies appealed to ranged from one to 13. Only 17 subjects had approached the media and then only after exhausting internal and external avenues.

Fifty external bodies were mentioned, covering several states, so the numbers for each were small. Only three were rated as helpful by more than one person. Unions scored two helpful ratings but also six harmful, seven neither helpful nor harmful, and one hopeless. Only six bodies scored any helpful mentions, while there were 22 harmful and 51 neither helpful nor harmful mentions.

The problem complained of continued unchanged or increased in 25 cases, decreased in four, and was unknown in the remaining six. No action had been taken against those responsible or they had been promoted in 30 cases, and in five cases those responsible had received minor disciplinary action. In only one case were all those responsible disciplined and none promoted.

Thirty four of the 35 subjects had been victimised as a result of exposing the misconduct; the one exception had not been working for the organisation concerned. In three cases victimisation started before any complaint—for example, when they refused a bribe. In 26 it started immediately after their first complaint. In five it was delayed (range 3 weeks to 8 months). The form of victimisation is detailed in table II. Of the 31 people originally working for the body they confronted, only three were still employed by the organisation at the same level. Five others had been demoted, with three more having taken prolonged sick leave or workers' compensation. Eight had been dismissed. Three had retired at the expected time; another nine had retired early or resigned because of ill health related to victimisation.

TABLE II—*Types of victimisation experienced by 31 whistleblowers*

	No of subjects
Major change to job	
Dismissal	8
Pressured to resign	15
Position abolished	3
Transferred to another town	5
Pressed to take redundancy	1
Informal tactics	
Personal isolation	17
Removal of normal work	15
Abuse/denigration	15
Forced psychiatric referral	13
Under scrutiny/regular inspections	12
Impossible demands	9
Physical isolation	8
Threat of:	
Defamation action	7
Disciplinary action	7
Demotion	5
Accusations	4
Other harassment*	18

*For example, performance of menial duties, denial of benefits, barring from site, removal of files, death threats, adverse reports, fines, internal inquiries, falsification of records, unrelated charges, adverse reports sought from previous supervisors.

Ten of the whole sample were currently unemployed, two were working part time for a new employer, and two were receiving an invalid's pension. Only 10 of the 35 were currently working full time in any job.

Fewer than 18 subjects received support from workmates; 26 of them were ostracised, actively victimised, and betrayed to some extent.

Twenty seven had been in a long term relationship at the time they exposed the corruption or malpractice. Twenty were still in that relationship, which had been negatively affected in 10 and positively affected in one; the effect was neutral in nine, but most subjects citing a neutral effect made it clear that there had been both positive and negative components. Five of the remaining seven said that the whistleblowing was wholly responsible for the breakdown of the relationship; two said that it was partly responsible. Five had never married, two saying that their whistleblowing made finding a partner difficult.

The 30 subjects with children had a total of 77. Of these, 60 had been adversely affected by divorce and forced separation of their parents; disrupted education, anxiety, insecurity, and stress; poverty; public attacks on the parent's image; anger and loss of faith; and the parent giving a role model of constant conflict, being preoccupied, absent, unable to relate, and in poor physical or mental health and having little time for or interest in the children's activities. Three cases involved organised crime: one family was unable to go out because the father was under police protection with a contract on his life; a 6 year old girl received a personal death threat letter; and a teenage boy's pets were killed.

Loss of income occurred in 25 cases. In 11 the decrease was half or less; in 14 it was three quarters or more. Other costs were predominantly legal and medical. Total estimated financial loss was thousands of Australian dollars in six, tens of thousands in eight, hundreds of thousands in 16, and one million in one long running case.

Twenty nine subjects experienced symptoms they attributed to stress. The most common were difficulty in sleeping, anxiety, panic attacks, depression, suicidal thoughts, and feelings of guilt and worthlessness. Other symptoms included nervous diarrhoea, trouble in breathing, stomach problems, loss of appetite, loss of weight, high blood pressure, palpitations, hair loss, grinding of teeth, nightmares, headaches, tiredness, weeping, tremor, frequency of urination, and feeling stressed. In addition, one subject developed diabetes and another stomach cancer, which both attributed to the stress but were probably not related to it. Those with symptoms had an average of 5·3 when under the greatest stress and an average of 3·6 currently. Fifteen were prescribed drugs that they had not been taking before for depression, hypertension, and peptic ulcers. Two had attempted suicide, one twice; 17 had considered suicide, 10 seriously. Eighteen subjects were non-drinkers at the time they blew the whistle. Of the 19 current drinkers, five considered that drinking was now a problem. Six were smokers. All had increased their intake.

Thirteen subjects (10 men, three women) were forced by their employer to see a psychiatrist, under threat of disciplinary action. Subjects saw a median of three (range 1 to 6) psychiatrists. Four found the experience helpful or neutral and nine found it unhelpful or distressing. In three more cases the employer

tried to insist on a consultation with a psychiatrist but was successfully resisted.

The most upsetting aspects of the experience were classed as lies, deceit, and corruption in high places (15); attacks or harassment (five); effects on health or career (four); destruction of family and distress to family and friends (four); the guilty not being brought to account (three); and isolation, loneliness, and loss of friends (three).

Nineteen subjects said that they still thought about the whistleblowing and its aftermath daily, 18 of them for an hour or more. This occurred regardless of how long ago it happened.

Fifteen subjects thought that they had been damaged as a person by the experience, 13 felt strengthened, and six felt both damaged and strengthened.

In an estimate of personality type with a rough adaptation of the Myer Briggs system, 21 subjects were introverted and 14 extraverted.[11] On the remaining three axes the sensing, thinking, perceiving combination occurred in 16.

Twenty one subjects classed themselves as Christian and 14 as having no formal belief.

The motives behind their action were described by 31 subjects as duty, justice, concern for others, and a desire to stop the wrongdoing; two gave no reason and two more personal reasons.

Despite what had happened, 23 subjects said that they would to it again because, "Deep down I know I did the right thing, and by my doing it, it may help others to do the right thing." Six said that they would not and six were unsure. Twelve, however, advised others not to expose corruption or to think hard or twice about it. Other advice was to be thoroughly prepared: get outside help or advice first, research legal and other aspects, document everything, including by audio tape and videotape, and go straight to an outside agency rather than expose oneself to the employer.

When they were asked who or what had helped them most four responded "nothing"; 10 nominated family members or a helping professional; and 12 other whistleblowers.

Discussion

This non-random sample cannot be said to be typical of everyone who blows the whistle. Whistleblowers who had been fairly treated would not have contacted Whistleblowers Australia. Those who contacted the support group may not be typical either, perhaps being more assertive or less thoroughly crushed than others who did not. Nevertheless, in this small and essentially anecdotal study the similarity of the treatment meted out by different management staff, in different organisations, and even in different countries[12-14] is striking. "They all seem to be following the same handbook," as one subject put it. Some techniques, such as putting the whistleblower in a bare office with no telephone, seem almost diagnostic.

SHOOTING THE MESSENGER

In their response organisations can use any number of staff, for as long as it takes, to wear the lone whistleblower down. Their aim seems to be to isolate whistleblowers as incompetent, disloyal, troublesome, mentally unbalanced, or ill; to force them to leave; to frighten and alienate workmates and other supporters; and to avoid examining the issues they are complaining about. In the survey this had mostly been achieved: the wrongdoing continued, while the whistleblowers were left discredited and in poor health and poverty with their careers in ruins.

Whistleblowing is a type of "principled organisational dissent,"[15] highlighting parallels with heresy, mutiny, political dissent under totalitarian régimes, and intellectual dissent.[16] Principled dissenters challenge immediate and accepted authority because of conflict with what they regard as a higher authority—truth, justice, the public interest, or God.

Whistleblowers, however, may not always realise they are dissenting as the stated principles of organisations usually outlaw malpractice. It is often shattering for them to find deviance supported while they are savagely victimised.

It is disappointing that statutory authorities so often fail to help, seeming, like most workmates, to side with employers as part of the authority system. Obedience to authority and group conformity seem to be central to this. In the agentic state described by Milgram most people seem willing to do almost anything to others, disregarding personal morality, as long as some authority figure seems to be ultimately responsible.[17]

Forcing whistleblowers to see psychiatrists in order to discredit them, usually as having a personality disorder that could account for their irrational obsession with malpractice, is reminiscent of Soviet misuse of psychiatry.[18] If the first psychiatrist's report is unhelpful the subject can be forced to see another until the desired result is achieved. This practice is clearly unethical: coercion invalidates consent. (The personalities of the subjects in this study were not unusual, but nearly half were of the sensing, thinking, perceiving type (about 12% of the population), which is considered to be particularly suited to quality control or accountancy.[11])

CARING FOR THE MESSENGER

Doctors whose help whistleblowers seek voluntarily should aim at avoiding the common end result of lonely and bitter obsession, chronic anxiety, and other stress related illness in someone who is often unemployable and whose family is suffering or gone.

The victims must be reassured that what they are experiencing is a recognised phenomenon, occurring not because of their inadequacy but because of the organisation's failure to deal with the issues they have raised. Attacks on their credibility, competence, personality, and worth are "shooting the messenger" and to be understood as part of the process rather than taken personally. Intense guilt, anger, and mistrust are normal responses, and victims need safe opportunities to express these emotions to the doctor while not allowing them to increase the painful isolation they are already feeling.

The doctor also needs to advise on priorities. Intensely preoccupied with the injustice of the employer's reaction, and often incapacitated by anxiety and depression, whistleblowers tend to expend all their energy trying to get action on the malpractice. But this may take many years, and four priorities must apply.

(1) Look after the whistleblowers' physical and mental health. Victims have to be convinced of the need for regular excercise, relaxation, and time off from the stress. Support will reduce the need for symptomatic relief, but antidepressants may become necessary. Patients should be warned of the risks of dependence on alcohol, smoking, and benzodiazepines, which should be used only sparingly. Previous vulnerability—for example, from abuse in childhood—may be reactivated and will usually require psychiatric referral.

(2) Provide support for spouse and family. The doctor can help by seeing the spouse, arranging appropriate referral, and helping the couple to overcome the feelings of guilt and shame that may be inhibiting their enlisting help from family, church, and community.

(3) Seek the best possible exit from what is happen-

ing at work. Transfer to another department or leaving with the best possible financial settlement may be possible. Periods of sick leave are often needed to give breathing space from victimisation in order to consider options adequately.

(4) After all of these are in place start tackling the malpractice.

The doctor may be able to advise on external sources of help and support. But what helped many whistleblowers in this study most was the opportunity to meet others in the same situation. Most did so for the first time through Whistleblowers Australia. If there is no such contact point available it would be worth considering setting one up by advertising locally.

PREVENTION

Prevention of the problem, rather than its management, is obviously preferable. Given the importance of the issues, preventing whistleblowing itself is not really an option. Prevention of the workplace reaction is essential, which the legislation tries to do. Unfortunately, the reaction nearly always starts immediately after the first (internal) complaint. By the time whistleblowers realise that the complaint is not being handled appropriately it is already too late—the employer has victimised (possibly dismissed) them and is unable to withdraw without losing face and possibly being liable for damages.

Educating managers is essential—on group dynamics, the damage done to whistleblowers, their families, and the community, and the damage that failure to correct malpractice will in due course do to the organisation their denial tries to protect. More research, including both managers and staff, is urgently needed to find ways of changing this important and potentially devastating aspect of human behaviour.

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Economic Evaluation and Health Care

What does it mean?

Ray Robinson

This is the first in a series of articles that describe the ways in which methods of economic evaluation may be used to assess the economic costs and consequences associated with different forms of health care intervention.

Ever since the concept of value for money in health care was introduced into the NHS, economic terms and jargon have become part of our everyday lives—but do we understand what the different types of economic evaluation all mean, particularly those that sound similar to the uninitiated? This article introduces readers to the purpose of economic evaluation, and briefly explains the differences between cost-minimisation analysis (used when the outcomes of the procedures being compared are the same); cost-effectiveness analysis (used when the outcomes may vary, but can be expressed in common natural units, such as mm Hg for treatments of hypertension); cost-utility analysis (used when outcomes do vary—for example, quality of life scales); and cost-benefit analysis (used when a monetary value is being placed on services received). Further articles will deal with each one in more detail.

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Economic evaluation is a technique that was developed by economists to assist decision making when choices have to be made between several courses of action. In essence, it entails drawing up a balance sheet of the advantages (benefits) and disadvantages (costs) associated with each option so that choices can be made. Although the precise forms of economic evaluation may vary, the "cost-benefit" framework is common to all of them and constitutes the distinctive feature of this approach.

Origins

The most widely known form of economic evaluation, cost-benefit analysis, was developed over 50 years ago to assist public sector investment planning. Unlike the private sector, where costs, prices, and profits can be used as a guide to decisions about investment, goods and services provided by the public sector are often provided free (or at least substantially below their costs of production) or the prices charged to the consumer do not reflect the full social benefit of the service. In such cases there is a need for an alternative to private sector profit and loss accounting.

Early applications of cost-benefit analysis were undertaken in the United States during the 1930s in connection with flood control programmes. In Britain, it started to be applied widely during the 1960s to transport investment projects (for example, the M1 motorway, the Victoria underground line, and the proposed third London airport). Since then it has been applied in various forms and contexts, including education, town planning, and health care.