

Whistleblowers Australia National Conference 2006

WHAT HAVE WE LEARNED ABOUT WHISTLEBLOWING?

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***Whistleblowing in the Twenty-First Century:
Individual Corruption and Institutional Dysfunction***

by

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I should like to begin by reading to you a quotation which, I think, neatly summarises a health system in crisis:

The origins of this awful failure were complex and manifold; they stretched back through long years ...; they could be traced through endless ramifications of administrative incapacity – from the inherent faults of confused systems to the petty bunglings of minor officials, from the inevitable ignorance of Cabinet Ministers to the fatal exactitudes of narrow routine. In the inquiries which followed it was clearly shown that the evil was in reality that worst of all evils – one which has been caused by nothing in particular and for which no one in particular is to blame. The whole organisation ... was incompetent and out of date. ... There was an extraordinary overlapping of authorities, an almost incredible shifting of responsibilities to and fro. ... Thus the most obvious precautions were neglected, the most necessary preparations put off from day to day. ... Errors, follies, and vices on the part of individuals there doubtless were; but, in the general reckoning, they were of small account – insignificant symptoms of the deep disease of the body politic – the enormous calamity of administrative collapse.

You may be surprised to learn that the passage which I have just quoted does not apply to Queensland Health – or, I should say more accurately, was not written with specific reference to Queensland Health. Indeed, that quotation did not originate in Australia; nor was it penned with reference to a Twenty-First or even a Twentieth Century health bureaucracy.

I begin with this quotation for three reasons. One is to pay homage to a person who – although the term was not then invented – was, quite possibly, the first whistleblower in recorded history; a person who – though better remembered for achievements in other capacities – was certainly one of the greatest whistleblowers of all time. But I will return to this outstanding person a little later.

My second reason for commencing with this quotation is to make a point – perhaps a trite point, but an important point nonetheless: the point that, the more things change, the more they stay the same. As I hope to demonstrate, the need for conscientious whistleblowers, the obstacles which stand in their paths, and the techniques which they use to surmount those obstacles, have changed very little in 150 years.

But my primary reason for beginning with this quotation is to explain how my experience as Chairman of the Bundaberg Hospital Commission of Inquiry has convinced me that there is a fundamental distinction between two quite different bureaucratic diseases, which I term “individual corruption” and “institutional dysfunction”. Whistleblowers are just as vital in one case as in the other – but there is a marked difference between the roles of, and the challenges to, the conscientious whistleblower.

Individual Corruption

What we might term the “traditional” whistleblower situation involves an individual, or more commonly a group of individuals, who are somehow corrupt: they may be taking bribes – they may be misappropriating public funds or property – they may be using their positions to advantage themselves or their families or friends. This is the situation which I refer to as “individual corruption”.

The defining feature of individual corruption is that the individual or individuals concerned are, as it were, rowing against the tide: their conduct is contrary to the institutional interests of the organisation for which they are working; it is self-evidently wrong; it is morally indefensible.

In most public institutions, one can (I think) fairly assume that the majority are honest and decent people; people who want to do the right thing. So corrupt individuals tend to be at odds with the majority. Of course, many of the honest and decent majority will not wish to rock the boat; they will not stand up against the corrupt individuals. But they can be counted on, at least, to offer a silent prayer of thanks when somebody else has the courage to do so. Even if they do not actively support the whistleblower, it is unlikely that they will actively oppose the whistleblower.

I accept that there may be situations where individual corruption is so rife within an institution – or where the corrupt individuals hold positions of such seniority and power – that the conscientious whistleblower does not even have the silent collaboration, or the tacit support, of an honest and decent majority. The pre-Fitzgerald Queensland Police Force may well be an example of this. But such cases are, I believe (and I hope), quite rare.

One of the surprising features of individual corruption is that the corrupt individual or individuals are not necessarily bad at their job; indeed, they are often fairly good at it. After all, it takes some ingenuity – some “rat cunning” – to be corrupt; and the skills which enable a person to be successfully corrupt sometimes also enable that person to be successful at other levels. I have heard it suggested, for example, that the corrupt Queensland Police Commissioner, the former Sir Terrence Lewis, is still held in some regard even by “straight” police officers who, whilst deploring his corruption, acknowledge that he was a competent administrator. I have heard similar comments about the late Russell Hinze, Queensland’s corrupt “minister for everything” in the Bjelke-Petersen Government.

Still, even where individual corruption is rife within an institution, or where it infects the institution’s highest echelons, it remains self-evidently wrong; it remains morally indefensible. Otherwise decent individuals may reconcile their own consciences by telling themselves that “it was always thus”; they may justify their own inaction by reassuring themselves that there is nothing which they can do; they may ask the rhetorical question which has been asked by sycophants and cowards since time immemorial, “Why should I be the one who goes out on a limb?” Secretly, some may even look forward to the day when they, too, can get their snouts in the trough. But they know what is going on; and they know, in their heart of hearts, that what is going on is bad.

Individual Corruption and Institutional Dysfunction

This may be contrasted with the phenomenon of institutional dysfunction. There is no obvious wrong-doing – no apparent dishonesty – no self-evident moral turpitude. Within a dysfunctional institution, even the honest and decent majority may not know what is going on; and, if they do know what is going on, they may honestly believe that it is for the good.

Institutional dysfunction is a product of entrenched bureaucratic ineptitude. And, in a purely moral sense, nobody would deny that corruption is worse than incompetence. But at a practical level – at the level of *realpolitik* – the consequences of institutional dysfunction can be just as bad, and sometimes far worse.

Even in the darkest days of the pre-Fitzgerald Queensland Police Force, the institution was still effective, at least in some areas: murderers and armed robbers and rapists were still being caught; road traffic was still well regulated; public order was, for the most part, maintained; in emergency situations and natural disasters, the community still felt – and rightly felt – that they could turn to the police for help. Terry Lewis may have had his fingers in the till; but he still presided over an organisation which was not manifestly less functional than similar law-enforcement agencies in other jurisdictions, including those which were not tainted by top-down corruption.

Let us compare the pre-Fitzgerald Queensland Police Force with Queensland Health before Jayant Patel. It has not been suggested that a single bureaucrat at Queensland Health was “on the take”¹; that a single bureaucrat misappropriated public funds or property; that a single bureaucrat abused his or her position for personal advantage, or to benefit family or friends. Yet the death-toll from corruption in the pre-Fitzgerald Queensland Police Force remains at nil; the death-toll from institutional dysfunction in Queensland Health, solely from the incompetence of a single surgeon, stands at seventeen.

As I have said, even in the darkest days of the pre-Fitzgerald Queensland Police Force, the institution was still effective. Contrast that with:

- a health system in which something like one-in-thirty of the Queensland population is currently on a waiting list for health treatment, and a significant proportion of those will die before they reach the top of the list;
- a health system in which more than 6,000 people, already approved for surgery, have been waiting more than 12 months for their operations;
- a health system in which, according to reports as recently as February of this year, the numbers of patients requiring semi-urgent surgery (known as “category two” patients), and who have been kept waiting for longer than the 3-month maximum recommended by their treating doctors, had increased by more than 2½ times, whilst there has been an increase of more than 500% in the numbers of patients requiring urgent surgery (known as “category one” patients), who have been kept waiting for longer than the 30-day maximum recommended by their treating doctors;
- a health system which, despite increasing waiting lists, actually performed less surgery following a budget increase of almost \$500 million in October last year, than in the corresponding period of the preceding year;
- a health system in which the number of hospital beds in virtually every major hospital – from Cairns and Townsville in the North, to Rockhampton and Bundaberg in the central region, to the Princess Alexandra, Royal, and Prince Charles Hospitals here in Brisbane – has actually been downgraded over the last two decades;
- a health system which, according to the 2006 Productivity Commission “Report on Government Services”, had the lowest *per capita* recurrent health expenditure in the country, the lowest number of employed medical practitioners *per capita*, and, behind Western Australia, the second lowest number of employed nurses *per capita*;
- a health system which has, historically, paid its doctors and nurses less than healthcare professionals at equivalent levels almost anywhere else in Australia;

¹ there do, however, remain some unanswered questions regarding the involvement of the former Minister, Mr Gordon Nuttall, in approving an acquisition of land at the Sunshine Coast from a person with reputed ALP links, and who was allegedly involved in private dealings with Mr Nuttall – a matter which is currently being investigated by the CMC

- a health system which has become the subject of almost daily reports in the local media – genuine and real-life horror stories – of toddlers dying due to delayed transfers from regional hospitals; of patients left in the backs of ambulances because public hospital emergency departments are overcrowded; of road accident victims turned away from public hospitals because of inadequate staffing.

A cynic might well say that, if these are the consequences of institutional dysfunction, give me good, old-fashioned individual corruption any day!

The causes of Institutional Dysfunction

What, then are the causes of institutional dysfunction? The primary cause of individual corruption can be summed up in a single word: greed. The causes of institutional dysfunction are far more subtle and complex.

I. Incompetence.

Individual incompetence is undoubtedly a factor. But it is not the sole, or even the primary, factor. I would be the first to acknowledge that, of the tens of thousands of people working for Queensland Health, the great majority of them – especially the clinical staff: the doctors, the nurses, and the other healthcare professionals – are competent, committed, and well-intentioned people, who do a first-class job in appalling circumstances, at least whenever they are permitted to do so.

It is true that there is some incompetence, of which Jayant Patel is the outstanding example. But perhaps the enduring tragedy of Jayant Patel is the myth of a “rogue surgeon” who has become a scapegoat for everything that is wrong in Queensland Health. Patel is not, and never was, the problem: at his worst – and his worst was very bad indeed – he was no more than a by-product of an institution in crisis.

II. The size of the bureaucracy.

Bureaucratic over-administration, and indeed mal-administration, is at the heart of the problem. It takes some 9,250 bureaucrats – 9,250 bean-counters and pen-pushers – to run Queensland Health. That is more than double the number of hospital beds provided by Queensland Health, and more than 2½ times the number of medical practitioners employed by Queensland Health.

It is not simply the case that every dollar spent on administration is one dollar less that is available to spend on patient care. I have been told that as little as 20% of Queensland Health’s budget actually reaches the coal-face of health treatment. Even then, I would be the first to accept that 9,250 bureaucrats serve a useful purpose, if their presence in the system had the effect of making the delivery of health services more efficient – the effect of relieving some of the burden on healthcare providers. But, frankly, every indication is to the contrary: every indication is that these 9,250 bureaucrats simply create more red tape to impede, and ultimately to strangle, the clinical staff who provide primary health care services.

It is a truism to say that decision-making, unlike almost every other form of human endeavour, is retarded rather than accelerated by the number of people involved. A hole may be dug more quickly if there are 10 workers involved rather than one; but the decision where to dig the hole will be made much more quickly if it is left to one person rather than a committee of 10.

Professor C. Northcote Parkinson, the author of *Parkinson's Law*², offers statistical proof for what he terms "Parkinson's First Law": the proposition that "a Civil Service expands at an inexorable rate of growth, irrespective of the work (if any) which has to be done".

- One example he gives is the Royal Navy. As early as the 1930s, Parkinson had successfully predicted that the Royal Navy would eventually have more admirals than ships – an interesting contrast with a health service which has more administrators than the total number of hospital beds and doctors combined. Parkinson noted that, in 1914, "4,366 officials could administer what was then the largest navy in the world" – a navy comprising 542 capital ships and about 125,000 officers and men. By 1967, when the number of ships had fallen from 512 to 114, and the number of officers and men had declined to under 84,000, the number of public servants had risen from 4,366 to some 33,000 – a number, Parkinson concludes, "barely sufficient to administer the navy we no longer possess".
- Another example is the British Army, which – according to Parkinson – "need never shirk comparison with the Admiralty":
In 1935 a civilian staff of 9,442 sufficed to administer an Army reduced to 203,361 officers and men; the low-water mark of unpreparedness for a conflict which was by then obviously inevitable. By 1966 a civilian staff of 48,032 was giving encouragement to some 187,100 men in uniform, a 7.9% reduction in fighting strength being accompanied by a 408% increase in paperwork.
- Parkinson's third example is the British Colonial Office. In 1935, a mere 173 bureaucrats were sufficient to administer an empire which encompassed about a quarter of the world's population, and a similar proportion of its land mass. By 1960, the bureaucracy had grown from 173 to 2,827 – a sixteen-fold increase – despite the fact that the empire had virtually ceased to exist.

III. The Crisis in Decision-Making.

However, the problem is not simply that there is too much bureaucracy. If the bureaucracy were merely bloated, that would be a bad thing in itself, to the extent that a bloated bureaucracy soaks up resources which should be expended on health treatment. But the bureaucracy is not merely bloated – it is incapable of making decisions. The problem is not simply that there are too many people; the problem is also that they are the wrong people. They are the people who appear to lack either the intellectual capacity, or at least the self-confidence, to lead.

One clear manifestation of this is the committee system which exists within Queensland Health. No issue of any significance can be, or is, decided, unless it has been considered by a committee – or, as is more often the case, a myriad of different committees, examining the same issue from different viewpoints.

A cogent example of this emerged during the Inquiry. It involved a minor set of legislative amendments which the higher echelons of the bureaucracy regarded as essential. The evidence revealed that these amendments had been under consideration by the so-called "legislative projects unit" for some eight months. As I commented at the time (and I stand by my comment) "that project would take anyone – any competent lawyer – about half a day to finalise".

When Winston Churchill became Prime Minister in the darkest days of 1940, one of his first steps was to commission a supply of stickers, which he would subsequently affix to ministerial directions and memoranda, bearing the words "ACTION THIS DAY". Any contemporary politician who sought to emulate

² a book almost unique for the fact that it is often quoted (or perhaps I should say misquoted) by people who do not even know that there is a book of that name

Churchill's attempt to overcome bureaucratic inertia would need rather larger stickers, reading something like this:

- ACTION THIS DAY
or as soon as possible hereafter, once:
- (1) a business case study has been prepared;
 - (2) a detailed feasibility report has been obtained;
 - (3) an environmental impact statement has been commissioned;
 - (4) indigenous welfare issues have been fully addressed;
 - (5) approval has been given by the legislative standards committee;
 - (6) compliance with equal opportunity guidelines has been ensured;
 - (7) workplace health and safety implications have been reviewed;
 - (8) there has been compliance with the "Smart Directions Statement for Information Technology Conditions within the Queensland Government"³;
 - (9) appropriate consultation with community interest groups has been undertaken;
 - (10) the proposal has been submitted to the relevant inter-departmental review committee;
 - (11) all relevant ethical and integrity considerations have been satisfied in conformity with "whole of government" policy;
 - (12) detailed costings have been prepared and approved by Treasury;
 - (13) tenders have been let in accordance with the *Financial Accounting and Audit Act*, the whole-of-Government buying policy, and the Auditor-General's Guidelines;
 - (14) media releases have been prepared by the Department's media office in consultation with the Minister's press secretary; and
 - (15) the launch date has been confirmed with the Cabinet Office and all relevant Ministers and Heads of Departments.

IV. Misplaced Loyalties.

The fourth factor – and, I think, the most critical of all – is that an oversized bureaucracy tends to subvert the loyalties of the administrators who comprise it. Instead of caring about the people whom they are employed to serve, they care only about the institution by which they are employed. Their loyalty is to the department, and the people in charge of it, rather than the community. Bureaucrats become prone to a "them and us" mentality; the mentality that they, being an endangered species, have to stick together for their mutual protection. Other people – whether they be members of the public whom the public service supposedly exists to serve, or even those professionals (such as doctors and nurses) who actually have a focus on providing service to the public – are the enemy.

Thinking about the way in which I could best demonstrate this phenomenon, it seemed to me that a number of specific incidents which emerged from the Bundaberg Hospital Commission of Inquiry serve to make the point very tellingly:

- The first example concerns a document generated out of Queensland Health's headquarters in Charlotte Street – a so-called "risk rating matrix". This document, we were told, is designed to assist staff in categorising the seriousness of an adverse incident. A death – whether resulting from medical malpractice, or resulting from a workplace health and safety incident – is regarded as a "major" issue. On the other hand, "significant damage" to Queensland Health's own reputation is an "extreme" issue. I am candidly at a loss to understand how anyone can begin to understand the mentality of the bureaucrat (or committee of bureaucrats) who designed an official document which treats the death of a human

³ I am not making this up – there is actually a "whole-of-government" policy called the "Smart Directions Statement for Information Technology Conditions within the Queensland Government"

being – any human being, whether a patient in one of the Department’s hospitals, or even an employee of the Department – as being a less serious matter than an injury to the Department’s own reputation.

- The second example concerns another of the decisions generated out of Queensland Health’s headquarters in Charlotte Street – the decision to cover up the fact that the Department had hired, as a psychiatrist at the Townsville Hospital, a man whose credentials in psychiatry were later discovered to be forged. The local administrators in Townsville, to their credit, recognised that the Department had a plain duty to inform patients that the man who had been treating them was at best a charlatan, and at worst, in need of psychiatric treatment himself. But the administrators at Townsville Hospital were overruled by Charlotte Street, who – consistently with the so-called “risk rating matrix” – decided that the risk to Queensland Health’s own reputation overshadowed the need to ascertain whether, for example, this man had prescribed inappropriate mind-altering medications to patients who consulted him at a public hospital. Maybe the Charlotte Street bureaucrats could not have been expected to guess that this man was also (as has since been alleged) a practising paedophile, who took advantage of young patients under the pretext of providing them with psychiatric treatment. But, had they been aware of that fact, one supposes that it would only have strengthened the case for non-disclosure so as to protect Queensland Health’s reputation.
- The third example is the decision not to release – in other words, to cover up – a report which Queensland Health commissioned from two eminent independent specialists, to review the Orthopaedic Department at Hervey Bay Hospital. The report found serious deficiencies in the functioning of the Orthopaedic Department; it identified grossly inadequate clinical staff numbers; it expressed concern that the senior orthopaedic surgeon was unavailable to provide adequate supervision of more junior surgeons when operating; and it recommended that all orthopaedic surgical health care at Hervey Bay should cease, with the transfer of patients to hospitals capable of handling such cases. As Mr Davies noted in his final report:

... it would have been reasonably expected that, immediately Queensland Health became aware of any situation, such as that revealed at Hervey Bay, it would have respond to it appropriately regardless of whether the ... report became public or not. However, that just did not happen. Queensland Health delayed at several stages. Each had the consequence of permitting continuation of a serious risk of harm to patients.
- A fourth example involves similar bashfulness on the part of Queensland Health in disclosing another report which it commissioned – this time concerning the Emergency Department at Rockhampton. The report highlighted serious problems in the operations and staffing of the Emergency Department, as well as issues in relation to the inadequacy and misuse of information management processes; the provision of services that fell outside its core role, thus draining its resources; the fact that the Emergency Department was small, crowded, and unsuited to the volume of patients attending the Department; concerns that the Emergency Department’s triage practices fell short of accepted standards; and problems connected with the absence of clear lines of communication. The report was dated June 2004, but would probably never have seen the light of day unless its existence was revealed by a whistleblower to Queensland’s major daily newspaper, over a year later – only then did Queensland Health see fit to disclose it to the Inquiry.
- The fifth and final example which I would cite is Queensland Health’s palpable dishonesty in not only concealing, but also actively falsifying, waiting list statistics. To borrow Andrew Lang’s aphorism (as I have done before), Queensland Health uses statistics as a drunken man uses a lamp-post – for support, rather than for illumination.

The Whistleblower's role in cases of Institutional Dysfunction

I would never say that being a whistleblower is easy; but I suspect that being a whistleblower is easier when you are dealing with individual corruption, as compared with institutional dysfunction.

For one thing, in cases of individual corruption, you can confidently rely on your own moral compass to tell right from wrong. In cases of institutional dysfunction, there is no clear dichotomy between “right” and “wrong”.

Take the examples, just mentioned, arising from the Bundaberg Hospital Commission of Inquiry. A reasonable person, outside Queensland Health, may think it is obvious that, in each instance, the “wrong” decision was made. But, surprising though it may seem, I can tell you that, in each instance, there were witnesses from Queensland Health – very senior and highly-paid bureaucrats, some even possessing medical qualifications – who were prepared to testify on oath, not only that the decisions taken were the right ones, but that any different approach would assuredly have produced disastrous consequences. And I do not doubt, for a moment, that those witnesses honestly believed that that was the case.

A related problem facing the whistleblower, in cases of institutional dysfunction, is that it is often impossible to tell who is wearing the black hats, and who is wearing the white hats. Take the decision concerning the man held out to patients in Townsville as a qualified psychiatrist; the decision to conceal the fact this man was actually a fraud. When senior administrators not only seek to justify such a decision, but honestly believe that the decision was unarguably correct, it is but a small step – at least in the minds of the bureaucrats concerned – to concluding that anyone who takes a different view (such as the conscientious administrative staff in Townsville, who urged public disclosure) is, at best, an imbecile, and at worst, a malevolent trouble-maker.

What necessarily follows is that, in cases of institutional dysfunction, conscientious whistleblowers face the prospect of alienation, ostracism, antagonism, and active opposition, even from honest, decent and well-meaning workplace colleagues. I have no illusions as to how hard it must be for any public servant to “blow the whistle” on a corrupt individual or group of individuals. But how much harder is it for a public servant (say, one of the 9,250 bureaucrats at Queensland Health) to admit that the institution as a whole is bumbling and inept; that it is over-crowded with time-servers and seat-warmers; and that it wastes tens (if not hundreds) of millions of dollars each year on utterly vacuous and often counter-productive activities: on countless committees, ceaseless symposia, meandering meetings, contrived conferences, and crepuscular conclaves – on pointless paperwork, meaningless memoranda, worthless writings and useless utterances – on dubious data, spurious statistics and colourable collocations – on apocryphal announcements, prejudicial publicity, perjurious pronouncements and perverted propaganda – on pedantic practices, empty exercises, profitless procedures, and mindless machinations – on arrogant administration, officious oversight, circumlocutory circulars, desultory directives and superfluous supervision.

Such a whistleblower will not have a single friend. Certainly not amongst the 9,250 co-workers, whose jobs will be jeopardised if any serious attempt is made to improve the situation, and whose entire reason for being is called into question by denouncing the utility of what they do for a living. Certainly not amongst the departmental mandarins, whose competence is directly challenged, and whose prestige is threatened by the risk of down-sizing. And least of all amongst politicians, on either side of the political divide, who have presided over this administrative quagmire since its inception; who have hand-picked its comptrollers; who

have been happy to repeat the half-truths and dissimulations fed to them by departmental boffins to justify the current state of affairs; who have unquestioningly voted more funds to prop up the bureaucratic behemoth, even imposing new taxes and imposts for that purpose; and who are acutely aware of the political risks involved in admitting the mistakes which have undoubtedly been made, and attempting the fundamental restructuring which would undoubtedly be required to address those mistakes – especially if it should require (horror of horrors !) actually sacking a few thousand redundant public servants.

There can be no “smoking gun” to back up such a whistleblower – no immediate and conclusive proof of bureaucratic ineptitude – as contrasted with the situation where a phone tap, a hidden video recording, or even a review of bank records, can catch a corrupt individual red-handed. Often, only a detailed statistical analysis can reveal the extent of waste and duplication. And even then, there are two obvious defences open to the guilty parties: no statistical analysis can demonstrate, at least conclusively, that a different administrative regime could have managed things any more efficiently; and, at the very worst, the senior bureaucrats were only doing their best within an administrative system which has evolved over generations.

Florence Nightingale

Let me then return to the quotation with which I commenced. I hope you will agree that it bears repeating:

The origins of this awful failure were complex and manifold; they stretched back through long years ...; they could be traced through endless ramifications of administrative incapacity – from the inherent faults of confused systems to the petty bungle of minor officials, from the inevitable ignorance of Cabinet Ministers to the fatal exactitudes of narrow routine. In the inquiries which followed it was clearly shown that the evil was in reality that worst of all evils – one which has been caused by nothing in particular and for which no one in particular is to blame. The whole organisation ... was incompetent and out of date. ... There was an extraordinary overlapping of authorities, an almost incredible shifting of responsibilities to and fro. ... Thus the most obvious precautions were neglected, the most necessary preparations put off from day to day. ... Errors, follies, and vices on the part of individuals there doubtless were; but, in the general reckoning, they were of small account – insignificant symptoms of the deep disease of the body politic – the enormous calamity of administrative collapse.

That passage, from Lytton Strachey's *Eminent Victorians*⁴, summarises the conditions of the British Army's medical corps at the time of the Crimean War, when Florence Nightingale came to its rescue.

Nightingale is remembered for many things: as the woman who, almost single-handedly, created the modern nursing profession; as an early leader in the field of hospital design and organisation; as an innovative promoter of healthcare practices which are today regarded as commonplace, such as the importance of sanitation and hygiene, and of sound nutrition for both medical and surgical patients; as an opponent of practices which are today considered barbaric, including bleeding, blistering and purging, and the use of “medicinal” products based principally on opiates, alcohol, arsenic, and heavy metals; as practically the inventor of the process now known as “triage”; as one of the first healthcare professionals to repudiate differential treatment of patients based on class, religion, and race; as one of the first, also, to promote her staff solely on the basis of their skill and ability, rather than their class or contacts; and as a pioneer in education, not only for nurses, but for women generally.

Yet, above and beyond all these things, Florence Nightingale was a healthcare whistleblower. It is no exaggeration to say that her other achievements, as important as they were, would have come to naught, unless she had garnered political clout and harnessed public opinion to force change on a government and bureaucracy which were (quite literally) killing patients by their thousands – both in civil and in military hospitals – through a combination of indifference, incompetence, obstinacy and neglect. She achieved this in three ways: as a political activist; as a media operative; and finally through a Royal Commission.

⁴ Lytton Strachey, *Eminent Victorians*, chapter II “Florence Nightingale” (London: Chatto & Windus, 1918), available online at: <http://www.bartelby.net/189/201.html> (viewed 21 November 2006)

I. Florence Nightingale – the Political Activist

In the episode ***Dish and Dishonesty*** of the BBC comedy ***Blackadder the Third***, Edmund Blackadder (Rowan Atkinson) attempts to bolster Parliamentary support for the Prince Regent (Hugh Laurie) by having the incompetent Baldrick (Tony Robinson) elected to the “rotten borough” of Dunny-on-the-Wold – “a tuppenny-ha’penny place. Half an acre of sodden marshland in the Suffolk Fens with an empty town hall on it. Population: three rather mangy cows, a dachshund named ‘Colin’, and a small hen in its late forties.” This was easily accomplished, since the constituency had only one voter. Although obviously exaggerated, this is not an altogether inaccurate portrayal of British Parliamentary democracy prior to the ***Great Reform Acts*** of 1832.

It is no coincidence that Nightingale lived at the time of the ***Great Reform Acts***, which abolished “rotten boroughs” and, for the first time, extended the electoral franchise to a significant proportion of the UK’s male population. Until then, fewer than 10% of the adult male population – or 5% of the total adult population – were entitled to vote, and a significant number of Parliamentary seats were returned by ridiculously small electorates, often under the effective control of a single landowner. From 1832, politicians rapidly became aware that their remaining in office depended on their heeding public opinion.

Of course, Florence Nightingale, being a mere woman, was ineligible for election, and not even considered competent to vote. But she returned from the Crimean War a national hero. As Strachey observes⁵: “Scutari had given her knowledge; and it had given her power too: her enormous reputation was at her back – an incalculable force”. Whilst she could not cast a vote of her own, she had the capacity to influence how great numbers of the newly-enfranchised populace might exercise their democratic rights, and, therefore, to influence the policies of elected and aspiring politicians.

Nightingale therefore set about recruiting the three forces which she saw as being most influential to the formation of public opinion: the media; politicians; and official public inquiries. She assiduously, and unapologetically, used all three to convey her message to a receptive audience.

Her starting-point on the road to public prominence was being engaged by the Secretary for War, Sidney Herbert (later Baron Herbert of Lea), as superintendent of nurses in Scutari. Herbert was already – and remained – a close friend: so close, indeed, that Herbert’s letter to Nightingale, offering her the position, crossed in the post with a letter from Nightingale to Herbert, volunteering for it. But another important ally was already on her side: the press.

II. Florence Nightingale – the Media Operative

Just as it is no coincidence that Nightingale lived at the time of the ***Great Reform Acts***, it is likewise no coincidence that her experiences in Turkey during the Crimean War coincided with a new innovation in journalism – the first war correspondents:

During the 39 years that elapsed between Britain’s last war in Europe, the Napoleonic Wars, and the outbreak of the Crimean War in 1854, journalism was transformed. Technological advances such as the development of the telegraph had encouraged the public to demand accurate, informative and up-to date news from around the world. In order to satisfy these requirements, newspapers sent representatives to the Crimea to deliver unprecedented records of a war as it unfolded.⁶

⁵ Strachey, *ibid.*

⁶ “Reporting from the Front Line” in *The Journal* (publication of the Chartered Institute of Journalists), April/May 2004, at page 9, available online at:

<http://www.cioj.co.uk/Journal%20-%20May%202004.pdf> (viewed 27 July 2006)

Herbert's decision to send a contingent of nurses was prompted by press reports – especially by correspondents for *The Times*, William Howard Russell and Thomas Chenery. The latter provided a dispatch which was published on 12 October 1854:

... it is with feelings of surprise and anger that the public will learn that no sufficient medical preparations have been made for the proper care of the wounded. Not only are there not sufficient surgeons – that, it might be urged, was unavoidable – not only are there no dressers and nurses – that might be a defect of system for which no one is to blame – but what will be said when it is known that there is not even linen to make bandages for the wounded? The greatest commiseration prevails for the suffering of the unhappy inmates of Scutari, and every family is giving sheets and old garments to supply their want. But, why could not this clearly foreseen event have been supplied? ... It rests with the Government to make enquiries into the conduct of those who must have so greatly neglected their duty

Nightingale embraced media support with an enthusiasm which, today, might almost have her labelled as a “media tart”. Her arrival in Constantinople coincided with that of John Cameron Macdonald, also of *The Times*, responsible for administering large sums of money raised by that newspaper in a public appeal to aid the sick and wounded – possibly the first mass-media appeal of its kind.

Strachey reports that⁷: “when Lord Stratford de Redcliffe, our Ambassador at Constantinople, was asked by Mr Macdonald to indicate how the *Times* Fund could best be employed, he answered that there was indeed one object to which it might very well be devoted – the building of an English Protestant Church at Pera”. Macdonald was met by assurances, from the military and medical authorities, that the British Army did not require the assistance of private charity (least of all from a newspaper which had been highly critical of those same authorities), and that they lacked nothing that was required. It did not take him long to decide that better use could be made of the fund by putting it at Nightingale's disposal.

Nightingale's use of her media contacts continued as she found her reform proposals blocked by obdurate army officers and doctors. John Delane, the editor of *The Times*, took up her cause. After a great deal of publicity, Whitehall sided with Nightingale over the military and medical establishment, giving her authority to organise the barracks hospital and improve the quality of sanitation and ventilation.

Towards the end of the Crimean war, Nightingale transferred herself and some of her nurses to Balaklava in the Crimea. She immediately ran up against her principal bureaucratic nemesis – the inspector-general of hospitals, Dr John Hall – who argued that her authority was limited to Scutari. Again, the press came to Nightingale's aid, resulting in her official appointment as “general superintendent of the Female Nursing Establishment of the Military Hospitals of the Army”.⁸ Hall was later awarded the KCB (Knight Commander of the Order of the Bath) for his services in Crimea, and Nightingale suggested that “KCB” stood for “Knight of the Crimean Burial-grounds”.

III. Florence Nightingale and a Royal Commission

On returning to England, Nightingale pressed for the establishment of a Royal Commission to inquire into the state of the Army Medical Board. The War Office – and especially the head of the Army Medical Board, Dr Sir Andrew Smith – was vehemently opposed. They saw it as an attack on their professional competence, which indeed it was: if Nightingale had had her way, Smith would have been court-martialled⁹. But, as Strachey says¹⁰, the proposal for a Royal Commission “supported as it was by the Queen, the Cabinet, and the united opinion of the country, ... was impossible to resist.”

⁷ Strachey, *ibid.*

⁸ see David Wright., “The Historical & Cultural Development of Nursing”, on the *Nursing and Midwifery History UK* website provided by Sheffield University:

http://www.shef.ac.uk/~nmhuk/adltnur/online/Short_history.pdf (visited 27 July 2006)

⁹ see Sir Edward Cook, *The Life of Florence Nightingale* (London: Macmillan, 1913)

¹⁰ Strachey, *ibid.*

Although Nightingale herself was the chief protagonist, her friend, Sidney Herbert, was appointed as chairman: presumably, even amongst the doctors whose professional competence had been called into question, none had the gall to attack a Royal Commission established in response to intense public pressure, even by suggesting that the close friendship between Nightingale and Herbert created an “apprehension of bias” (though history does not record whether they ever actually shook hands).

Strachey explains what then happened¹¹:

The Commission met, and another immense load fell upon Miss Nightingale's shoulders. To-day she would, of course, have been one of the Commission[ers] herself; but at that time the idea of a woman appearing in such a capacity was unheard of; and no one even suggested the possibility of Miss Nightingale's doing so. The result was that she was obliged to remain behind the scenes throughout, to coach Sidney Herbert in private at every important juncture, and to convey to him and to her other friends upon the Commission the vast funds of her expert knowledge – so essential in the examination of witnesses – by means of innumerable consultations, letters, and memoranda. It was even doubtful whether the proprieties would admit of her giving evidence; and at last, as a compromise, her modesty only allowed her to do so in the form of written answers to written questions. At length the grand affair was finished. The Commission's Report, embodying almost word for word the suggestions of Miss Nightingale, was drawn up by Sidney Herbert. Only one question remained to be answered—would anything, after all, be done? Or would the Royal Commission, like so many other Royal Commissions before and since, turn out to have achieved nothing but the concoction of a very fat blue-book on a very high shelf?

Needless to say, Strachey's question is purely rhetorical – of course, nothing happened in response to the Royal Commission's report; or, at least, nothing would have happened, if it were not for an unremitting campaign by Nightingale herself. Nightingale again marshalled her media contacts, and “arranged for the Report to be reviewed in the most influential monthly and quarterly journals, and nominated the reviewers in collaboration with Herbert”.¹²

The report¹³ included extensive statistical tables and graphs – it was probably the first Royal Commission report to do so – and much of this material was supplied by Nightingale herself. “As part of her ‘flank march’ against the forces of resistance to medical reform, Nightingale had the statistical section of the report printed as a pamphlet and distributed widely in Parliament, the government and the army. She even had a few copies of the diagrams framed for presentation to officials in the War Office and in the Army Medical Department.”¹⁴

At first, there was little progress: the new Secretary for War opposed the implementation of any one of the Royal Commission's recommendations; and in this he was staunchly supported by Andrew Smith, who had somehow managed to survive as head of the Army Medical Board.

Matters came to a climax in relation to the building of a new army hospital, Netley, the current plans for which contradicted everything that Nightingale had been fighting for, and everything that the Royal Commission had endorsed. In desperation, Nightingale obtained an interview with the Prime Minister – who happened to be an old family friend – and won him over. He wrote to the War Secretary saying, “... all consideration of what would best tend to the comfort and recovery of the patients has been sacrificed to the vanity of the architect, whose sole object has been to make a building which should cut a dash when looked at from the Southampton river”.¹⁵

¹¹ Strachey, *ibid.*

¹² W.J. Bishop and S. Goldie, *A Bio-bibliography of Florence Nightingale* (London: Dawson's, 1962).

¹³ *Report of the Commissioners appointed to inquire into the Regulations affecting the Sanitary Condition of the Army, the Organization of Military Hospitals, and the Treatment of the Sick and Wounded*. Presented to both Houses of Parliament by Command of Her Majesty (London: H.M.S.O., 1858)

¹⁴ Cohen, *ibid.*, p.134

¹⁵ quoted in Strachey, *ibid.*

But not even the Prime Minister seemed capable of overcoming bureaucratic inertia. In the result, “the chief military hospital in England was triumphantly completed on unsanitary principles, with unventilated rooms, and with all the patients’ windows facing northeast”¹⁶.

Victory only seemed to come within Nightingale’s grasp upon the fall of the Palmerston Government, and the return of Sidney Herbert to the War Office. Yet to achieve political support for reform was only the beginning; Nightingale and Herbert still had to reckon with a far more powerful and intransigent opponent – the bureaucracy. In Strachey’s words¹⁷:

Sidney Herbert had consented to undertake the root and branch reform of the War Office. He had sallied forth into that tropical jungle of festooned obstructiveness, of intertwined irresponsibilities, of crouching prejudices, of abuses grown stiff and rigid with antiquity, which for so many years to come was destined to lure reforming ministers to their doom. “The War Office [said Miss Nightingale] is a very slow office, an enormously expensive office, and one in which the Minister’s intentions can be entirely negated by all his sub-departments, and those of each of the sub-departments by every other.” It was true; and, of course, at the first rumour of a change, the old phalanx of reaction was bristling with its accustomed spears. At its head stood ... a yet more formidable figure, the permanent Under-Secretary himself, Sir Benjamin Hawes – ... a man remarkable even among civil servants for adroitness in baffling inconvenient inquiries, resource in raising false issues, and, in short, a consummate command of all the arts of officially sticking in the mud. “Our scheme will probably result in Ben Hawes’s resignation,” Miss Nightingale said; “and that is another of its advantages.” Ben Hawes himself, however, did not quite see it in that light. He set himself to resist the wishes of the Minister by every means in his power.

To overcome the Department’s rearguard resistance, Herbert appointed himself to chair each of the sub-committees recommended by the Royal Commission: one to preside over physical alterations to military barracks and hospitals (improvements in ventilation, heating, sewerage disposal, water supply and kitchens); another to draft a sanitary code for the army; a third to establish a military medical school; and a fourth to reorganise the army’s procedures for gathering medical statistics. But the effort broke Herbert’s health. At the time of his death, an Army Medical School had notionally been established: there were sites but no buildings, professors but no salaries, requisition forms but no equipment.

In truth, Nightingale was never satisfied that the reforms demanded by the Royal Commission’s report were ever fully achieved; and what was achieved seemed, to her at least, to be quickly undone. Yet it can confidently be said that, but for her efforts following publication of the report, nothing would have been achieved at all.

Lessons from Florence Nightingale and Toni Hoffmann

There are obvious parallels between Florence Nightingale and another whistleblowing nurse who set out to expose the shameful condition of a public medical system, Toni Hoffmann.

Indeed, the parallels are disturbing. The root causes of the problem – governmental inaction combined with administrative paralysis – have not changed in over a century and a half. The forces which Hoffmann deployed to bring this situation to light are the same as those used by Florence Nightingale 150 years earlier: one conscientious politician (Mr Rob Messenger MLA, National Party Member of the Queensland Parliament for Burnett), a handful of competent and assiduous press reporters (most significantly Mr Hedley Thomas, then of *The Courier-Mail*), and a Royal Commission. And the outcome has been identical: a Ministry which either will not, or cannot, implement real reform; and a bureaucracy which actively obstructs every attempt to do so, regardless of the Government’s stated intentions.

¹⁶ Strachey, *ibid.*

¹⁷ Strachey, *ibid.*

The example of Dr Andrew Smith – the head of the Army Medical Board in Nightingale’s time, who somehow survived the Royal Commission, and then made it his business to defeat the Commission’s recommendations by every means at his disposal – is chillingly familiar. Just as in 1856 the War Office continued to recycle medical administrators whose indifference and incompetence had been fully exposed at a public inquiry, in 2006 Queensland Health continues to recycle the self-same individuals whose apathy and dereliction produced the disaster which they are now still pretending to address.

History, however, does not merely repeat itself; it gets worse. In 1856, when it came to selecting a chairman for the very organisation supposed to prevent any recurrence of the lethal problems which had been exposed at the Royal Commission, Herbert himself assumed the task. Nobody even contemplated the cynical possibility of appointing the discredited Dr Smith – or any of the other medical pen-pushers who had presided over the fog of organisational stupefaction, bureaucratic penny-pinching, departmental decrepitude, and medical maladministration, which cost so many patients their lives and limbs.

By contrast, in 2006, the Queensland Government has responded to the issues first brought to light by Toni Hoffmann by creating a “Health Quality and Complaints Commission” – on any view, an extremely progressive step – but has then appointed, as its first chairman, Dr John Youngman. Dr Youngman is a former Deputy Director-General of Queensland Health, and more recently has been employed as “a special advisor to the Minister for Health”¹⁸. It is not immediately apparent how the appointment of former top bureaucrat, and later Ministerial adviser, to this position can be reconciled with the “main objects” expressed in the legislation, which include “independent review and management of health complaints”¹⁹.

Dr Youngman was specifically identified, in unchallenged evidence at the Royal Commission, as the medical bureaucrat who studiously ignored pleas for urgent help by Bundaberg Hospital’s former director of surgery, Dr Charles Nankivell. His response – which did not even attempt to address Dr Nankivell’s safety concerns – was described in the report by Commissioner Geoff Davies QC as “trite”. For Dr Nankivell, Dr Youngman’s failure to address safety problems was “the straw that broke the camel’s back”, and he quit in disgust. His replacement, Dr Sam Baker, left for similar reasons, resulting directly in the hiring of the incompetent Jayant Patel.

Reacting to Dr Youngman’s appointment, Dr Don Kane, Queensland President of the Australian Salaried Medical Officers Federation, stated²⁰:

Our members tell us where issues affecting medical clinicians are concerned they have absolutely no faith in Dr Youngman in any role that involves the handling of complaints raised by clinicians. ... We have called repeatedly for evidence that a cultural change is occurring in Queensland Health, yet Dr Youngman’s appointment merely reinforces that what is happening on the ground does not match the rhetoric.

Dr Zelle Hodge, Queensland President of the Australian Medical Association, criticised the appointment process as resulting in a Commission “stacked with bureaucrats”²¹. Toni Hoffmann described Dr Youngman’s appointment as “terrible”, commenting that: “I’m very disappointed because I was hoping the new complaints commissioner would be someone completely independent of the old Queensland Health”²².

How did Dr Youngman – arguably the most inappropriate appointee for this job – get selected ? Supposedly, the appointment was to be made by an independent selection panel, following advertisements calling for “expressions of interest”, after eligible candidates had been interviewed. It is understood that about 150

¹⁸ *HealthMatters* (News and information from Queensland Health), volume 11 number 3 April 2006, at p.6

¹⁹ *Health Quality and Complaints Commission Act 2006*, section 3(1)(b)

²⁰ Australian Salaried Medical Officers Federation Queensland *Media Release*

²¹ *The Courier-Mail*, 28 June 2006

²² *The Courier-Mail*, 28 June 2006

applications were received, including applications from medical clinicians of the greatest standing and eminence, but it seems that few (if any) of these were even granted an interview.

The only explanation which has been forthcoming is this: whilst the (supposedly independent) selection process was under way, the so-called “Office of Public Service Merit and Equity” advised that “the matter is in the realms of being at the Ministerial level”²³. What makes this all the more troubling is that a representative of another institution which is supposed to operate as an independent watchdog – namely the Queensland Crime and Misconduct Commission – was actually a member of the selection panel which apparently buckled to ministerial pressure in appointing Dr Youngman.

In the mid-Nineteenth Century, the British public acclaimed Florence Nightingale as a national hero. Similar acclaim has deservedly been given to Toni Hoffmann. Nightingale lived to the ripe old age of 90, and, although an invalid suffering from what would probably now be diagnosed as Post Traumatic Stress Disorder²⁴, continued from her sick-bed to prosecute a relentless campaign for real improvements in public health standards. One hopes that Toni Hoffmann will enjoy a similarly long life, without the stress-induced ill-health which plagued Florence Nightingale. But one also hopes that, unlike Nightingale, Hoffmann will not have to spend the rest of her life lobbying and campaigning to achieve real reform, the need for which she so clearly demonstrated at a Royal Commission.

Sadly, Dr Youngman’s appointment suggests that such hopes are desperately unrealistic.

Conclusions

Toni Hoffman’s experience shows that the obstacles which stood in the way of the conscientious whistleblower in Florence Nightingale’s time have not lost any of their force in the intervening century and a half. But the combined experience of these two magnificent women also offers some guidance to the contemporary whistleblower who is attempting to blow the whistle on institutional dysfunction.

A Royal Commission or Commission of Inquiry can be a useful tool for such a whistleblower, after the event, but it can never be the starting-point. Unfortunately, one has to take the risk of blowing the whistle first, in the hope that this may lead to the establishment of a public inquiry, and ninety-nine times out of a hundred that will not happen.

A conscientious politician – like Sidney Herbert or Rob Messenger – can also be a very useful ally. But common experience suggests that one can never entirely predict a politician’s agenda, and the chances of securing an alliance with a politician as insightful and courageous as either Herbert or Messenger are slim.

Ultimately, the whistleblower’s best hope is with the press and media. Without in any way derogating from Mr Messenger’s role in Bundaberg, I can say quite emphatically that the problems identified, both by my Inquiry and the Inquiry chaired by Mr Davies – not only the specific problems in relation to Jayant Patel, but the wider problems of dysfunction within Queensland Health – would never have come to light if it were not

²³ email from the Office of the Public Service Commissioner dated 9 June 2006

²⁴ see Professor A.C. McFarlane (Department of Psychiatry, University of Adelaide), *The Traumatic Effects of Crime on Front Line Service Providers* (paper presented to “VICTIMS OF CRIME: WORKING TOGETHER TO IMPROVE SERVICES” Adelaide Conference, 25-26 May 2000). A fuller discussion of Nightingale’s own medical condition was given in the *British Medical Journal* by D.A.B. Young, formerly principal scientist of the Wellcome Foundation: “Florence Nightingale’s fever”, *BMJ* vol.311, pp.1697-1700 (23 December 1995), available online at: <http://bmj.bmjournals.com/cgi/content/full/311/7021/1697> (viewed 27 July 2006)

for the efforts of competent and assiduous journalists, with Mr Hedley Thomas at their forefront. Whether or not those problems will now be addressed in a meaningful way depends entirely on whether the press and media are prepared to continue pursuing the issue.

In this context, I should like to express my warmest congratulations to the Beattie Labor Government, here in Queensland, for proposing amendments to the **Whistleblowers Protection Act 1994**. Under these amendments, a person may make a public interest disclosure to a member of the Legislative Assembly, if after a period of 30 days, the ombudsman has not advised that the matter has been resolved to the ombudsman's satisfaction. Moreover, a person who makes a public interest disclosure to a member of the Legislative Assembly may then make that disclosure to a representative of the media, if, after a further period of 30 days, the matter has still not been resolved to the satisfaction of the ombudsman.

This is an important reform. But I would strongly urge the Government to take the next logical and necessary step – to amend the **Evidence Act 1977**, and enact a form of journalistic privilege, to allow journalists to protect the confidentiality of their sources. In my view, the arguments in favour of such a privilege are compelling.

A person who is in a position to “blow the whistle” will often be reluctant to do so, unless he or she is confident that the journalist will protect his or her anonymity as the source of the information; without a guarantee that journalists will protect their anonymity as the sources of information, many whistleblowers would not be prepared to blow the whistle, especially after other appropriate avenues of redress have been exhausted. Under the current state of the law in Australia, a journalist is unable to offer such a guarantee unless the journalist is prepared (if necessary) to risk imprisonment rather than complying with an order to disclose a source – indeed, within relatively recent times, a number of journalists have been imprisoned in Australia for refusing to disclose their sources²⁵. It is manifestly unfair, both to whistleblowers and to journalists, that a whistleblower's anonymity should depend entirely on whether or not the journalist concerned is willing to risk indefinite incarceration by placing his or her journalistic ethics above the law of the land; and there is an obvious public interest in ensuring that whistleblowers are able to report to journalists instances of misconduct by public officials, without fear that the journalist will be compelled to disclose the source of information under threat of imprisonment.

No doubt the formulation of any such privilege would have to be undertaken very carefully. There would have to be protections, both for journalists and for innocent victims, where a pretended whistleblower attempts to use the privilege as a cover to spread false and malicious allegations. On the other hand, the privilege might have to yield – in the same way that legal professional privilege yields – in cases where a greater public interest is at stake. But these are matters which can readily be addressed as part of a drafting process: the merits of the underlying principle, that journalists and their sources should be protected in respect of public interest disclosures, cannot, in my view, be rationally gainsaid.

²⁵ The most well-known example in Queensland is Joe Budd, a *Courier-Mail* reporter imprisoned by order of the Supreme Court of Queensland in 1992. Instances in other States include the journalists Tony Barrass (imprisoned and fined by a magistrate in Western Australia, 1989-90), David Hellaby of the *Adelaide Advertiser* (fined by the Federal Court, 1993), Chris Nicholls of the ABC (gaoled by the District Court in South Australia, 1993) and Deborah Cornwall of the *Sydney Morning Herald* (given a suspended sentence of imprisonment in New South Wales, 1993). Journalists who have been threatened with such punishment, but not in fact punished, include John Synott of *The Sun-Herald*, Madonna King of *The Australian*, and Paul Whittaker and Hedley Thomas of *The Courier-Mail*.