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British Psychological Society response to the Robert Francis QC Independent Review

Whistleblowing in the NHS: independent review

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The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries

We are content for our response, as well as our name and address, to be made public. We are also content for you to contact us in the future in relation to this inquiry. Please direct all queries to:-

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About this Response

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We hope that you find our comments useful.

David J Murphy CPsychol
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Purpose

This contribution seeks to share psychological evidence about the experiences and consequences of whistleblowing and introduce scientific evidence about how to create cultures of openness, honesty and transparency for patient and staff safety. We intend for this to act as a useful adjunct to the experiential evidence also collected through this request for information.

Psychological safety and speaking up

Psychological safety in the workplace is the critical factor that enables people both to speak up about concerns at work and learn from errors (Edmondson 1999, Dollard & Bakker 2010). There is consistent evidence across different nations, sectors and working contexts of this impact (Edmondson & Lei, 2014). Low psychological safety generates perceptions that an organisation is toxic, unfair and set in its ways and in such working contexts, people will 'keep their heads down', 'keep their mouths shut' and 'turn a blind eye' as a rational response to danger (Wilde, 2014).

Grynderup et al (2013) present robust research results demonstrating that work environments characterised by low levels of psychological safety and fairness are a serious risk factor for clinical depression, which brings with it the real risk of suicide. The current estimate is that mental ill-health at work, driven by low psychological safety, costs the UK economy £105 billion pa. (Faculty of Public Health 2010 & HM Government, 2011).

The impact of whistleblowing

Whistleblowing is 'after the fact' action, so is an act to 'cure' a situation rather than inherently preventative. Research evidence indicates that this act brings the following serious negative consequences for individuals and organisations.

- Retaliation against the whistleblower with serious mental ill health impacts.
- Lowered organisational effectiveness over the long-term.
- Health damage to bystanders.

Nearly all whistleblowers report workplace bullying after speaking up (Bjerkelo, 2013) with the associated mental health damage consequent upon this treatment (Grynderup et al, 2013). Retaliation is more extreme for favoured employees (Parmelee et al, 1982); indicating that those who are more likely to know what is going are actually at greater personal risk if they take such action (Bernstein et al 2010).

In 75% of cases investigated, the employer took action to dismiss the whistle-blowing employee with very negative consequences for individual financial viability (Katz et al, 2012). Physical violence against known whistleblowers is also on the rise; research from the US indicates that 22% of whistleblowers now report physical retaliation and this type of treatment is mentioned increasingly in litigation (Greenwald 2012). We can find no evidence of equivalent research undertaken in the UK as yet and hopefully this inquiry will be able to address this gap.

In addition, while organisations with a whistle-blowing allegation against them can show a short-term improvement in corporate governance, the longitudinal research shows a substantial longer-term negative impact on both market perception and operating effectiveness (Bowen et al, 2010; Dasgupta & Kesharwani, 2010).

A bystander who has been aware of malpractice in the workplace and having knowingly taken no action, in situations where someone else has spoken up, also suffer negative health impact. This 'blind eye' response to the possibility of backlash comes at a significant cost (Fredin, 2012). The rationale that bystanders give for not speaking is that they are scared of losing their jobs, which given the research evidence is a reasonable fear.

Based upon the substantial research from social psychology, whistleblowing in effect could be conceptualized as a 'betrayal' of social identity, group membership and hence effectively compromises group status. In doing this, it activates the 'in group – out group' response (Tajfel & Turner, 1979) that would predict the experiences described above.

Whistleblowing may, therefore, be experienced as a form of treachery and the backlash is therefore psychologically predictable. It is helpful to consider taking such action as an act of psychological suicide or martyrdom. We would recommend the need to engage with this reality and consider whistleblowing as a last resort in efforts to keep the population safe from corporate malfeasance rather than depending upon such pro-social acts that generate such negative personal consequences.

Deciding to blow the whistle

Whistle-blowers are more likely to be highly educated, show good job performance and hold higher-level positions (Miceli & Near, 1988; Abhijeet et al, 2010). However, whistle-blowing is more likely to take place against those who score low on likeability and on performance (Robertson, 2011) so will not necessarily lead to balanced reporting of wrongdoing or error.

The type of wrongdoing, particularly how negative it is (Robinson, 2012) has implications for the likelihood it will be reported. Case study research examining likelihood to speak up indicated that a 'cost-to-benefit' assessment will be made in each situation. This process is a significant moderator of intent to speak up about serious concerns. What is critical in this assessment process is whether or not the observer considers that anything can or will be done about the problem (Mesmer-Magnus & Viswesvaran 2005, Keil et al, 2010; Waples and Culbertson, 2011). This is also impacted by awareness of who is available to inform (Hopman & van Leeuwen, 2009). Research on individual difference suggests that whistleblowing is more likely from those who show high dominance and low agreeableness (Bjerkelo et al, 2010) indicating that the basis of this cost-to-benefit trade off varies based on individual differences.

The probability of reporting is also mediated by how widely known the problem is (Robinson, 2012). The impact of the presence of others on the likelihood of speaking up is complex, as human compliance pressures impact. Sometimes being observed will make it more likely that an individual will 'do the right thing' even when there is a potential personal negative impact (Fischer & Grietmeyer, 2013) if the pro-social act confirms their sense of positive social identity. However, if there are a lot of 'bystanders' ignoring the problematic situation, then there is the likelihood of 'pluralistic ignorance' (Gardiner and Chater, 2013). This is where each individual assumes that the others know better, so lack of action must be appropriate – hence in this situation social identity works to silence observers.

Speaking up is more likely by people in organisations perceived by others to be responsive to complaints (Miceli & Near, 1988) suggesting that organisational culture is a significant factor in

encouraging the positive and timely use of employee voice (Loyens, 2013).

A comparison of whether the use of internal processes (such as that required by Public Interest Disclosure Act (1998) (PIDA) or the Enterprise and Regulatory Reform Act (2014), ratified in the latest BIS review) or an external hotline in a large multi-national employer encouraged better disclosure, indicated that an external hotline was much more effective in encouraging people to speak (Jian el al, 2013). Further, there is evidence of increased disclosure of problems when those who wish to speak trust both the anonymity of the reporting mechanism and the fairness (on all parties) with which the disclosure will be handled (Lowry et al, 2013).

The rationale given by employees in follow up interviews was about the need to avoid a personal negative impact, based on previous experience that organisations punish the messenger. There was also the concern that speaking up did not lead to the inappropriate negative impacts on fellow workers.

Protection for **whistleblowers**

In the context of this inquiry, how current whistleblowers are treated and how organisations are helped to learn will be a profound indicator of effective attention to psychological safety and the Society would welcome significant positive attention to this.

The research indicates that the obligation to follow a particular protocol to gain the protection from PIDA is not ideal. Complex and public processes around reporting and qualifying for protection are likely to reinforce a view that speaking up is too high risk and nothing will change, which leads to the cost- benefit assessment that speaking up is pointless. Specifically, the need to make disclosures internally first to build the case for the disclosure being made in good faith are likely to prevent the majority of concerned employees taking action.

Psychologically, this indicates that creating alternative approach to mitigating the negative impact on whistleblowers is appropriate. We have concerns about a reliance on the Tribunal system for three reasons:

1. The unintended psychological impact of the good faith requirements in PIDA will tend to increase the likelihood of retaliation or the decision not to speak.
2. The tribunal mechanism is increasingly difficult to access due to cost and ACAS process requirements.
3. The reality of taking retributive action through the court system for retaliation will probably generate more psychological harm to the individual who has taken this action.

The Society would suggest two components for an alternative protective approach need consideration:

1. Careful consideration of implementing a well-designed anonymous process, which can encourage a shift in the emphasis in the individual decision making cost to benefit trade off around speaking up. This will of course need to be managed effectively without generating a wide punitive response, but instead designed to support organisational learning with the ability to execute careful symbolic intervention against those perpetrating significant wrongdoing if required.
2. An approach to intervention into the working life of the whistle-blower after the fact, centred on the principle of restorative justice with a focus on redressing any harm from the ‘psychological martyrdom’ which accepts the reality of the group process impact from this action.

Recommendations to prevent the need for whistle-blowing

Prevention of the need for whistle blowing, through creating environments where people speak before there is a major problem, is clearly better than cure. As mentioned in the first section, psychological safety is the critical factors.

Predictors of low psychological safety are deficiencies in work design, role ambiguity and high demands (Clegg et al, 2014), and deficiencies in leadership behaviour including evidence of a tolerance for bullying, micro management and abusive regulation (Einarsen, 1999, Hershcovis et al, 2007). In addition, a history of organisational trauma described as 'survivor syndrome', following events such as re-structuring, redundancy and public humiliation is predictive of low psychological safety (Baruch & Hind, 1999). Low psychological safety at work is more harmful to minority ethnic groups than for majority groups (Singh et al, 2013) so allowing workplaces to continue with low levels of psychological safety is probably a form of unlawful discrimination in the workplace.

The overwhelming emphasis in the literature on patient safety is on the importance of these organisational factors that generate psychological safety for staff (Kapur, 2014) Increasingly safety concepts in health care seek to downplay the role of heroic individuals, which includes both the full autonomy of medical practitioners and the reliance on whistleblowers, and instead emphasises the importance of teams and whole organizations to increase and apply group knowledge of good practice and safety values (Lewis 2012). In healthcare, the balance between professional autonomy and regulation for public confidence is critical.

Treatment errors have a curvilinear relationship with regulation. High levels of regulation predict error as do low levels of regulation (Dodds and Kodate, 2013). Continuous patient safety improvement is high when practitioner autonomy is high (Naveh, 2011). There have been various studies of interventions:

- There was a significant reduction in errors in patient care when implementing a no blame localised 'audit and coaching' programme (Thomas et al, 2011).
- The quality of clinical peer review and processes for self-reporting on errors was predictive of wider medical engagement in quality and safety initiatives in hospital environments (Sujan, 2012, Edwards, 2013).
- Patient safety is significantly higher when critical mass of >60% of staff report being exposed to leadership walk-rounds (Schwendimann, 2013).

To repair healthcare cultures that are currently 'silent' (Edwards et al, 2009), we must build psychologically safe work environments for the 1.03 million staff in the NHS (2013 figures from the Kings Fund). This includes all people; those providing direct day-to-day care for patients, their managers and senior managers, the clinical leaders, the commissioners of services and those regulating the context.

Psychological safety does not emerge 'naturally' but instead requires the active capability of 'managers' in the workplace knowingly 'setting the tone' and actively creating the environment for wellbeing and learning (Edmondson & Lei, 2014, Donaldson-Feilder et al, 2013). Given the consequences of mismanaged human processes at work it is not surprising that the question about needing to accredit managers has been raised out of the recent sickness absence review (Black and Frost 2012).

Broadly, the psychological literature indicates that psychological safety and openness will be enabled through:

- The compassionate moderation (Dutton et al, 2014) of counter-productive group processes that cause bias, silo thinking, groupthink, compliance, hostility, discrimination, apathy, learned helplessness and fear in the workplace (Dollard & Bakker, 2010, Hicks, 2011).
- Positive participative job design with appropriate levels of autonomy (Clegg et al, 2014).
- The design of grounded improvement interventions that are highly supportive, low in hassle and have meaning for those impacted (Neilsen, 2013).
- The presence of active and accessible role models, ideally from those with authority in the system (Moberg, 2000, Gibson, 2003, Carlin & Duffy, 2013).
- Creating positive working environments where psychological responsibility for self and other wellbeing is enabled (Mowbray 2014).
- Creating double loop responses to staff feedback, whereby feedback is used productively, and its impact is shared and then evaluated so that the work of improvement becomes habitual; known as organisational learning (Argyris & Schon, 1978).
- Intelligent and open signal detection; the 'passive' awareness of what is going on. (Schwendimann, 2013).
- Diagnostic approaches to evidence that infer system patterns (Wilde forthcoming), both over short and long term (Searle & Legood, 2014), rather than deploying simple measures (Michener & Bersch, 2013) that lead to unintended consequences (Harris and Egbonna,2002) – moving beyond targets to intelligence.
- Behavioural strategies within governance practices, ensuring report integrity by managing bias and groupthink (Janis, 1972).

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